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
	24242	A. BUILDING: ______ B. WING ______	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF DES PERES	13460 MANCHESTER ROAD DES PERES, MO 63131

(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
A2019	19 CSR 30-85.022(10)(B) Fire Alarm System-Test/Maintain Complete Fire Alarm Systems. (B) All facilities shall test and maintain the complete fire alarm system in accordance with NFPA 72, 1999 edition. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure only authorized personnel could access, silence and reset the main fire alarm panel. This deficient practice had the potential to affect all occupants in the building. The facility had a capacity of 102 and a census of 74 at the time of survey. Observation on 10/2/24 at 7:38 A.M., of the main entrance sun room showed the facility's main fire alarm control panel mounted to the wall in a black metal enclosure with an open-swinging faceplate used to access the panel. The faceplate was unlocked and hanging open, leaving the panel accessible. Observation on 10/2/24 at 9:41 A.M., of the main entrance sun room showed the facility's main fire alarm control panel mounted to the wall in a black metal enclosure with an open-swinging faceplate used to access the panel. The faceplate was unlocked and hanging open, leaving the panel accessible. Observation on 10/2/24 at 11:38 A.M., of the main entrance sun room showed the facility's main fire alarm control panel mounted to the wall in a black metal enclosure with an open-swinging faceplate used to access the panel. The faceplate was unlocked and hanging open, leaving the panel	A2019		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Barron

TITLE: Senior Executive Director

(X6) DATE: 11/8/24

470 558 7127
barbara.barron@sunriseseniorliving.com

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A2019	Continued From page 1 accessible. During interview on 10/2/24 at 1:33 P.M., the facility's Maintenance Director said he expected the fire alarm panel to be kept locked and only accessible by qualified personnel in the facility. A contractor came out to do routine inspection and testing of the system on 9/30/24 and was given a key to the panel to access it, but had left it unlocked after the work was completed. Ensuring the panel is kept locked is the responsibility of the facility maintenance staff and the Maintenance Director. During interview on 10/2/24 at 2:28 P.M., the Administrator said she expected fire alarm panels to be kept locked per regulation guidelines. NFPA 72 (1999) 1-5.4.8 Alarm Signal Deactivation. A means for turning off activated alarm notification appliances shall be permitted only where it is key-operated, located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use.	A2019		
A2071	19 CSR 30-85.022(40)(A) Wastebaskets, Metal/UL/FM Trash and Rubbish Disposal Requirements. (A) Only metal or UL- or FM-approved wastebaskets shall be used for the collection of trash. II This regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure all trash cans were only metal or Underwriters Laboratory (UL) or Factory Mutual (FM) approved. This deficiency had the potential to affect all residents in three of nine smoke	A2071		

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A2071	Continued From page 2 compartments, in resident use areas. The facility had a capacity of 102 and a census of 74 at the time of survey. Observations during the Life Safety Code tour on 10/2/24 conducted between 7:31 A.M. and 2:28 P.M. showed: -In an office printing room near room 134, a gray plastic trash can with no UL or FM rating and lined with a plastic bag; -In room 121 to the left of the door, a small white plastic trash can with no UL or FM rating and lined with a plastic bag; -In room 123 near the doorway, a small black plastic trash can with no UL or FM rating and lined with a plastic bag; -In the "Wellness" room on the second floor, a medium-sized white plastic trash can with no UL or FM rating and lined with a plastic bag; -In the second floor Therapy gym, a small, black circular plastic trash can with no UL or FM rating and lined with a plastic bag. During interview on 10/2/24 at 11:10 A.M., the facility Maintenance Director said he expected all trash cans in the facility to be properly UL or FM rated, and the facility provides these for residents and in all office spaces. Often times family members will bring in trash cans that are not properly rated. Monitoring for properly rated trash cans is the responsibility of the maintenance staff and the Maintenance Director.	A2071		
A3048	19 CSR 30-85.032(48)(A) Additional Businesses-Requires DHSS Approval Only activities necessary to the administration of the facility shall be contained in any building used as a long-term care facility except as follows:	A3048		

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A3048	Continued From page 3 (A) Related activities may be conducted in buildings subject to prior written approval of these activities by the department. Examples of these activities are home health agencies, physician ' s office, pharmacy, ambulance service, child day care, food service, and outpatient therapy for the elderly or disabled in the community; II/III This regulation is not met as evidenced by: Class III Based on observation, interview and record review, the facility failed to obtain an active second business license from the Department of Health and Senior Services (DHSS) for a salon with an office in the building that provided services to facility residents. The facility's license for the salon as a second business expired on 8/31/23. The census was 74. Review of the facility's second business approval letter from DHSS, dated 8/26/21, showed: -The Section for Long-Term Care Regulation (SLCR) Second Business Committee has approved your request for the following additional businesses located in the intermediate care facility. This second business approval will be for a period of two (2) years; -If you wish to renew this approval, you must make a written request to the SLCR for a review forty-five (45) days before the expiration date of August 31, 2023; -Approved additional business included utilization of office space for a beauty salon. Observation on 10/2/24 at 11:45 A.M., showed the facility's beauty salon, located on the first floor of the facility. No second business approval was posted in the beauty salon or near the concierge	A3048		

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desk, where other licenses and certificates were posted. During an interview, Concierge E said the beauty salon is open every Monday.

During an interview on 10/2/24 at 11:21 A.M., the Executive Director (ED) said the facility has a beauty salon as a second business. The second business approval has expired and she is in the process of resubmitting for the approval. The approval expiration has not resulted in a lapse of services and the beauty salon is still operating as a second business with services provided. A new contract between the beauty salon and facility was signed on 9/30/24 and the next step is to submit the new contract and floor plan to the regulation unit for approval.

During an interview 10/2/24 at 4:06 P.M., the ED said she started working at the facility in February 2024. The previous ED should have re-submitted a request for second business approval, prior to its expiration in August 2023.

A4075 — 19 CSR 30-85.042(66) Nursing Care per Res Condition — A4075

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*

Based on interview and record review, the facility failed to monitor one resident (Resident #22), assessed as having advanced dementia or cognitive impairment, confusion about his/her environment, and who required standby

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assistance and a walker for mobility throughout an evening shift. Facility staff failed to make visual observation of the resident from between 9:30 P.M.-10:00 P.M. on 9/6/24 until 5:30 A.M. on 9/7/24, when the resident was found on the commode with no vital signs. Additionally, the facility failed to follow their policy and the resident's health care directive, when staff failed to provide timely 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 Resident #22 until Emergency Medical Services (EMS) arrived. The resident expired. The census was 74.

Review of the facility's Care Manger (CM) job description for resident care, dated September 2023, showed:
-Reviews, reads, notates, and initialized Daily Log to document and learn pertinent information about residents;
-Responsible for a designated group of residents during the shift, knows where the residents are, and physically checks on them throughout the shift.

Review of the facility's Cardiopulmonary Resuscitation (CPR) policy, dated June 25, 2005, showed:
-It is the policy of the community that a resident, who is found unresponsive, without a pulse, and does not have a Do Not Resuscitate (DNR, a physician's order instructing health care providers not to do CPR if the resident's breathing stops or the heart stops beating) Order, will have CPR initiated by a team member certified in CPR;
-A resident who is found unresponsive and without a pulse, the Team Member will:
-Validate the resident's code status, available on

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A4075	Continued From page 6 the SCC (no definition in policy-Executive Director (ED) said their software used for this was Point Click Care) and the resident's face sheet (first page of a medical record with the resident's demographics, medical diagnoses, family contacts, and physician contacts); -The CPR Certified Team Member will start CPR; -Continue CPR until Emergency services arrive and assume care for the resident; -There are a few exceptions where withholding CPR would be considered appropriate: -In the event a licensed healthcare professional (such as a physician, physician extender, Registered Nurse (RN), acting within established scope of practice in the jurisdiction, determines that the following signs are present, CPR will not be initiated: -Situations that would place the rescuer at risk of serious injury or mortal peril; -Clinical signs of irreversible death (rigor mortis, dependent lividity, decapitation, transection, decomposition); -A valid advance directive, a physician order for life-sustaining treatment indicating that resuscitation is not desired, or a valid DNR order; -The RN will document the event in the resident's progress notes: -The date and time the resident was found; -The time the emergency medical personnel were called; -The time the CPR was initiated or decision to not initiate CPR was made; -The time the physician was called; -The time the resident's legally responsible party family member was notified. Review of the resident's Service Estimate Health Assessment (SEHA, a systematic collection & analysis of health-related information for care planning and for calculating the resident's	A4075		

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activities of daily living or care level monetary rate), completed by the Resident Care Director (RCD) and the Assisted Living Coordinator (ALC) H, at the resident's home on 7/15/24 (two days before move-in) and completed at the facility on 7/17/24, showed:
-Diagnoses of:
-Chronic Obstructive Pulmonary Disease (COPD, obstruction of air flowing in and out of the lungs, is permanent, and becomes worse over time);
-Mild dementia;
-Psychotic disturbance (a collection of symptoms that cause a person to lose touch with reality);
-Mood disturbance (a disconnect between actual life circumstances and the person's state of mind or feeling);
-Anxiety;
-Hypertension (high blood pressure);
-Atherosclerotic heart disease of the coronary artery (buildup of plaque in a heart artery);
-Gastro-esophageal reflux disorder (GERD, chronic acid reflux into the esophagus);
-Sleep apnea (a sleep disorder that causes people to repeatedly stop or shallowly breathe while sleeping);
-Occlusion and stenosis of carotid artery (stenosis is a narrowing of the carotid artery, while occlusion is the complete blockage of the artery);
-Abnormalities of gait and mobility (unusual walking pattern that can range from subtle changes in rhythm and coordination to more pronounced disturbances);
-Health Care Directives:
-Health care directives, Yes;
-Durable power of attorney for healthcare, No;
-Living Will, No;
-Physician order related to code status, No;
-Focus-"My code status is Full Code";

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A4075	Continued From page 8 -General Assessment-Vital Signs: -Advanced dementia or cognitive impairment noted, Yes; -Alert and oriented to one, person; -Forgetful/short attention span noted, Yes; -Confused about environment noted, Yes; -Unable to remember recent events; -Unable to remember specific events; -Unable to remember the time (year, month, day of the month, time of day) -Unable to remember where they are; -Unable to remember recent events; -Intervention: Assist to all activities and meals, remind frequently what time of day it is, and current events; -Intervention: Observe for and report any changes in cognitive function, specifically changes in memory recall and general awareness, level of alertness, and mental status; -Cognitively unable to complete tasks; -Cognitively unable to focus; -Cognitively unable to exercise appropriate judgment; -Cognitively unable to handle personal affairs; -Cognitively unable to problem solve; -Cognitively unable to manage own finances; -Intervention-Give simple cues, prompts, and step by step direction to assist with decision making; -Intervention-Offer limited choices and options so resident may continue to make decision about care; -Skin conditions: -Exposed stent, with wires, sticking out of chest wall; -Fall risk factors: -Gait problems; -Impaired balance; -Impaired vision; -Intervention: Inform resident and caregivers	A4075		

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about safety reminders and what to do if a fall occurs;
-Intervention: Remind resident to rise and change positions slowly;
-Activities of Daily Living (ADL) assessment:
-Standby assistance required for mobility;
-Walker needed for mobility assistance;
-Standby assistance required for transfers;
-Independent with grooming, oral care, dressing, use of bathroom, dining, and bathing;
-A shower/tub chair needed to assist with bathing/showers;
-The resident needs to be shown to and from the dining area, and to his/her room, to orientate to surroundings.

Review of the resident's Physician Order Sheet (POS), dated 9/7/24, showed:
-7/16/24-Full Code;
-7/17/24-Admission date.

Review of the resident's Bedside Individual Service Plan (ISP,written details of the resident's supports needed, and the best way to prove them, created via a person-centered planning process that involves assessments to gather information about the individual's needs, goals, abilities, health, and other available supports), no date, showed:
-Code Status: Notify the resident's responsible party and physician of any changes in clinical status;
-Memory, cognition, and approach: Offer limited choices and options so the resident may continue to make his/her own decision about care;
-Assistive devices: When not in use, store the assistive device;
-Mobility: The resident needs a walker to assist with mobility;
-Dressing: The resident is independent;

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-Grooming: The resident is independent;
-Toileting: The resident is independent;
-Bathing: The resident is independent;
-Transferring: The resident is independent.
-There were no instructions for staff to prompt, and oversee, the resident for all his/her ADLs.

Review of the resident's Individual Service Plan, initiated 7/17/24, showed:
-Focus-Code status is full code;
-Intervention-Notify the resident's responsible party and physician of any changes in clinical status;
-Focus-The resident is unable to remember his/her surroundings, year, or recall events;
-Intervention-Assist with all activities and meals, remind frequently the time of day and current events;
-Focus-Impaired cognitive function related to dementia;
-Intervention-Give simple cues, prompts, and step by step directions to assist with decision making;
-No documentation directing staff on the frequency of rounds.

Review of the resident's medical record on 9/27/24, showed no advanced directives (a legal document that outlines a person's medical care preferences and designates a surrogate decision maker if the resident is unable to communicate their wishes).

Review of the resident's progress/nursing notes, showed:
-7/17/24 at 4:31 P.M., Licensed Practical Nurse (LPN) F documented the resident was alert and oriented one to two (knew his/her name and sometimes knew where he/she was), will need reminders for mealtimes and activities, and will

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need cues for ADLs. The resident did not take any routine medications;
-7/18/24 at 2:57 P.M., LPN G documented the resident was alert and oriented to self only;
-7/19/24 at 10:52 A.M., LPN F documented the resident required cueing for ADLs;
-7/22/24 at 1:46 P.M., LPN F documented the resident continued to require cueing for ADLs;
-7/23/24 at 3:40 P.M., LPN F documented the resident was alert to self only.
-8/27/24 at 1:28 P.M., LPN F documented the resident was alert and oriented to self only, able to make simple needs known, required directions when coming out of room;
-9/7/24 at 5:30 A.M., late entry, RCD documented he/she was called at 5:30 A.M. by the Certified Medication Technician (CMT) B who said the resident was found on the toilet at 5:30 A.M. and was not responsive. He/She instructed CMT B to call 911 as the resident was a full code. CMT B called back at 5:56 A.M. to report 911 responded and the resident had expired. CMT B was advised to call the Wellness Nurse, scheduled for work that morning, to request number for the Medical Examiner;
-9/7/24 at 12:59 P.M., LPN C documented CMT B and CM A found the resident unresponsive in his/her bathroom, on the toilet, around 5:30 A.M., was not breathing, and did not have a heartbeat. Emergency Medical Services (EMS) and the RCD were called. EMS gave 5:30 A.M. as the time of death. CMT B called the family to inform them of the resident's death. The facility's medical director was contacted and gave the cause of death as myocardial infarction (MI) and coronary artery disease (CAD).

Review of the Facility's final Investigation Report, dated 9/25/24 at 12:00 P.M. by the ED, and received 9/27/24, showed:

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-CM A opened the resident's door at 3:30 A.M. to check on him/her. CM A yelled the resident's name, he/she did not respond, and he/she did not lay eyes on him/her. At 5:30 A.M., CM A was making last rounds, went into the resident's room, to get the trash, and found the resident deceased on his/her toilet;
-CM A was placed on leave during the investigation (no date placed on leave given);
-Summary of interview with staff responsible for oversight and supervision of the location where the alleged victim resided:
-CMT B was on duty when CM A came to get him/her, after finding the resident deceased on the toilet. CMT B called 911, EMS arrived and pronounced the resident deceased;
-Summary of interview with staff responsible for oversight of the alleged perpetrator: (No interview information provided, with CM A's direct supervisor.)
-Conclusion of the investigation:
-The allegation was verified that CM A failed to check on the resident during his/her 3:30 AM rounding, after the resident did not respond to him/her.

Review of CM A's email statement, dated 9/30/24 at 3:19 P.M., showed his/her first round was at 3:30 A.M., at which time the resident did not respond when his/her name was called from the door. CM A thought the resident was in a deep sleep and did not enter the room to check on him/her. CM A's next round was at 5:30 A.M., when the resident was found in his/her bathroom, on the toilet, and appeared asleep. CM A called the resident's name, five or six times, got no response, and instantly panicked. He/She ran out of the room, yelling "(Resident #22) is dead." CMT B rushed down the hall and they both went into the resident's room. CMT B called the

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SUNRISE OF DES PERES	13460 MANCHESTER ROAD DES PERES, MO 63131

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resident's name and when there was no response, he/she touched the resident's neck and wrist, said he/she was dead, and said they have to call the paramedics for help.

During an interview on 10/3/24 at 2:28 P.M., CM A said when he/she arrived at work on 9/6/24 around 10:30 P.M., CM M and CM N said they had just completed rounds, the residents were all changed and were okay and all there was left to do was the laundry. CM A said that night, he/she did not do his/her normal routine, because of what CM M and CM N had said. There was a lot of laundry to fold, including all the dining room tablecloths and napkins, so first rounds were not done on the resident until 3:30 A.M. that night. CM A said, rounds are to be done "every two hours," but he/she was late because of the laundry. CM A said the resident was independent and did not need checking on every two to three hours, according to management and the direct care staff. ALC H, who hired him/her and explained how to do his/her job on the night shift, said the residents who are considered self-care or independent, do not need to be checked on all the time. ALC H even wrote, next to each resident's name on the sheet that tells them what to do, who needed checking on frequently because they needed changing, and those who did not need checked on because they were independent. At 3:30 A.M., he/she opened the resident's door, called his/her name a few times, but there was no answer. He/She could not see the resident's bed from the door, because the bed was on the window side of the room. CM A did not walk into the room to check on the resident because he/she thought the resident was in a deep sleep. CM A started calling the resident's name from the door, because when he/she first moved to the first floor, he/she had to walk all the

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A4075	Continued From page 14 way into the room, "to get up on (him/her) in bed," to see if he/she was breathing because he/she did not snore, and it scared him/her. That was why he/she started calling the resident's name from the door, so he/she would not get scared/startled. Sometimes the resident would get up, go to the door, and talk to him/her, and sometimes he/she would not respond. CM A did rounds around 5:00 A.M., and walked into the resident's room at 5:30 A.M., because he/she had to pull everyone's trash. CM A saw the resident was not in bed and when he/she walked to the bathroom, the sensor light came on and he/she saw the resident sitting on the toilet, and it looked like he/she was asleep. CM A started calling the resident's name, over and over, because he/she did not move. CM A knew the resident was dead because the resident did not respond. One of the resident's arms was hanging down and it was gray. He/She was too scared to touch the resident's body. CM A called his/her name so many times, then ran down the hall and told CMT B he/she thought the resident was dead. CMT B was close by, at the medication cart on the first floor, preparing to start passing medications. CMT B rushed to help, touched the resident's wrist and neck, then said to call 911. CMT B made the 911 call. CM A was not sure if CMT B called 911 first or called the RCD first. CM A said none of them knew the resident was a full code, and had it not been for CM N, calling out from upstairs, "is (he/she) a full code," no one would have known. CMT B then checked and said he/she was a full code. When asked why CPR was not started, CM A said he/she knew what to do, because he/she was CPR certified, but he/she panicked because no one had ever died on him/her before. CM A had not been told, or shown, how to find a resident's code status and had not been told if a resident is a full code, CPR	A4075		

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must be started immediately, no matter how long the resident may have been without vital signs, and continued until EMS arrives. The only training he/she received at the facility, was on the computer training modules. They showed him/her, after the resident's death, how to look up the residents' code status in their electronic work tablet and he/she kind of remembers how to do it.

Review of CM M's statement, dated 9/20/24 (no time), handwritten by the ED, showed CM M was assigned to the resident on the evening shift of 9/6/24 and the resident was not acting different, other than he/she did not want to get up and go to dinner. The resident said he/she was not hungry and would eat some snacks in his/her room. The resident was in bed, but that was normal for the resident. The last time CM M rounded on the resident was around 9:30 P.M. to 10:00 P.M. and the resident was lying in bed, and the bathroom light was on. CM M asked the resident if he/she needed anything, and the resident said no, he/she was okay.

During an interview on 10/2/24 at 8:47 A.M., CM M said on 9/6/24 he/she worked the evening shift on the first floor, with CM N, and moved to the second floor for the night shift. CM N was new and was also working the night shift to train with CM A, on the first floor. The last time they (CM M and CM N) saw the resident was sometime between 9:30 P.M. and 10:00 P.M. on 9/6/24, when they made their last rounds. The resident was in bed, was asked if he/she needed anything, and the resident said he/she did not want dinner. The resident had been sleeping a lot the last two weeks. CM A came in early, as usual, between 10:00 P.M. and 10:30 P.M. that night. They told CM A, that when he/she goes to check on the residents they should be fine because they had

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just done rounds on everyone. CM M said he/she never told CM A he/she did not have to do rounds.

During an interview on 10/2/24 at 10:54 A.M., CM N said on 9/6/24 he/she worked the first floor with CM M, then worked the night shift, for the first time, on the first floor with CM A. They (CM N and CM M) last saw the resident in bed asleep, sometime between 9:00 P.M. and 10:00 P.M. that night. CM A did not want to do rounds when he/she first got there. CM N said rounds should be done every two hours. CM N said he/she did not really do anything on the night shift, because CM A never asked for any help, so he/she spent most of the time in the office doing computer module training for work. CM N went to the second floor, toward the end of the shift, to help CM M. CM N recalled looking down to the first floor (first and second floors have a large open balcony in the middle) when he/she heard CM A, sometime between 5:00 A.M. and 6:00 A.M., calling the resident's name over and over. CMT B overheard CM A saying the resident was dead on the toilet. CM N said nobody did CPR and CMT B said the resident was a DNR. CM A was in shock, he/she was just standing there and did not know what to do. CMT B was yelling at someone on the phone, saying "(He/She) is on the toilet dead."

Review of CMT B's statement, dated 9/20/24 at 12:00 P.M., typed and signed by the ED, showed CM A came and got him/her around 5:00 A.M. to 5:30 A.M., on 9/7/24, and said he/she thought the resident was dead. CMT B checked for a pulse and could not find a pulse. CMT B then called the RCD, who instructed him/her to call 911. While CMT B called 911, CM A called the resident's family. The paramedics arrived and

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said they would not start CPR because the resident was deceased. The paramedics left. CMT B said he/she did not see the resident during the night shift before he/she was found without a pulse.

During an interview on 10/1/24 at 10:18 A.M., CMT B said the resident was quiet, never used his/her pendant (to call for help), was easy to overlook, which was why he/she was moved from the second floor to the first floor on 8/16/24. The resident had dementia and needed to be told/prompted to put on his/her pajamas, go to bed, and everything else. The resident needed to be checked on every two hours, because that is a universal rule of nursing. CMT B did not know if CM A knew this, and never talked to CM A about it. CMT B did not know if CM A did resident rounds. On 9/7/24, CM A said he/she thought the resident was dead. CMT B never had a resident die on his/her shift, and he/she panicked. He/She checked for a pulse, there was no pulse, and the resident's hands were gray. CMT B found out the resident was a full code from the computer. CMT B then called the RCD and then called 911. CMT B was CPR certified. When asked why he/she did not start CPR, or ask CM A to start CPR, when he/she discovered the resident was a full code, CMT B said, "My mind wasn't on that, it was on calling the RCD and calling 911. I was anxious and in shock. I never had a resident die on me, ever." CMT B then said he/she called 911 first, before the RCD, and the RCD did not tell him/her to call 911 or to do CPR.

During an interview on 10/2/24 at 8:11 A.M., Lead Care Manager (LCM) L said if you did not go into the resident's room and prompt him/her to go eat, he/she would never come out. The resident was not independent with anything. He/She needed

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prompts and oversight for everything. When asked if the resident needed to be checked on every two hours, LCM L said, "All residents need to be checked on every two hours, by going into their room, except for the ones who did not want to be checked on and the ED said they did not have to be checked on."

During an interview on 9/27/24 at 12:42 P.M., the RCD said CMT B called him/her at 5:32 A.M. (according to the time in her cell phone), on 9/7/24, and said they had found the resident on the toilet, and the resident appeared deceased. There was panic in CMT B's voice, which made him/her think it had just happened. He/She did not think to tell the CMT to start CPR, because he/she did not think he/she needed to tell that to a CMT. She immediately told CMT B to call 911 because the resident was a full code. The RCD did not ask any questions, because the priority was getting EMS there as soon as possible. In hindsight, he/she should have told CMT B to call 911 and start CPR. Staff are not allowed to stop CPR until EMS arrives to take over.

During an interview on 9/26/24 at 12:30 P.M., LPN C said the CMs have tablets they are to carry with them, and it has the residents' code status in it. They also have paper charts on the residents, that are locked in the nurse's office, which have a purple sheet of paper in the front of the chart for those who are DNR and a white sheet, or no sheet, for those who are a full code. However, only the nurses and CMTs have a key to the nurse's office. LPN C did not know the process CMs used to access residents' code status on their tablets and said that was an Assisted Living Coordinator question.

During an interview on 9/26/24 at 12:30 P.M.,

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LPN F said the CMs should check on the residents at night, every two to three hours. They all have keys to the resident's rooms and not all the residents lock their doors at night. LPN F did not know if staff knew they were to provide CPR for a full code resident, even if they thought the resident was clearly deceased.

During an interview on 9/27/24 at 2:44 P.M., CMT J said if he/she found a resident not breathing and without a pulse, he/she would inform the nurse, then look in the computer to see if the resident was a full code.

During an interview on 9/27/24 at 3:06 P.M., CM T K said if he/she found a resident without a pulse he/she would do CPR until he/she couldn't. When asked how long CPR should continue until stopped, he/she said, "two or three minutes."

During an interview on 9/26/24 at 4:18 P.M., ALC I said all the CMs must do is log into Point Care Click (PCC, electronic medical record software) on their tablet and the code status is there.

During an interview on 9/26/24 at 11:27 A.M., the ED said the resident was clearly deceased and she did not realize staff had to start CPR on someone who was clearly deceased. Licensed nurses are only in the building on the day shift and all CMTs are CPR certified. The two staff, CM A and CMT B, who found the resident deceased were CPR certified. They called 911 and upon arrival, EMS did not do CPR either. The ED said the facility had no rounding policy with no specific frequency to round on the residents. The CMs' job description is the only thing they have which addresses rounding. The CMs are to do frequent rounding, but not on the residents who have said they did not want to be checked on

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during the night. The resident was independent and there was no policy which said the staff needed to make rounds on residents every two hours. The ED said the CMs are to open the resident's door and go into the room, to look at the resident. CM A admitted he/she did not check on the resident until 3:30 A.M., at which time CM A opened the resident's door, called his/her name, received no response, and closed the door. CM A failed to lay eyes on the resident. CM A found the resident, in the bathroom on the toilet, at 5:30 AM with a dead appearance. The ED said she is "not over" direct care staff and did not know if staff had been inserviced regarding CPR administration when a resident is a full code, and that staff cannot declare a resident deceased.

MO00242417

* The higher classification merited due to the extent of the violation.

NOTE: At the end 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 exit visit, it was determined the facility had implemented corrective action to address the imminent danger at the time. During the onsite visit, staff were inserviced regarding validation of code status, CPR policies and procedures and rounding responsiblities. 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.

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A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to post visual alerts to notify staff and visitors of the need to adhere to transmission-based precautions (TBP, additional infection control precautions taken for residents who may be infected or colonized with infectious agents to prevent infection transmission) with use of personal protective equipment (PPE) when entering the rooms of residents who tested positive for COVID-19. The facility identified 11 residents who tested positive for COVID-19, of which problems were found with nine (Residents #7, #4, #13, 8, #19, #21, #18, #24 and #20). The census was 74. Review of the facility's COVID-19 Mitigation and Response Plan, revised 5/15/24, showed: -COVID-19: COVID-19 can be introduced into a community and spread by residents, team members, and/or visitors when an infected person breathes out droplets and small particles of the virus. These particles may then be inhaled	A4086		

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by others or pass through the mucous membranes of the eyes, nose, or mouth. Anyone infected with COVID-19 can spread the virus, even if they do not have symptoms of illness;
-When illness is present, use precautions to prevent spread;
-Standard (precautions used to care of all residents regardless of their diagnosis or presumed infections status) and airborne precautions (precautions that reduce the risk of an airborne transmission of infectious airborne droplets):
--In addition to standard precautions, airborne precautions are implemented for residents with suspected or confirmed COVID-19 (including residents taking antiviral therapy) for 5 days after symptoms improve or until 24 hours after the resolution of fever without fever-reducing medications. Airborne precautions include:
---Wear a respirator mask (e.g., N95 or KN95) upon entering the resident's room;
---Communicate information about residents with suspected, probable, or confirmed influenza to appropriate team members. (The policy did not specify how information would be communicated.)

Review of the CDC's Infection Control Guidance for SARS-CoV-2 (a strain of coronavirus that causes COVID-19), dated 6/24/24, showed:
-This guidance applies to all United States settings where healthcare is delivered, including nursing homes and home health. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency;
-Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic:
--Establish a process to identify and manage

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individuals with suspected or confirmed SARS-CoV-2 infection;
-Ensure everyone is aware of recommended IPC practices in the facility;
-Post visual alerts (e.g., signs, posters) at the entrance and in strategic places. These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations;
-Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others if they have any of the following three criteria:
-A positive viral test for SARS-CoV-2;
-Symptoms of COVID-19, or;
-Close contact with someone with SARS-CoV-2 infection or a higher risk for exposure (for healthcare personnel (HCP));
-For example:
-Provide guidance about recommended actions for patients and visitors who have any of the above three criteria;
--Implement universal use of PPE for HCP;
-Recommended IPC practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection:
--Patient placement:
-Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so);
--PPE:
-HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

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1. Review of Resident #7's medical record showed:
-Diagnoses included chronic kidney disease, history of COVID, atrial fibrillation (irregular heart beat) and dementia;
-A progress note, dated 10/1/24 at 5:27 P.M., showed the resident tested positive for COVID on 10/1/24. Resident in isolation times five days. PPE in place.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:11 A.M., showed the resident's door closed. No signs were posted on the resident's door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene).

Observation on 10/5/24 at 8:51 A.M., showed no sign was posted on the resident's door regarding isolation precautions. During an interview, the resident said he/she is waiting for staff to deliver breakfast to his/her room. He/She normally eats in the dining room, but yesterday, they told him/her she has to stay in his/her room because he/she has COVID. He/She is not sure how long he/she has to stay in his/her room.

2. Review of Resident #4's medical record showed:
-Diagnoses included heart failure, high blood pressure and Alzheimer's disease;
-A progress note, dated 10/1/24 at 2:36 P.M., showed the resident tested positive for COVID on 10/1/24. He/She has runny nose, hoarse, and stated he/she feels head congestion. Resident

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	24242	A. BUILDING: ______ B. WING ______	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF DES PERES	13460 MANCHESTER ROAD DES PERES, MO 63131

(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
A4086	Continued From page 25	A4086		

was on isolation for five days and staff to use PPE when entering room for care.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:17 A.M., showed the resident's door was closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). No PPE caddy was outside of the resident's room. The resident opened the door of his/her room and stood in the doorway. During an interview, the resident said he/she is waiting on breakfast. He/She has COVID and is not supposed to go to the dining room. He/She cannot leave his/her room.

3. Review of Resident #13's medical record showed:
-Diagnoses included dementia;
-A progress note, dated 10/1/24 at 3:16 P.M., showed the resident tested positive for COVID on 10/1/24. Resident to be on isolation in room for five days, staff to wear PPE when providing care. Resident has been reminded multiple times to keep his/her door closed to keep the spread of infection to a minimum. Resident has increased weakness and nasal congestion.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:05 A.M., showed the door to the resident's room open with no signs posted on or near the door regarding

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transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). No PPE caddy was outside of the resident's room. The resident in his/her bed with eyes closed.

4. Review of Resident #8's medical record showed:
-Diagnoses included diabetes, hypertensive heart and kidney disease without heart failure, atrial fibrillation and stroke;
-A progress note, dated 10/1/24 at 2:46 P.M., showed the resident tested positive for COVID on 10/1/24. Isolation for five days. Resident complained of general malaise, runny nose.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:17 A.M., showed the resident's door closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). No PPE caddy was outside of the resident's room.

5. Review of Resident #19's medical record showed:
-Diagnoses included diabetes, high blood pressure, atrial fibrillation and heart disease;
-A progress note, dated 10/1/24 at 3:31 P.M., showed the resident tested positive for COVID on 10/1/24. Resident to be on isolation for five days and staff to wear PPE when providing care. Resident complained of weakness and nasal drainage with congestion.

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A4086	Continued From page 27 Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed. Observation on 10/2/24 at 8:09 A.M., showed the resident's door closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). A PPE caddy was outside of the resident's room. The resident opened the door and walked down the hall with no mask on. 6. Review of Resident #21's medical record showed: -Diagnoses included bronchitis (inflammation of the lining of the tubes that carry air to the lungs), heart disease, high blood pressure, atrial fibrillation and chronic kidney disease; -A progress note, dated 10/1/24 at 2:59 P.M., showed the resident tested positive for COVID on 10/1/24. Resident will be on isolation for five days, staff to wear PPE when entering room for care. Resident has a runny nose with green nasal drainage. Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed. Observation on 10/2/24 at 8:05 A.M., showed the resident's door closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). No PPE caddy was outside of the resident's room. 7. Review of Resident #18's medical record	A4086		

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showed:
-Diagnoses included acute respiratory failure, malignant neoplasm (cancer) of unspecified breast, high blood pressure, tachycardia (increased heart rate), seizures and dementia;
-A progress note, dated 10/1/24 at 3:07 P.M., showed the resident tested positive for COVID on 10/1/24. Resident will be on isolation for five days and staff to wear PPE when providing care.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:22 A.M., showed the resident's door closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). No PPE caddy was outside of the resident's room.

8. Review of Resident #24's medical record, showed:
-Diagnoses included pneumonitis (inflammation of lung tissue) due to inhalation of other solids and liquids, history of COVID, high blood pressure, diabetes, acute kidney failure and stroke;
-A progress note, dated 10/1/24 at 3:38 P.M., showed the resident tested positive for COVID on 10/1/24. Resident is on isolation for five days and staff to wear PPE when providing care. Resident complained of generalized weakness and head congestion.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

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Observation on 10/2/24 at 8:11 A.M., showed the door to the resident's room open with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). A PPE caddy was outside of the resident's room.

9. Review of Resident #20's medical record showed:
-Diagnoses included malignant neoplasm of right kidney, chronic kidney disease, diabetes, heart disease, high blood pressure, and atrial fibrillation;
-A progress note, dated 10/1/24 at 3:24 P.M., showed the resident tested positive for COVID on 10/1/24. Resident to be on isolation for five days and staff to wear PPE when providing care. Resident complaint of general malaise and head congestion.

Review of the facility's list of residents who were COVID positive or with COVID symptoms, provided 10/2/24, showed the resident listed.

Observation on 10/2/24 at 8:09 A.M., showed the resident's door closed with no signs posted on or near the door regarding transmission based precautions, including current infection prevention and control recommendations (e.g., when to use source control and perform hand hygiene). A PPE caddy was outside of the resident's room.

10. During an interview on 10/2/24 at 11:55 A.M., Care Manager (CM) D said yesterday morning, one resident on the second floor tested positive for COVID. The nurses started testing residents and by lunch, several more residents tested positive for COVID. Many of the residents were

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SUNRISE OF DES PERES	**13460 MANCHESTER ROAD** **DES PERES, MO 63131**

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asymptomatic. Once residents tested positive, staff placed PPE caddies outside of their doors. Signs should be posted on their doors to show they are on precautions. Staff should wear full PPE in the rooms of COVID positive residents, including N95 masks, gowns, and gloves. The signs posted on resident rooms tell staff that PPE is required and people would not know to wear the full PPE unless the sign was posted. Residents who test positive for COVID have to stay in their rooms with the doors closed.

During an interview on 10/2/24 at 1:36 P.M., Certified Medication Technician (CMT) O said the other day, he/she noticed some residents having symptoms, like coughs, so he/she reported it to the nurse. The nurses started testing residents using the rapid tests that give results in about 10 minutes. Several residents tested positive for COVID. When residents are positive for COVID, they are placed on isolation and have to stay in their rooms with the door closed. PPE caddies are put out in the halls and a sign should be posted on the resident's door to show they are on isolation. Staff should wear N95 masks, gowns, and gloves in rooms of residents with COVID. Staff won't know to wear PPE in certain rooms unless a sign is posted.

During an interview on 10/2/24 at 4:06 P.M., the Regional Nurse and the Executive Director (ED) said yesterday, some residents had signs/symptoms of colds, no fevers. The nurse contacted the Medical Director and he said to test the symptomatic residents. All the residents who were tested were either symptomatic or they hang out in activities or the same areas as the residents who were symptomatic. The nurse tested the residents with rapid tests, which give results in 15 minutes. If a resident was positive

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A4086	Continued From page 31 for COVID, PPE was placed outside of the door. PPE should have been placed in the general area in the hall by the resident's room, not necessarily right outside of the door. Signs should have been posted on the doors for isolation precautions. If a resident tested positive, they should have had isolation signs immediately posted on their door. The signs would indicate what type of precautions to take for those residents, including to wear additional PPE in the resident rooms. Staff may not have known where to find the signs. The signs are in a computer program utilized by the facility that. Ultimately, the signs should have been hung by the Care Coordinator or nurse upon the positive COVID tests.	A4086		

Sunrise Senior Living
Plan of Correction Template

Name of Community: Sunrise of Des Peres
Address: 13460 Manchester Rd. Des Peres, MO 63131
License number: 24242
Inspection date(s): 10/15/2024 date survey completed
Name and Title of Sunrise Representative:
Barbara Barron, Senior Executive Director
Signature of Sunrise Representative: Signed on 1st page of Statement of Deficiencies
Date of Submission: 11/7/2024

Regulation	Target Date by Which Correction will be completed	Plan of Correction
A2019 19 CSR 30-85.022(10)(B) Fire Alarm System-Test/Maintain	11/30/2024	**A. With respect to the specific resident/situation cited:** The faceplate to the main fire alarm panel was closed and locked by the Maintenance Coordinator (MC) and the keys to the fire panel were relocated to a secure area where only authorized Team Members have access. The MC also contacted the contractor/vendor that services the fire alarm system and reinforced the importance of their service personnel conferring with the MC after completing an inspection or an adjustment/repair to the system in order to confirm the fire alarm panel is locked and secured.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The MC, Administrator/Executive Director than continued to make random rounds for the next 72 hours to confirm the fire alarm panel was locked and secured. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern: Refresher training regarding confirming the faceplate to the panel is closed and locked and that the keys to the fire panel are in a secured area is in the process of being

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		conducted with the concierge and maintenance/housekeeping teams by the Administrator/ED. The MC, Administrator/ED, or Designee will conduct walking rounds of the community weekly for 3 months to confirm that the faceplate of the fire alarm panel is closed and locked and keys for the fire panel are appropriately secured. Issues that may be identified will be addressed and resolved and refresher training initiated.
		D. With respect to how the plan of correction will be monitored: The MC and/or designee will present results of the walking rounds/observations and any refresher training that may have been completed during the Quality Assurance and Performance Improvement (QAPI) process for the next three QAPI meetings. During the conclusion of each QAPI meeting, the QAPI committee will re-evaluate and initiate necessary action or extend review period. The Administrator/Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
A2071 19 CSR 30-85.022 (40)(A) Wastebaskets, Metal/UL/FM	11/30/2024	**A. With respect to the specific resident/situation cited:** Wastebaskets are in the process of being replaced with approved UL trashcans by the Maintenance Coordinator (MC). The wastebaskets in the following areas are being replaced: ▪ The office printing room ▪ Room 121 ▪ Room 123

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		▪ The Wellness office ▪ The second-floor therapy gym
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Administrator/Executive Director and the Maintenance Coordinator (MC) conducted walking rounds of the community to confirm UL approved trashcans are in place. Issues that were observed are being addressed and resolved.
		C. With respect to what systemic measures have been put into place to address the stated concern: The Director of Sales and/or Administrator will reinforce the wastebasket/trashcan UL requirement during residency agreement signing sessions with new residents and their responsible parties and this requirement will be discussed on a quarterly basis at Resident Council Meetings. The MC, Administrator/ED, or Designee will conduct walking rounds of the community weekly for 3 months to confirm only UL approved trashcans are in place. Issues that may be identified will be addressed and resolved and refresher training initiated.
		D. With respect to how the plan of correction will be monitored: The MC and/or designee will present the results of the walking rounds/observations of trashcans and any refresher training that may have been completed during the Quality Assurance and Performance Improvement (QAPI) process for the next three QAPI meetings.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		During the conclusion of each QAPI meeting, the QAPI committee will re-evaluate and initiate necessary action or extend review period. The Administrator/Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
A3048 19 CSR 30-85.032(48)(A) Additional Businesses – Requires DHSS Approval	11/30/2024	**A. With respect to the specific resident/situation cited:** The Administrator/ED contacted the DHSS to obtain a second business license for a salon located in the community. DHSS approved the salon license and the license has been received and posted.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Administrator/Executive Director also applied for a therapy second business license and is awaiting approval from DHHS. The application was submitted and DHHS has indicated that the agency has everything they need to make a determination.
		C. With respect to what systemic measures have been put into place to address the stated concern: The Administrator/Executive Director has added second business license renewals to the annual business office calendar to confirm renewal licenses are tracked and applied for and received prior to expiration and will review the calendar on a quarterly basis.
		D. With respect to how the plan of correction will be monitored:

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<table>
<tr><th>Regulation</th><th>Target Date by Which Correction will be completed</th><th>Plan of Correction</th></tr>
<tr><td></td><td></td><td>The Administrator/Executive Director will present the results of the quarterly calendar review and the status of any second business applications that may have been submitted during the Quality Assurance and Performance Improvement (QAPI) process for the next three QAPI meetings.

During the conclusion of each QAPI meeting, the QAPI committee will re-evaluate and initiate necessary action or extend review period.

The Administrator/Executive Director (ED) is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.</td></tr>
<tr><td>A4075
19 CSR 30-85.042(66)
Nursing Care Per Resident Condition</td><td>11/30/24</td><td>A. With respect to the specific resident/situation cited:

The Administrator/Executive Director, RN Resident Care Director (RCD) and/or the Reminiscence Coordinator (RC) met with each team member on an individual basis that was working during the event on 9/6/24.

The meeting included a review of:
The Care Manager and Medication Care Manager job descriptions
The CPR Policy and adherence to the components in the policy (conducted by the RCD and/or RC) – including initiating and continuing CPR until EMT arrives when a Resident is a Full Code
Checking on code status and advance directives
Communicating with the physician and the responsible party
Expectations for the frequency of rounding and checking on Residents and what constitutes an actual “check”
The process and timing of calling 911
Communication with the Resident Care Director during an emergency
Process for Care Manager review of ISPs</td></tr>
</table>

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		In addition, the training listed above was conducted with the wellness and clinical team members not on duty on 9/6/24. The training was conducted by the Administrator/Executive Director and the Reminiscence Coordinator. CM A is no longer employed at the community.
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Resident Care Director audited the current Residents to confirm each Resident has a current code status that is entered in PCC and the code status is available on the devices carried by the Care Managers. No issues were identified.
		C. With respect to what systemic measures have been put into place to address the stated concern: The CPR Policy, expectations for rounding and checking on Residents, and checking on code status was reviewed with care team members at shift-to-shift crossover meetings and in small groups by the Administrator/ED and the Reminiscence Coordinator. In addition, these topics will be reviewed at Whole House monthly Town Hall Meetings for the next 3 months and then quarterly through June 2025. The code status of new Resident move-ins is being reviewed and confirmed by the Interdisciplinary Team at weekly meetings. During Care Plan Meetings, the Care Coordinator or Wellness Nurse or RCD will inquire of the Resident and Responsible Party to determine if any new advance directives or code status changes have been executed and to confirm the code changes and directives are entered into the medical records.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		A member of the Leadership Team will continue to make unannounced community visits on a monthly basis to confirm Resident checks are being completed. If an issue is identified, the issue will be addressed and resolved by the Administrator/ED.
		D. With respect to how the plan of correction will be monitored: The Resident Care Director and/or designee will present results of the audits, unannounced monthly leadership visits/checks, and the IDT and Care Plan Meeting discussions and any refresher training that may have been completed during the Quality Assurance and Performance Improvement (QAPI) process for the next three QAPI meetings. During the conclusion of each QAPI meeting, the QAPI committee will re-evaluate and initiate necessary action or extend review period. The Administrator/Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.
~~A0486~~ A4086 (per Admin via email on 11/11 at 12:25 PM) 19 CSR 30-85.042(77) Infection Control/Communicable Disease	11/30/2024	**A. With respect to the specific resident/situation cited:** Visual Alerts/Signs were immediately placed on doors #4, #7, #8, #13, #18, #19, #20, #21, and #24 by the Activity Director.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns: Refresher training was initiated by the Resident Care Director and the Care Coordinators with the Care Managers and Wellness Team Members regarding infection control procedures and strategies including posting appropriate visual alerts/signage on Resident doors. In addition, a Whole House Town Hall Meeting (includes all departments) will be conducted, and the Administrator/ED Director will discuss infection control procedures with an emphasis on appropriate signage. Team Members who do not attend the meeting will be contacted by their Department Coordinator and the material discussed will be conveyed to the Team Member. The Sunrise COVID – 19 Mitigation and Response Plan is being used for the training.
		C. With respect to what systemic measures have been put into place to address the stated concern: The plan for responding to and managing a COVID positive situation has been thoroughly reviewed with the Leadership Team, the Care Coordinators and the Wellness Team, including the responsibility and timing of posting visual alerts/signage. This was conducted by the Administrator/ED. If an infectious disease outbreak occurs, the Administrator or Resident Care Director or Designee will make regular daily rounds to confirm visual alerts/signage is posted and remains posted. The observations and interventions of the rounds will be documented.

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Regulation	Target Date by Which Correction will be completed	Plan of Correction
		In addition, COVID and infectious disease management will be reviewed at the next three Whole House Town Hall Meetings (includes all departments) and thereafter quarterly until June 2025. Team Members who do not attend a Town Hall Meeting will be contacted by their Department Coordinator and the material discussed conveyed to the Team Member.
		D. With respect to how the plan of correction will be monitored: The Resident Care Director or Designee will present results of the walking rounds/observations if an outbreak occurs, and any refresher training that may have been completed during the Quality Assurance and Performance Improvement (QAPI) process for the next three QAPI meetings. During the conclusion of each QAPI meeting, the QAPI committee will re-evaluate and initiate necessary action or extend review period. The Administrator/Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.

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