STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. BUILDING _____ B. WING _____	C 10/21/2024

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LIFE CARE CENTER OF ST LOUIS	3520 CHOUTEAU AVE SAINT LOUIS, MO 63103

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F 684 SS=J	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 follow physician orders for x-rays for one of seven sampled residents (Resident #1) who had fallen from his/her bed on 9/6/24. The x-ray order was not completed for nine days, during which time the resident experienced pain and refused care, which he/she had not done prior. The resident was diagnosed with a fractured hip. The sample was 7. The census was 86. The Administrator was notified on 10/21/24 at 3:46 P.M., of the Immediate Jeopardy (IJ) past non-compliance, which occurred on 09/06/24. Facility staff were inserviced beginning on 9/13/24 and a system was implemented to monitor the completion of ordered x-rays. The IJ was corrected on 9/16/24. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/13/24, showed the following: -Diagnoses of diabetes, heart failure and peripheral vascular disease (PVD, a circulatory condition that occurs when blood vessels outside of the heart and brain narrow, spasm, or become	F 684	Past noncompliance: no plan of correction required.	

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

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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F 684	Continued From page 1	F 684		

blocked);
-Short-term memory loss;
-No behaviors;
-Dependent on staff for toileting, bathing, and transfers.

Review of the resident's progress notes, dated 9/6/24 at 3:34 P.M.: Late entry for 9/6/24 at 12:15 P.M., showed the following: Noise heard from room, resident yelled for help. Resident lay on the left side of the bed with his/her phone in his/her hand. Resident stated he/she was reaching for his/her phone. Range of motion (ROM) completed with complaints of pain. Assisted off the floor with Hoyer lift (mechanical device used to assist residents who are unable to stand and transfer) and three staff members. Spouse and physician notified. Orders received.

Review of the resident's Physician Order Sheet (POS), dated 9/2024, showed the following:
-Order dated 9/6/24, for a stat (urgent or rush) x-ray of the left shoulder, left arm, left hip two views, right hip two views and chest x-ray;
-Tramadol (medication used to treat moderate to severe pain) 50 milligram (mg) every six hours as needed (PRN) for pain;
-Tylenol extra strength 500 mg one tablet by mouth every six hours PRN for pain and elevated temperature.

Review of the resident's progress notes, showed the following:
-9/7/24 at 11:16 A.M., Resident screaming out in pain during care. Staff reported the resident requested pain medication. Tramadol 50 mg every six hours PRN for pain;
-9/7/24 at 10:56 P.M., Tylenol extra strength given for complaint of pain;

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F 684	Continued From page 2	F 684		

-9/8/24 at 2:31 P.M., Tramadol 50 mg given for complaint of pain;
-9/8/24 at 5:34 P.M., Tramadol 50 mg given for complaint of pain;
-9/9/24 at 12:20 P.M., Cleanse right medial (closer to the midline of the body) thigh with normal saline, cover with hydrocolloid dressing (forms a hydrated gel over the wound, creating a moist environment that promotes healing and protects new tissue) every Monday and Friday. Resident refused to allow nurse to touch his/her thigh;
-9/9/24 at 2:06 P.M., Resident remains on incident follow up for unwitnessed fall. Resident had pain pill this shift. Refused treatment due to pain;
-No documentation to show whether x-rays ordered for 9/6/24, were completed.

Review of the resident's care plan, updated 9/9/24, showed the following:
-Problem: At risk for falls/injury related to history of falls and bilateral amputee;
-Intervention: Ensure frequently used items are within reach. Fall mats beside bed when in bed. Hoyer lift used for transfers, staff to ensure proper positioning while in bed

Review of the resident's progress notes, showed the following:
-9/10/24 at 06:47 A.M., Tramadol 50 mg given for complaint of leg pain;
-No documentation to show whether x-rays ordered for 9/6/24, were completed.

Review of the POS, dated 9/10/24 at 8:00 A.M., showed an order for a x-ray to bilateral hips.

Review of the resident's progress notes, showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 3	F 684		

the following:
-No documentation whether x-ray to bilateral hips was completed on 9/10/24;
-9/12/24 at 12:24 A.M., Tramadol 50 mg as needed for pain;
-9/12/24 at 12:24 A.M., Tylenol extra strength 500 mg given for pain;
-9/13/24 at 6:28 A.M., Tramadol 50 mg given for pain;
-9/13/24 at 6:37 A.M., Resident medicated with Tramadol 50 mg for complaints of pain when turned and repositioned during care.

Review of the resident's progress note, dated 9/13/24 at 10:55 A.M., showed mobile x-ray in the facility to complete x-ray to right and left shoulder and right and left hip.

Review of the resident's progress notes, showed the following:
-9/13/24 at 10:30 P.M., Certified Nurse Aide (CNA) reported the resident being combative during night rounds times two;
-9/14/24 at 5:32 A.M., Tramadol 50 mg effective for pain;
-9/15/24 at 9:10 A.M., Tramadol 50 mg for complaint of pain all over body. 10 out of 10.

Review of the resident's x-ray, completed on 9/13/24, showed the following:
-Left hip and pelvis: No evidence of obvious fracture;
-Right hip and pelvis: Possible fracture at the femoral (thigh) neck;
-Handwritten by staff: Staff notified the resident's physician on 9/15/24 at 10:10 A.M. Order received to repeat stat x-ray of the right pelvis and hip.

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F 684	Continued From page 4	F 684		

Review of the resident's progress notes, showed the following:
-9/15/24 at 1:49 P.M., Tylenol extra strength 500 mg given for complaint of pain, 10 out of 10;
-9/15/24 at 8:57 P.M., Result of x-ray showed possible fracture at the neck of the femur. Physician ordered a computed tomography (CT, imaging technique that uses x-rays to create detailed cross-sectional images of the body) scan of the right hip and pelvis to be scheduled on 9/16/24;
9/16/24 at 4:07 A.M., Staff attempted to provide peri care (cleansing of the hips, genitals and rectal area), resident allowed limited peri rectal hygiene.

During an interview on 9/16/24 at 9:06 A.M., the Medical Director and resident's physician said she was sending the resident to the emergency room for continued complaints of pain. His/Her x-ray showed possible fracture of the right hip.

Observation on 9/16/24 at 9:13 A.M., showed the resident lay in bed on his/her back. Fall mat noted to left side of the bed. Bruises noted to left inner arm. The resident had bilateral above the knee amputations. The resident was unable to say how he/she got the bruises to his/her arm.

Review of the resident's progress notes, showed the following:
-9/16/24 at 10:10 A.M., Tramadol 50 mg given for complaint of hip/pelvis, 10 out of 10;
-9/16/24 at 12:50 P.M., New order received to send resident to the hospital for evaluation of pain to right hip and pelvis.

Review of the resident's hospital admission records, showed he/she was admitted to hospital

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F 684	Continued From page 5	F 684		

on 9/16/24 for repair of right hip fracture.

During an interview on 10/8/24 at 1:43 P.M., CNA A said he/she worked on the day-shift and has taken care of the resident. On 9/6/24, the resident fell from his/her bed. When he/she and CNA B entered the room, the resident said he/she was reaching for his/her phone and fell out of the bed. The Assistant Director of Nurses (ADON) entered the room and assessed the resident. They used a Hoyer lift to assist the resident back to bed. The resident complained of pain in his/her back and said his/her legs hurt. The ADON said he/she was going to call the physician for an x-ray order. CNA A took care of the resident several days after his/her fall. The resident complained of severe pain each time he/she went in to change him/her. It was difficult to provide care. The resident required two staff to provide care because the resident would resist. At times, the nurse would come in to assist. This was not the resident's normal behavior. It usually took one staff member to provide care and the resident was able to turn to each side when asked. Now two staff had to roll him/her from side to side and the resident would yell out in pain. CNA A could tell the resident was in a lot of pain. They would report it to the nurse each time the resident complained. The nurse would give him/her pain medication. CNA A was concerned about the resident and thought the pain was caused by the fall.

During an interview on 10/8/24 at 2:30 P.M., the ADON said she assessed the resident after his/her fall on 9/6/24. She called the physician and got orders for stat x-rays of his/her left shoulder, left arm, left hip two views, right hip two views and chest x-ray. The orders were sent to the x-ray company. She didn't realize the x-rays

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F 684	Continued From page 6	F 684		

weren't completed until grand rounds with the Director of Nursing (DON) on 9/13/24. No one reported the resident's increase in pain. She was surprised the resident was taking the Tramadol because that was not something he/she usually did. She expected staff to inform her of the resident's complaints of pain. She should have followed up the next day to ensure the x-rays were completed. She doesn't know why she failed to do so.

During an interview on 10/16/24 at 12:56 P.M., Licensed Practical Nurse (LPN) D said he/she worked for an agency. He/She worked on 9/13/24. In report, he/she was told the resident had an order for a hip x-ray to be completed on his/her shift. He/She didn't receive the results on his/her shifts.

During an interview on 10/16/24 at 10:36 A.M., LPN E said he/she worked the night shift and had taken care of the resident. Prior to the fall, one staff member could provide care. After the fall, it took two people to turn and provide care. At times, LPN E had to go in and help the staff. The resident complained of pain while staff provided care. LPN E gave the resident pain medication a couple of times when he/she asked for it. He/she doesn't recall receiving any x-ray results on nights but if he/she had, they would come directly to the floor via the fax machine. If a result came in and it showed a fracture, LPN E would call the doctor to report it. He/She would also notify the DON and document it.

During an interview on 10/15/24 at 2:25 P.M., LPN G said the ADON asked him/her to help get the resident off the floor on 9/6/24. When they entered the room, the resident sat on the left side

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F 684	Continued From page 7	F 684		

of the bed, on the floor. After the ADON assessed the resident, several staff assisted the resident via the Hoyer lift to the bed. The ADON reported the fall to the doctor and got orders for x-rays. LPN G didn't follow up because he/she wasn't the resident's nurse. Several days later during morning rounds, the DON asked if the x-ray was completed. It was at that time staff realized the x-ray wasn't done.

During an interview on 10/15/24 at 1:00 P.M., LPN F said he/she worked for the agency and recalled hearing in report about an x-ray from the ADON. LPN F wasn't the resident's nurse so he/she didn't follow up. Several days later, when he/she returned to work, the DON asked whether the x-ray had been completed during rounds. They talked about the x-ray not being completed.

During an interview on 10/8/24 at 1:35 P.M., CNA B said he/she has taken care of the resident on day-shift. The resident required total care from the staff. After the fall, the resident would complain of pain in his/her back, legs and refused to get out of bed. CNA B would report to the nurse when the resident complained of pain.

During an interview on 10/8/24 at 2:21 P.M., CNA C said he/she works on the day-shift and has taken care of the resident. Prior to the fall, the resident was able to turn easily by him/herself. During rounds, the resident would complain of pain in his/her back and hips. It was difficult to clean him/her because of the pain. It took two staff to get him/her cleaned up. The resident would say, I can't do it, it hurts when staff would try to clean him/her. CNA C reported the resident's complaints of pain to several nurses. The nurse would go in to check on him/her and

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F 684	Continued From page 8	F 684		

give pain medication.

During an interview on 10/9/24 at 1:37 P.M. a representative from the mobile x-ray company said on 9/6/24, they received an order for x-rays of the left shoulder and arm, left hip two views, right hip two views and chest x-ray. They tried to contact the facility to recommend the resident be sent to the hospital due to the high exposure to radiation. They placed several calls to the nursing station but no one answered the phone.

During an interview on 10/21/24 at 11:20 A.M., the DON said she was unaware the x-rays ordered on 9/6/24 weren't completed until 9/13/24, during rounds. No one reported the resident's complaints of pain during care. She expected the ADON to follow up the next day regarding the x-rays. She was unaware a new order was received on 9/10/24. Staff failed to complete the x-ray until 9/13/24. She expected staff to complete orders as written.

During an interview on 10/17/24 at 11:14 A.M., the resident's physician and Medical Director said she expected staff to complete the 9/6/24 x-rays as ordered. Staff notified her on 9/10/24 of the resident's complaints of pain. She ordered an x-ray of the right and left hip and pelvis. She was not aware the x-ray was not completed until 9/13/24. She expected the x-rays to be completed as ordered. She expected staff to notify her if mobile imaging is unable to complete the x-ray as ordered.

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