DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265586	A. BUILDING ______ B. WING ______	C 08/14/2017

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

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F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 309		

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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failed to follow a physician's order and the facility policies for a resident, under strict aspiration precautions, with a tube feeding and to receive tube feeding formula via bolus (using a syringe or gravity to deliver the feeding) infused over the course of an hour. The nurse administered the formula in 30 minutes. Approximately one hour later, staff found the resident, who had a full code order, unresponsive with tube feeding formula coming out of his/her mouth and nose. The nurse failed to assess the resident, immediately check his/her code status, perform cardiopulmonary resuscitation (CPR, life sustaining measures in the event the heart stops beating) and call 911 in accordance with the facility's policy. This affected one of three sampled residents (Resident #1). The census was 60.

Review of the facility's policy titled "Aspiration Precautions Guidelines" dated 7/1/16, showed aspiration (choking) precautions are interventions to reduce the risk of aspirating on food, liquids, and/or secretions during the swallowing process into the trachea and lungs. Inhaling foreign materials into the lungs and bronchial tubes may cause aspiration pneumonia. Residents receiving enteral feedings are at risk for aspiration (see enteral feeding section).

Review of the facility's policy titled "Enteral and Parenteral Feedings (General Guidelines)" revised 1/18/17, showed direction for staff, under standard orders for all tube feedings, to document the amount of formula and water provided every eight hours. Total intake every 24 hours. They are to check tube placement before initiation of formula, medication administration, and flushing the tube or at least every eight

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hours. Nursing staff is to observe condition of tube site when checking placement. They must also check and record residuals every shift. The head of the resident's bed is to be elevated 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding was stopped.

Review of the facility's policy titled "Resuscitation of Patients/Residents With and Without Automatic External Defibrillation (AED)," revised 1/2/13, showed direction for staff to follow practice guidelines for CPR by initiating resuscitation with and without an AED, as appropriate and in accordance with patient/resident advance directives. Appropriate staff members in the immediate area are to respond and call and designate a person to call 911 or locally appropriate emergency number. Staff is to assist with basic life support, direct visitors out of the room, relocate any roommates to another room, verify clearance of the hallway and room. A staff person is to verify transportation of the emergency cart to the patient/resident location.

Review of the facility's policy titled "Emergency, 'Code Blue'-Initiation of" revised 1/5/12, showed direction for staff to announce code blue to notify the appropriate team members to participate in a systematic, organized procedure during a potential life-threatening situation for a full code resident. Staff is to follow practice guidelines for CPR, page overhead "code blue (room and unit)" and repeat it two times. Those expected to respond, include but are not limited to, the following: physician (if in-house), respiratory therapist (if available), charge nurse, and DON. Staff is to call 911 for emergency transfer to an

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F 309	Continued From page 3 acute care center, unless the resident is coding, and staff has determined that he/she is a DNR. Staff is to contact the resident's physician for further orders and notify the resident's responsible party of the resident's change in condition. Staff is to continue CPR efforts as appropriate, in accordance with the resident's advance directives, until an advanced rescue team arrives or until spontaneous respirations, pulse and blood pressure return. Staff is also expected to provide transport to an acute care center if appropriate, send the appropriate documentation with the resident for transport if appropriate and document in the appropriate area of the medical record. Review of the facility's policy titled "Emergency Cart" revised 9/2011, showed direction for the licensed nursing staff or designee to maintain the emergency cart and store it in an easily accessible location. Nursing staff or a designee is to verify that the cart contains all supplies and equipment needed for emergencies and resuscitation. The facility is to delegate the specific times the cart will be checked for supplies and restocking. Review of Resident #1's hospital pulmonary consultation, dated 4/29/17, showed the resident was hospitalized on 4/10/17, after he/she was involved in a motor vehicle accident as a pedestrian. He/she sustained lumbar transverse process (bony protrusion from the back of a vertebrae bone in the spine) fracture, closed fracture of the temporal bone (bones that form part of the sides of the skull), subdural hematoma (bleeding into the space between the brain cover and the brain itself), traumatic subarachnoid hemorrhage (bleeding in the space between the	F 309		

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F 309	Continued From page 4 brain and its surrounding membrane), closed fracture of multiple pubic rami (thin, flat part of the pelvis which extends to the side and rear of a midline joint), tibial plateau fracture (break in the very top of the shin bone, within the knee joint) on the right, traumatic pneumocephalus (presence of air or gas within the cranial cavity associated with disruption of the skull), orbital wall fracture (traumatic injury to the eye socket), forehead laceration, and closed fracture of the left zygomatic arch (bony arch at the outer border of the eye socket). The resident underwent several interventions to stabilize the fractures and trauma related injuries. On 4/17/17, the resident underwent an upper tracheostomy tube placement (a surgical hole through the front of the neck into the windpipe through which a breathing tube/trach tube inserted to help the patient breathe) and percutaneous endoscopic gastrostomy (a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach). He/she also underwent a right craniectomy (a neurosurgical procedure in which part of the skull is removed to allow for swelling and the brain room to expand) for subdural hematoma evacuation (a surgical procedure to remove pooling of blood on the brain) and decompression. Review of the resident's hospital neurology progress note, dated 7/11/17, showed the resident was awake and making eye contact, but not tracking. He/she did not follow any of the physician's commands. The resident did not attempt to mouth any words or communicate in any other way. His/her vital signs were stable. The resident's flexion knee contractures (inability to fully straighten the knee) were improving with increased range of motion exercise.	F 309		

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F 309	Continued From page 5 Review of the resident's undated face sheet, showed an admission date to the facility on 7/14/17 and full code status. The resident was documented as being responsible for self. Review of the nurses notes, dated 7/14/17 at 3:30 P.M., showed the resident was admitted to the facility. He/she arrived via ambulance, in semi-fowler's position (lying in bed with the head of the bed at approximately 30 to 45 degrees), eyes open, not following. Lower extremities contracted, right side of head sunken due to craniotomy. Gastrostomy tube feeding (g-tube, a tube inserted through the abdomen to deliver nutrition directly to the stomach), patent and intact, aphasic (partial or total loss of ability to speak), Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) on sacrum. Dry dressing applied, no distress noted. Review of the resident's social services progress notes, dated 7/14/17 (no time documented), showed the resident's code status was full code, he/she had no known advance directives or funeral home preferences. The resident was non-responsive beyond opening his/her eyes when his/her name was loudly called. Review of the resident's admission paperwork, dated 7/14/17, showed an advance directive acknowledgement initialed by his/her family member to indicate that he/she elected not to execute any advance directive measures. Review of the resident's undated interim plan of	F 309		

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F 309	Continued From page 6 care, showed the following: -Monitor tube feeding intake; -Tube feeding protocol; -Intake and output. Review of the resident's physician's orders, dated 7/14/17 through 7/31/17, showed the following: -7/14/17, TwoCal high nitrogen (HN) (high calorie formula used for increased protein and calorie requirements) every four hours, infuse over one hour by pump-strict aspiration precaution; -7/14/17, Flush g-tube with 50 cubic centimeters (cc) of water before and after each feeding; -No documentation of the resident's code status. Review of the Post Acute History and Physical, dated 7/17/17, completed by the resident's physician, showed the following: -Seizures, chronic obstructive pulmonary disease (COPD, progressive lung disease), multiple fractures; -Full code; -Review of systems: unable because of dementia/language; -G-tube; -Vegetative state. Review of the resident's physician's orders, dated 7/18/17, showed the following: -Clarify tube feeding order as bolus, one can TwoCal HN every four hours. Change flush to 100 milliliters every four hours. Review of the resident's medication administration record (MAR), dated 7/14/17 through 7/31/17, showed an order for TwoCal HN bolus every four hours (2:00 A.M., 6:00 A.M., 10:00 P.M., 2:00 P.M., 6:00 P.M. and 10:00 P.M.), infuse over one hour. Strict aspiration	F 309		

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precaution.

Review of the resident's nurse's notes, showed no documentation on the resident after 7/14/17 until the nurse's notes, dated 7/23/17 at 6:10 A.M., which showed Nurse A was called to the resident's room by a certified nurse aide (CNA), who said that his/her co-worker's patient passed away. The resident was unresponsive with no blood pressure, no apical pulse and no respirations. He/she was lying supine (lying face up), slightly reverse Trendelenburg (the body lying flat with the head 15-30 degrees higher than the feet) and the CNA was providing post-mortem care. Nurse A went from the resident's room to the resident's chart where he/she noted the resident was a full code, but notification delays and discovery delays and knowledge of the brain's activity after eight minutes of no oxygen prevented the nurse from providing CPR. Family, Director of Nurses (DON), coroner, funeral home and physician notified.

During an interview on 8/9/17 at 8:28 A.M., Charge Nurse A said he/she became a registered nurse in May 1993 and at previous places of employment, had served as charge nurse for up to 50 to 60 residents during a single shift. Nurse A taught first aid and community CPR since 1999. Nurse A's first day off of orientation at the facility was during the night shift on 7/22/17. During the early morning hours of 7/23/17, he/she was the only nurse on duty. At 4:00 A.M., he/she administered the resident's bolus tube feeding and watched 240 cc of TwoCal HN flow into the resident's g-tube port. The tube feeding was completed at 4:30 A.M. After flushing the tube, Nurse A disconnected it from the g-tube port and left the room.

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F 309	Continued From page 8 During interviews on 8/7/17 at 8:20 A.M. and 8/9/17 at 6:30 A.M., CNA B said he/she had only been employed at the facility for a month. Because the resident was non-verbal, bedridden, contracted and receiving tube feedings, CNA B entered the resident's room during rounds in order to make sure his/her head was up (due to the tube feedings), ensure he/she was still breathing and dry. On 7/22/17, CNA B checked on the resident at 11:00 P.M. and found him/her asleep. CNA B checked on the resident again at 2:00 A.M. and 4:00 A.M. He/she was fine at those times. CNA B returned to the resident's room between 5:30 A.M. and 5:45 A.M. and called out the resident's name. Normally, the resident looked at CNA B and tracked CNA B a little with his/her eyes. That time, the resident's eyes were already open, but they just stared blankly into space, as though he/she were "daydreaming." The head of the bed was at approximately a 45 degree angle. His/her skin was "really cold," because the air conditioner was on. The resident's skin and nail bed colors were unchanged. Tube feeding formula was coming out of the resident's nose and mouth. CNA B felt for a pulse and could not find one. He/she did not know what the resident's code status was and did not know where to find that information. CNA B believed it was the charge nurse's responsibility to initiate and perform CPR. CNA B assumed the resident died and went to inform Nurse A, who was not at the nurse's station. CNA B asked CNA C to find Nurse A and inform him/her the resident passed away. CNA B returned to the resident's room and began cleaning him/her from head to toe. CNA B moved the resident up onto his/her right side, in order to drain as much of the tube feeding formula as possible, because it continued	F 309		

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F 309	Continued From page 9 to run out of the resident's nose and mouth. His/her back was very wet, because the formula had pooled in the bed underneath him/her. During an interview on 8/7/17 at 9:00 A.M., CNA C recalled that towards the end of his/her shift on the morning of 7/23/17 (exact time unknown), when it was time to start getting residents up, CNA B saw CNA C standing at the nurses' station and said if CNA C saw Nurse A, to let Nurse A know the resident needed suctioning. CNA B did not at any point tell CNA C the resident was dead. Consequently, CNA C waited until he/she saw Nurse A come out of the medication room to convey CNA B's message. CNA C worked on the 100 and 700 halls and consequently, did not find out the resident passed away until his/her next shift at the facility. During an interview on 8/8/17 at 1:20 P.M., Certified Medication Technician (CMT) D said from where he/she stood passing medications on the 200 hall on 7/23/17, sometime between 5:45 A.M. and 6:00 A.M., CMT D heard CNA B tell Nurse A, that a resident was dead. Nurse A said, "What?" CNA B said a specific resident was dead. Nurse A left his/her medication cart on the 700 hall, ran past the nurses' station and into the resident's room. CMT D remained on the 200 hall and continued to pass medications. He/she did not respond to the room or check the resident's medical chart. Nurse A never made a code blue announcement or asked CMT D for assistance. During interviews on 8/8/17 at 10:06 A.M. and 8/9/17 at 8:28 A.M., Nurse A said he/she was on another hall passing 6:00 A.M. medications when CNA C reported the other CNA said that one of	F 309		

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F 309	Continued From page 10 his/her people passed away. Nurse A asked where the CNA was and CNA C led him/her to CNA B, who was providing post mortem care to the resident. That "threw" Nurse A, who had just been in the room at 4:30 A.M. and watched the tube feeding drain into the resident's g-tube port without any problems. At that time, the resident's vital signs were normal and he/she did not exhibit any signs of dying. Nurse A was shocked to find CNA B had the head of the bed flat and tilted backwards approximately 10 degrees. The resident's skin was cool and dusky in coloration. The resident did not have good color when he/she was alive. CNA B pushed him/her up so far onto his/her right side that it looked as though the resident was going to drop off the bed, as CNA B stood behind him/her washing his/her back and trying to change his/her bed sheet. Nurse A told CNA B to hold on, went to the medication cart at the end of the hall, (he/she said there was one at the end of each hall) and returned with a stethoscope as well as a blood pressure monitor. The resident's arm was so stiff, CNA B had to help apply the blood pressure monitor. Nurse A checked and found no pulse or blood pressure. Nurse A did not know if the blood pressure monitor display screen kept showing "E" because it needed batteries or if it was an indication the resident had no pulse. Nurse A then held the resident up, so that CNA B could clean him/her. Nurse A noticed that approximately 1/3 to 1/2 of the tube feeding formula had pooled in the bed underneath the resident's back. It was running out of his/her nose and mouth. Nurse A had previously disconnected the feeding tube from the resident's g-tube port. However, Nurse A checked the tubing to see if that was where all the formula was coming from. The clamp on the tube was	F 309		

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F 309	Continued From page 11 still closed. Nurse A was in the room with them for 20 to 25 minutes. He/she then went to the nurses' station and pulled the resident's medical chart, in order to notify the resident's family and physician of his/her passing. Nurse A looked at the resident's records and realized that his/her code status was full code. At that point, the resident had gone without respirations and oxygen for a little over 10-15 minutes. In Nurse A's mind, the resident could not be resuscitated. Nurse A did not initiate CPR or call 911. Nurse A realized he/she should have done those things. However, during that shift, Nurse A was very overwhelmed with trying to learn the facility procedures and there were no other nurses on duty to answer his/her questions. Nurse A believed the policy binder was probably out where he/she could have found it. Normally, when a resident became unresponsive, Nurse A would check the resident's code status, call a code, start CPR and send the CNA to call 911. Nurse A knew what was expected of him/her and there was no excuse for failing to follow proper procedure. Nurse A believed CNA B was employed at the facility for a while and would have known to come and get Nurse A at the first sign of trouble for all full code residents. Consequently, Nurse A assumed the resident's code status was do not resuscitate (DNR). The CNAs were both behaving as though the resident's status was DNR. When the Assistant Director of Nursing (ADON) asked if Nurse A had done CPR on the resident, Nurse A said, "yes" because of all of the "chaos." The next day, when he/she returned to the facility, in order to provide a written statement and nurse's note regarding the incident, the ADON read his/her statement and realized that staff had not performed CPR on the resident. Nurse A did not	F 309		

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know why he/she initially told the ADON that staff performed CPR on the resident.

During interviews on 8/7/17 at 8:20 A.M. and 8/9/17 at 6:30 A.M., CNA B said Nurse A entered the room approximately ten minutes after CNA B asked CNA C to inform Nurse A the resident had passed away. CNA B told Nurse A the resident was dead. Nurse A walked over to the bed, looked into the resident's eyes and said, "Yeah" he/she was dead, checked the tube feeding device and briefly assisted CNA B by holding up the resident, before leaving the room. Nurse A never checked the resident's pulse or blood pressure. CNA B never put a blood pressure monitor on the resident or assisted Nurse A to put one on him/her.

Review of facility records, showed Nurse A and CMT D were certified in CPR. CNA B and CNA C were not certified in CPR.

During interviews on 8/9/17 at 12:12 P.M. and 8/10/17 at 8:42 A.M., the Director of Nursing (DON) said the resident did not have a signed advanced directive or code status sheet. The facility was using a gravity bag with a slow drip clamp, not a tube feeding machine, to deliver the resident's bolus tube feedings. Per his/her physician's order, TwoCal HN was to be infused over the course of an hour. In order to ensure that it infused for at least an hour, the nurse administering the feeding was to open the clamp on the tubing far enough to permit a slow drip and then remain in the room for the duration of the feeding or periodically check the progress of the infusion. The resident arrived at the facility from the hospital with those orders. Hospital staff said because the resident was at high risk for

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	265586	A. BUILDING ______ B. WING ______	C 08/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LOUIS PLACE HEALTH & 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
F 309	Continued From page 13 aspiration, it was necessary for the tube feeding to infuse for an hour. If the resident was to receive the formula in under an hour, then it would increase his/her risk for aspiration. The resident's tube feeding residuals (volume of tube feeding remaining in the stomach) should have been documented on his/her medication administration record (MAR), but they were not documented there or anywhere else in the resident's record. Upon discovery of an unresponsive resident, staff were to check his/her code status. If the resident's status was full code, then staff were expected to start CPR, call 911 and notify the resident's physician of the resident's change in condition. If a CNA was the first to discover an unresponsive full code resident, then the CNA could start CPR. The charge nurse was expected to bring the emergency cart to the resident's room. The facility's policy regarding CPR was not discussed during nurse or CNA training. However, the facility conducted monthly mock codes with the staff on duty during each shift. The facility did not have an automatic external defibrillator (AED). During orientation, the trainer notified staff that there was a binder containing the facility's policies located in the 700 hall medication room and one was in the administrator's office. Nurses and CMTs had keys to the 700 hall medication room. The administrator, admissions coordinator, and social worker had keys to the administrator's office. During interviews on 8/10/17 at 8:48 A.M. and 8/16/17 at 10:32 A.M., the administrator said nurses were expected to check residuals prior to administering tube feedings. However, they did not document the resident's residuals, because there were no physician's order in place for them	F 309		

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F 309	Continued From page 14 to be documented. Normally, a resident's advance directive and code status forms were filled out and signed upon admission. The resident was admitted to the facility without an advance directive. Consequently, his/her code status automatically became full code. The resident was his/her own responsible party. During an interview on 8/9/17 at 12:23 P.M., Physician E said if the resident's nurse saw the tube feeding formula flow into the resident's g-tube port and then the formula flowed out of the resident's nose and mouth, then the resident most likely aspirated or vomited the formula. A large amount of formula coming up through the resident's nose and mouth at the same time would prevent the resident from being able to breathe. As soon as staff discovered that a full code resident was unresponsive to stimuli, they should immediately start CPR. A delay in initiating CPR could result in the resident expiring. Staff should call 911 for a full code resident whether or not they believed the resident was dead. Note: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level "J". Based on 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. During the onsite visit, the facility developed a plan of correction which included re-educating nursing staff on the CPR policy and process, emergency procedures for residents found unresponsive, the procedure for administering and documentation of tube feedings and proper physician's orders. A final revisit will be conducted to determine if the facility	F 309		

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F 309	Continued From page 15 is in substantial compliance with participation requirements. At the time of 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. MO000130819	F 309		