

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 265627	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OF SUPPLIER GARDEN VIEW CARE CENTER OF CHESTERFIELD		STREET ADDRESS, CITY, STATE, ZIP 1025 CHESTERFIELD POINTE PARKWAY CHESTERFIELD, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0622 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on interview and record review, the facility failed to provide an appropriate immediate discharge letter for three of three sampled residents (Residents #1, #2 and #3). The facility discharged the residents to the hospital and would not allow them to return to the facility. The census was 50. Review of the facility's resident discharge list, dated 5/5/20 through 6/5/20, showed the following: -Resident #1 discharged on [DATE], with expectation to return from outpatient services; -Resident #2 discharged on [DATE], with expectation to return from outpatient services; -Resident #3 discharged on [DATE], with expectation to return from outpatient services. 1. Review of Resident #1's face sheet, showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's Coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome Coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath and loss of smell and taste) test result, dated 5/29/2020, showed the following: -Collection date, 5/29/20; -Received date, 5/29/20; -Result [DIAGNOSES REDACTED]-COV-2 (COVID-19), detected. Review of the resident's physician's orders [REDACTED]. Review of the resident's nurse's notes (NN), dated 5/29/20 (no time noted), showed staff documented the following: -Notified by the administrator the resident is positive for COVID-19. Administrator wants the resident sent to the hospital for treatment; -Family and physician aware; -No documentation of immediate discharge notice. Further review of the resident's medical record, showed the discharge summary template was not completed. 2. Review of Resident #2's face sheet, showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's POS, showed the following: -An order, dated 5/28/20, to obtain a COVID-19 test; -An order, dated 5/28/20, to send the resident to the hospital for positive COVID-19 results; Review of the resident's COVID-19 test result, dated 5/28/20, showed the following: -Collection date, 5/28/20; -Received date, 5/28/20; -Result [DIAGNOSES REDACTED]-COV-2 (COVID-19), detected. Review of the resident's NN, dated 5/28/20 at 6:30 P.M., showed staff documented the following: -Notified resident test results on COVID swab was positive; -Call placed to physician; -Received orders to send to hospital per protocol; -Call placed to ambulance company to arrange transportation; -Resident transported to hospital; -No documentation of immediate discharge notice. Further review of the resident's medical record, showed the discharge summary template was not completed. 3. Review of Resident #3's face sheet, showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's POS, showed the following: -No order for a COVID-19 test; -An order dated 5/29/20, to send the resident to the hospital for positive COVID-19 results. Review of the resident's COVID-19 test result dated, 5/29/20, showed the following: -Collection date, 5/29/20; -Received date, 5/29/20; -Result [DIAGNOSES REDACTED]-COV-2 (COVID-19), detected. Review of the resident's NN, dated 5/28/20 at 10:30 P.M., showed staff documented the following: -Resident tested positive for COVID-19; -Sending to hospital for treatment; -Family and physician notified; -No documentation of immediate discharge notice. Further review of the resident's medical record, showed the discharge summary template was not completed. 4. During an interview on 6/4/2020 at 11:24 A.M., hospital social worker (SW) A, said the following: -The facility apparently did facility wide testing for COVID 19; -They sent two residents (Residents #1 and #2) to the hospital because of the positive results; -The two residents are roommates at the facility; -The facility had them sent to the hospital for admission; -Neither resident is symptomatic with signs or symptoms of COVID-19; -The facility is refusing to allow either resident to return to the facility until they have two negative COVID-19 test results; -SW A called the owner and the owner said, No, the facility will not accept the residents back under any circumstances until they have two negative COVID-19 tests; -The facility did not send or provide an immediate discharge notice with either resident. 5. During an interview on 6/4/2020 at 12:15 P.M., the Director of Nurses (DON) said the following: -The facility did facility wide testing (FWT) for all residents and staff for COVID-19; -Three residents tested positive and were sent to the hospital for treatment. -They were only sent because of positive COVID-19 test result; -The hospital called and said two of the residents were stable and awaiting discharge back to the facility; -The owner refused to take them back until they all have two negative COVID-19 test results; -The facility did not send immediate discharge notices with any of the three residents. 6. During an interview on 6/4/2020 at 12:34 P.M., the facility's owner said the following: -He is not accepting any residents that are COVID-19 positive; -He had three residents and one staff test positive; -He has suspended all admissions and restricted visitors; -He is not bringing known COVID-19 residents into the facility; -Staff should have sent an immediate discharge notice with the residents. 7. Review of the facility's Transfer or Discharge, Emergency policy, revised December 2016, showed the following: -Emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s); -Resident will not be transferred unless; -The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility; -The transfer is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; -The safety of individuals in the facility is endangered to the clinical or behavior status of the resident; -The health of individuals in the facility would otherwise be endangered; -The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies: *If the resident does not submit the necessary paperwork for third party payments; *After the third party, including Medicare or Medicaid denies the claim and the resident refuses to pay for his/her stay; -The facility ceases to operate; -If a resident exercises his/her right to appeal a transfer or discharge notice, he or she will not be transferred or discharged while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility; -If a resident is transferred or discharged despite his or her pending appeal, the danger that failure to transfer or discharge would pose, will be documented; -Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures; -Notify the resident's attending physician; -Notify the facility that the transfer is being made; -Prepare the resident for transfer; -Prepare a transfer form to send with the resident; -Notify the representative (spouse) or other family member; -Assist in obtaining transportation; -Others as appropriate or necessary; -Should it become necessary to transfer residents during an emergency or disaster situation, transfer procedures outlined in the disaster plan will be implemented; -The resident's medical record must be forwarded to the Medical Records office within twenty-four (24) hours of the transfer/discharge. 8. Review of the facility's undated Template for Discharge, showed the following: -Check the reason why the discharge or transfer is necessary (check all that apply) -The resident's welfare and the resident's needs cannot be met in the facility. If so, specify; *The specific resident's need(s) that cannot be met; *The facility's attempts to meet the resident's needs; *The services available at the receiving facility to meet the resident's need(s);</p>		
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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 265627	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OF SUPPLIER GARDEN VIEW CARE CENTER OF CHESTERFIELD		STREET ADDRESS, CITY, STATE, ZIP 1025 CHESTERFIELD POINTE PARKWAY CHESTERFIELD, MO 63017	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0622 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>(continued... from page 1)</p> <p>*Name of resident's physician; -The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; -Name of physician; -The safety of other individuals in the facility is endangered due to the clinical or behavioral status of the resident; -Why the resident is endangered; -Name of physician making determination; -The health of other individuals in the facility would otherwise be endangered; -Why others are endangered; -Name of physician making determination; -The resident has failed after reasonable and appropriate notice, to pay or refused to pay for a stay at the facility AND the resident has not submitted the necessary paperwork for third party payment (e.g. Medicaid or Medicare). (Note: Non-payment pending Medicaid eligibility does not justify transfer or discharged); -The facility ceasing to operate; -Note: The facility cannot discharge or transfer a resident when an appeal by the resident (and/or their representative) is pending unless failure to discharge or transfer would endanger the health and safety of the residents or other individuals in the facility. 9. Review of the facility's (undated) Discharge Summary Template, showed the following: -Space designated for resident's name; -Space designated for date of birth (DOB); -Space designated for admission and discharge date ; -Space designated for [DIAGNOSES REDACTED]. for radiology or other test and results (most recent); -Space designated for consultations along with findings and recommendations; -A copy of Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff; -Copy of discharge plan from comprehensive care plan; -Signed consent of the resident or resident's representative to share discharge summary; -Space designated for name, date and date completed. 10. Review of the facility's policy for Coronavirus disease 2019 (COVID-19), dated 3/31/20, showed the following: -Monitoring and evaluating in-house residents; -Staff/Charge nurse will continuously monitor all residents for signs and symptoms of respiratory illnesses. The nurses will notify the resident's attending physician, resident representatives, administrator, DON of any changes in the resident's condition; -A clinical assessment will be done for all residents exhibiting respiratory like illnesses. The charge nurse will collect the clinical data and the DON or Registered Nurse (RN) designees will evaluate the data collected. This information will be documented in the resident's chart as well as on the form Resident Screening Tool. Once the data collection portion of the form is completed by the nurse, the form is to be submitted to the DON who will notify the appropriate channels; -Should the resident exhibit signs and symptoms of COVID-19, the resident's attending physician and if necessary the Department of Health will be notified to obtain an order for [REDACTED]. The DON will notify the County Health Department of any identified COVID-19 occurrence; -Monitoring and evaluating incoming residents; -The admissions coordinator (AC) will question all potential residents, hospital discharge planners and family members at the time of initial inquiry to determine if the potential resident or readmitted resident currently exhibits or has recently been exposed to others who have signs and symptoms of respiratory illness or flu-like symptoms; -If the response is No, the potential resident or readmitted resident may be admitted to the facility as per usual admission policies; -If the response is Yes, the AC will refer the inquiry to the administrator and DON. The DON will determine the next appropriate steps for assessment and evaluation; *If the hospital patient exhibits symptoms of COVID-19 during the hospital assessment and does not have a [DIAGNOSES REDACTED]. *If the resident has been residing in his/her own home or the home of a family member, exhibits signs and symptoms of respiratory like illness during the home visit by the DON/Designee, the nurse must ask the potential resident or resident's family to have the resident evaluated by his/her consulting physical prior to admission to the facility; *If the potential resident is residing in another healthcare community/facility and exhibits signs and symptoms of respiratory like illness, the DON/Designee must ask the other healthcare facility to have the resident evaluated prior to admitting the potential resident to the facility; *The DON/RN designee will use the Resident Screening Tool form to document his/her assessment; *The DON/Designee will use the assessment information gathered to determine which unit/room the resident should be admitted to within the facility based on the policies. The nurse will inform the admitting physician of the resident's COVID-19 status. -The policy did not address what to do if a resident tested positive for COVID-19 while residing in the facility. 11. Review of the facility's undated Addition and Clarification to Pandemic COVID-19 policies and procedures, showed the following: -This addendum is made to clarify the policies and procedures regarding COVID-19. These requirements are now feasible since the facility is now able to test residents with test provided by the State of Missouri within a 24-hour timeframe; -Testing and transfer to the hospital; -Immediately upon indications that a resident or staff member has been infected with the Coronavirus, the resident and staff member shall be immediately tested for COVID-19 by the use of a nasal swab test provided by the State of Missouri. The swab shall be delivered to the State laboratory in Columbia and given priority. If the test is positive, the facility shall commence to test the remaining staff and residents; -All residents that test positive shall be immediately discharged and transferred and admitted to a hospital by the Medical Director. Any staff member testing positive shall immediately be sent home for a period of two weeks and shall not return until the staff member is tested and receives two negative test results 48 hours apart; -After discharge, the infected resident shall not be readmitted to the facility until the facility receives proof from the hospital of two negative tests of the resident at least 48 hours apart; -Signed by the administrator and Medical Director. MO 024</p>		