STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265236	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenir at Mark Twain	11988 Mark Twain Lane Bridgeton, MO 63044

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice when staff failed to administer treatments as ordered for non-pressure wounds, to complete comprehensive skin assessments on a routine basis, and to reassess for efficacy of treatments for skin integrity issues for one resident (Resident #54). The sample was 6. The census was 72.Review of the facility's Skin Assessment policy, revised 1/18/24, showed:-Policy: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment;-Policy Explanation and Compliance Guidelines included:--A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury;--Considerations for a bariatric (obese) resident; -Thoroughly inspect each surface of a skin fold; -Consider moisture and weight exerted by opposing skin and/or body folds when determining pressure versus moisture related etiology (cause);--Documentation of skin assessment: -When a new skin concern is identified, documentation will be completed according to the established guidelines. This documentation process is designed to ensure that each newly identified skin concern is thoroughly recorded. Accurate and complete documentation supports effective treatment planning and ongoing care for residents. Review of the facility's Wound Treatment Management policy, undated, showed:-Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-Policy Explanation and Compliance Guidelines included:-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;-Treatments will be documented on the Treatment Administration Record (TAR) or in the electronic health record (EHR);-The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: -Lack of progression towards healing; -Changes in the characteristics of the wound. Review of Resident #54's comprehensive admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/25/25, showed:-Cognitively intact;-Lower extremity impairment on both sides;-Substantial/maximal assistance required for showering/bathing;-Dependent for lower body dressing, putting on/taking off footwear, and personal hygiene;-Dependent in mobility areas of rolling left and right, sitting to lying, lying to sitting, and transfers;-Diagnoses included paraplegia (paralysis affecting one side), complete traumatic amputation at knee level to left lower leg, morbid obesity, kidney failure, osteomyelitis (bone infection), and generalized muscle weakness;-At risk of developing pressure ulcers/injuries;-Three venous and arterial ulcers (open sores caused by circulatory problems) present;-Skin and ulcer/injury treatments included pressure ulcer/injury care, application of nonsurgical dressings other than to feet, applications of ointments/medications other than to feet, and application of dressings to feet. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Actual impairment to skin integrity related to left stump wound;-Focus: Actual impairment to skin integrity related to excoriation to buttocks, thighs, and calves and open areas to right stump, right hip, and right buttocks;-Interventions/Tasks included: Administer treatments as ordered and monitor for effectiveness. Monitor pressure areas for changes in color, sensation, temperature and report any changes to nurse;-Focus: Activities of daily living (ADL) self-care performance deficit;-Intervention/Tasks included: Resident is totally dependent on staff to provide a bath three times a week and as necessary. Review of the resident's shower sheets for September and October 2025, reviewed 10/7/25, showed:-On 9/8/25, staff documented a bed bath completed. No documentation of any areas noted during a visual assessment of the resident's skin;-On 9/12/25, staff documented on a shower sheet with no indication of whether bed bath or shower provided. Skin tears noted on the buttocks and swelling noted to the lower legs of a drawing of a person;-On 9/19/25, staff documented a bed bath completed. No documentation of any areas noted during a visual assessment of the resident's skin;-On 9/22/25, staff documented assessment of bruising, skin tears, rashes, drying, and scratches, with areas marked on the back, buttocks, and inner thighs of a drawing of a person. No documentation of any areas noted to the legs;-On 9/29/25, staff documented the resident refused a bed bath. No documentation of a visual assessment of the resident's skin or of a shower offered;-No documentation of any other showers or bed