STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265331	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Rehab and Nursing	10954 Kennerly Road Saint Louis, MO 63128

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 44950 Based on observation, interview and record review, the facility failed to prevent the diversion (the unauthorized removal) of Schedule II controlled medications (medication with higher potential of dependency and abuse) for two residents (Resident #1 and Resident #2) of 4 sampled residents. This had the potential to affect all residents in the facility. The census was 92. The Administrator was notified on 7/23/24, of the past non-compliance which began on 7/4/24. The facility began an investigation, counted the medication carts, added a corrected count to all controlled substance logs, interviewed staff and residents, notified the police, the residents affected and their physician, in-serviced staff on abuse and misappropriation of resident property (including drug diversion) and terminated Licensed Practical Nurse (LPN) A. The deficiency was corrected on 7/10/24. Review of the facility's Abuse, Neglect, Misappropriation of Resident Property, Injury of Unknown Origin Policy, revised 8/1/22, included: Prevention and Reporting: -The Administrator has primary responsibility in the facility for implementation of the abuse/neglect program. -The facility will follow all state and federal guidelines on preventing abuse, neglect, mistreatment, exploitation and misappropriation of property. Abuse shall include physical harm, pain, mental anguish, verbal abuse, sexual abuse, or involuntary seclusion. -The facility encourages and supports all residents, staff and families in feeling free to report any suspected acts of abuse, neglect, misappropriation or injury of unknown origin. The facility takes all measures possible to ensure that residents, staff and families are free from fear of retribution if reports or incidents are filed with the facility. -Reports of abuse will be promptly reported and thoroughly investigated. Additionally the facility should immediately report all such allegations to Administrator/designee and to the Department of Health and Senior Services. In cases where a crime is suspected staff should also report the same to local law enforcement. (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: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents, interested family members or other persons may contact any member of the administration or the facility's nursing staff at any time with concerns relating to the Abuse, Neglect, Exploitation of a resident, or Misappropriation of resident Property, or concerns about a resident injury. In addition, such persons may file a grievance with the Grievance Official (Social Services) or with the Department of Health concerning any instance or suspicion of resident Abuse, Neglect, Exploitation of a resident or Misappropriation of a Resident Property. -The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc. -The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. -The facility has implemented the following processes in an effort to provide residents/patients and staff a safe and comfortable environment. -The Shift Supervisor (Charge Nurse, Nurse Manager or Administrator) is identified as responsible for immediate initiation of the reporting process. Review of the facility's Initial Investigation, dated 7/5/24, showed: -Date of incident: 7/4/24; -Type of incident: Suspected Crime; -Person involved: LPN A, Resident #1 and Resident #2; -Witnesses: LPN B; -Narrative Note: LPN B was counting cart with LPN A. LPN B noted the count to be accurate. However, several areas on two cards noted to have holes with a pill in it taped to the back. LPN B called the Director of Nursing (DON). When the DON arrived at the facility at 1:30 A.M. she discovered a total of 13 oxycodone (an opioid pain medication used to treat moderate to severe pain) missing and replaced with Claritin (Over the counter allergy medication. Used to treat allergy symptoms and hives): -LPN A suspended pending investigation; -Police Department notified-Report filed; -Board of nursing notified; -Pharmacy notified to replace missing medications; -Witness statement obtained. -Review of the facility's follow up investigation report, dated 7/10/24, showed: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No additional information at this time; -Incident reported to both residents; -Allegation reported to State Board of Nursing on 7/8/24, awaiting response; -Both residents were unaware of incident. Neither residents had a lapse in pain medication administration; -Called LPN A several times for a statement. LPN A never responded; -Summary: LPN B noted tampering with narcotic card. Notified DON immediately. LPN B noted several areas of tape on back of narcotic card; -Both residents unaffected by incident; -Police department report filed. Camera footage obtained and sent to police department. Board of Nursing notified of incident; -Conclusion: Verified; -LPN A was termed (terminated). In-services on narcotic count/card discrepancies; -DON/Assistant Director of Nursing (ADON) to do routine audits of medication carts. DON/ADON to do continued education. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/7/24, showed: -Cognitively intact; -Diagnoses of end stage renal disease (ESRD), heart failure, depression, and high blood pressure; -The resident was on a scheduled pain medication regimen. Review of the resident's electronic Physician Order Sheet (ePOS), showed an order dated 6/12/23, for Oxycodone 10 milligram (mg). Give one tablet every 6 hours as needed for pain. Review of the resident's pharmacy replacement record, showed: Quantity 4, replaced. Two-day supply drug price $21.33. Price per day $10.67. 2. Review of Resident #2's quarterly MDS, dated , showed: -Cognitively intact; -Diagnoses of diabetes, hemiplegia (paralysis on one side of the body), quadriplegia (paralysis from the neck down), anxiety, and depression; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was on a scheduled pain medication regimen. Review of the resident's ePOS, showed an order dated 4/23/24, for Oxycodone 10 mg. Give one tablet four times a day. Review of the resident's pharmacy replacement record showed: Quantity 10, replaced. Two-day supply drug price $26.66. Price per day $13.33. 3. Review of video footage provided by facility, showed LPN A on the rehab unit with the Certified Medication Technician's (CMT) cart open. He/She has a phone propped up to block part of camera view. LPN A is observed getting several pieces of tape. At one point, he/she is observed taking his/her keys out of his/her left pocket and 3 round small white objects fall out onto top of the cart. LPN A looks around and quickly picks them up and puts them back in his/her pocket. LPN A is also observed going off camera with a medication card and then coming back to the cart. He/She slips a small white object into his/her right scrub pocket. He/She is also observed opening up the top drawer of the med cart and opening and examining the different over the counter stock medications. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 7/19/24 at 10:00 A.M., the DON said the oncoming nurse, LPN B, came in for his/her shift at 11:00 P.M. on 7/3/24. When he/she was doing end of shift counts with LPN A, he/she noticed the cards appeared to be tampered with and called the DON. The DON told LPN B to report it to the supervisor which was LPN A. LPN B told the DON that LPN A was the concern. The DON said she came up to the facility right away. She looked at the narcotics and looked at the pills. She contacted the Administrator and spoke with LPN A who said he/she did not know anything. The DON said she did not send LPN A home because after counts were done, LPN A no longer had keys or access to pills. Once LPN B came in, LPN A was just overseeing staff. The DON said LPN A left about 7:00 A.M. The DON said when she arrived at the facility that night, LPN B told her that LPN A did not give up the medication cart keys right away. LPN A worked as the floor nurse from 7:00 P.M. to 11:00 P.M. because the facility had messed up staffing. They confused LPN B's start time and did not have a nurse so LPN A worked until LPN B came in for his/her shift. When LPN B came in at 11:00 P.M. and asked LPN A if he/she was ready to count, LPN A said no he/she was cleaning. At that point, LPN B went upstairs and then came back down. The video showed LPN B on the camera waiting. As soon as LPN A got done, the video showed LPN B and LPN A counting well after midnight at approximately 12:45 A.M. LPN B took the medication cart keys and called at approximately 1:00 A.M. after LPN A walked away. The DON said she came up to the facility at around 1:00 A.M. and left around 3:30 or 4:00 A.M. For the rest of the shift, LPN A did not have keys. He/She had access from 7:00 P. M. to 12:45 A.M. Both LPN B and LPN A left the facility around 7:00 A.M. The DON said she did a full audit the morning after the incident. She went back and did an audit on all cards/sheets. Most narcotics are located on the CMT cart. The nurse cart has overflow, liquid morphine (opioid narcotic medication used to treat moderate to severe pain) and liquid Ativan (used to treat anxiety). There are six carts in the facility. There are three CMT carts and three nurse medication carts. There are also three medication rooms. The DON said LPN A reported to her that she left her previous facility because he/she felt that they were bullying her and were not supporting him/her as a supervisor. The DON said she did not get a statement from LPN A. The DON said she called the police and State Board of Nursing. LPN A was scheduled to work on 7/7/24. The facility called LPN on 7/5/24 to suspend him/her pending investigation. LPN A asked why and they told him/her because of an issue with narcotics. LPN A said he/she did not know anything was wrong. Then on the evening of 7/5/24, LPN A texted the DON because he/she did not know why the police was calling. The DON said they terminated LPN A on 7/9/24. The DON and Administrator both attempted several times to notify LPN A he/she was terminated. LPN A never answered. The facility changed all door codes and they are considering sending LPN A a certified letter for proof that LPN A knows he/she is terminated. 5. During an interview on 7/19/24 at 11:05 A.M., the Administrator said there was no harm done to the residents. The charge nurse has the keys, not the manager. LPN A would not have had the keys and she does not think any of the nurses that worked that night would have given LPN A the medication cart keys. The Administrator said after the incident they did in services, audits, contacted pharmacy, and did risk management assessments. Pharmacy came in and reviewed guidelines with all nurses/CMTs. 6. During an interview on 7/19/24 at 11:14 A.M., the DON said the nurses who were there that night on overnights would have not have given LPN A the medication cart keys. 7. During an interview on 7/19/24 at 12:35 P.M., LPN D said he/she also worked the night shift on 7/3/24 but on a different unit. He/She saw LPN A in passing but other than that he/she did not talk to LPN A that night. LPN D said LPN A just seemed tired. LPN D said he/she would not give anyone his/her keys, even a manager. It would not seem right, no one should ask for your medication cart keys. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. During an interview on 7/19/24 at 1:40 P.M., LPN B said he/she came in at 11:00 P.M. on 7/3/24. He/She went straight to the unit and told LPN A he/she was ready to count. LPN A said just give me a minute, he/she said he/she was straightening out the cart. LPN A had the big drawer on the medication cart open and the narcotic box open. LPN B did not see any narcotic cards out; just the box was open. LPN B said he/she walked away and came back after a few minutes. LPN A was still with the cart. LPN B said he/she then went upstairs for approximately 10 minutes. Around 11:30 P.M., LPN B went back downstairs to see if LPN A was done. LPN A was still messing with the cart so LPN B walked away to complete other tasks. At approximately 12:30 A.M., LPN B said he/she texted the upstairs nurse out of frustration that he/she still did not have the medication cart keys. At about 12:45 A.M., LPN A told LPN B he/she was ready. LPN B said everything was put back that LPN A had out. LPN B said he/she noticed a piece of tape stuck to the top of the medication cart and thought that was odd. He/She did not ask LPN A about it because he/she did not know anything was going on that would be a concern. LPN A then told LPN B that his/her allergies were horrible and he/she needed Benadryl (antihistamine used to relieve symptoms of allergy, hay fever, and the common cold). LPN B watched LPN A put four 25 mg Benadryl tablets in a cup and put it on top of the cart. LPN B said they counted both the CMT cart and the nurse cart. The count appeared to be correct. LPN B said he/she regularly works on that unit and when you work down there you do not normally need to touch the nurse cart. He/She said when they were counting the nurse cart, a piece of tape got stuck to his/her finger. LPN B flipped the card over and saw several missing. LPN B said he/she did not say anything though at this point. Then LPN B and LPN A went back to the CMT cart. LPN B said he/she knew several residents who never ask for medications have several cards taped. After LPN A walked away, LPN B said he/she called the on-call phone and got the DON. The DON asked LPN B to confront LPN A. LPN B said he/she said yes at first but then called the DON back and said no that he/she was not comfortable doing that. The DON came up to the facility. LPN A was still upstairs when the DON got there. LPN B and the DON noticed there were three or four cards messed with for a total of 15 pills. All the cards tampered with were for Oxycodone 5mg. Resident #1's card on the CMT cart was messed with, Resident #2's regular card was missing pills. What should have been a full card on the overflow cart was also missing pills. LPN B said Resident #1 rarely asks for pain pills. LPN B showed the DON what he/she found. The DON said we have to correct the count. LPN B saw the DON talking to LPN A but it did not seem like LPN A was in trouble. The DON left the facility at around 330 or 4:00 A.M. that morning. LPN A did not say anything to LPN B the rest of the night. LPN B said he/she looked at the pills under the tape. They said G and were thinner. When he/she googled it, it said it was Claritin. LPN B said he/she never asked LPN A why or about the tape. LPN B said he/she was not comfortable because LPN A was a staff nurse and supervisor while LPN B is an agency nurse. LPN B said he/she did not really know LPN A and had not seen or worked with him/her prior to this incident. 9. On 7/19/24, two attempts were made to call LPN A, with no answer. On 7/22/24, a certified and non-certified letter was sent to LPN A, requesting him/her to call the surveyor. MO00238558

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44950 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #3) received care consistent with professional standards and facility policy to prevent and/or treat pressure ulcers (a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction). The facility identified small break down on the resident's buttocks on 5/25/24. The area was not staged at that time. No treatment order was obtained and treatments were documented as provided from 5/25/23 until 7/3/24. Licensed nursing staff failed to complete weekly skin assessments between the dates of 6/15/24 and 7/3/24. On 7/3/24, a stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) was discovered. Staff failed to identify and treat the pressure ulcer until it had already progressed to a stage III. The sample size was 4. The census was 92. Review of the facility's Skin Program Policy and Procedure, implemented April 2023, showed: -Purpose: The purpose of the skin program is to ensure that every resident's skin condition is assessed on admission and a comprehensive and interdisciplinary care plan is developed and maintained to treat actual and/or prevent potential skin problems; -Policy: All residents are assessed upon admission and as needed (PRN) for actual and/or potential skin problems. All residents will receive an individualized preventative skin plan of care at the time of admission. All residents with skin problems will receive an active skin plan of care at admission. Skin Care team meetings will be held weekly to address all ulcers and any other pertinent skin problems; -Procedure: -The nurse assesses/evaluates all residents upon admission. The initial skin assessment is a full body audit and completion of the Braden Skin Risk Assessment (standardized assessment to determine risk for skin breakdown) in the electronic medical record. After admission the Braden Skin Risk Assessment will be completed weekly x 3 weeks and then a minimum of quarterly, a significant change of condition and annually; -Residents admitted to the facility with skin areas/pressure ulcers will have treatment orders initiated upon admission/re-admission. -Director of Nursing (DON)/Designee to review all residents weekly with skin ulcers for condition of wound, treatment changes, and additional barriers to healing and will document weekly using the Wound-Weekly Observation Tool (Licensed Nurse) in the electronic medical record; -State tested Nurse Aide (STNA) will complete the Bath/Shower Report Sheet with each resident's scheduled bath/shower. Each resident will be assessed/evaluated a minimum of weekly by the nurse using the Skin Observation Tool in the electronic medical record; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The Nurse/Designee will notify the resident's responsible party if the resident is admitted /readmitted from the hospital or another healthcare facility with a skin ulcer and document notification in the clinical record. The nurse/designee will continue to notify/update the physician, resident/sponsor weekly of progress/lack of progress of healing of all stage III and 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) ulcers, and surgical wounds. Resident/Sponsor will be educated by the nurse on skin care and the prevention of skin injury PRN. All education as well as the resident/sponsor response will be documented in the clinical record. Review of the Resident #3's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 6/13/24, showed: -admitted [DATE] and readmitted on [DATE]; -Cognitively intact; -Upper and lower extremity impairment on one side; -Incontinent of bladder and has a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall); -Diagnoses include: anemia (decrease in number of red blood cells), diabetes, hemiplegia (paralysis on one side of the body), seizures, and malnutrition; -Determination of Pressure Ulcer Risk: Clinical assessment. Risk of Pressure Ulcers: Yes; -Does resident have one or more unhealed pressure ulcers at Stage 1 or higher: No. Review of the resident's Braden skin risk assessment, completed on 11/23/23, showed high risk. No further Braden skin risk assessments were completed. Review of the resident's electronic Physicians Order Sheet (ePOS) showed an order, dated 3/2/24, for weekly skin assessment every week on (day). Please complete weekly skin assessment. Review of the resident's care plan, in use at the time of the investigation, showed: -Focus dated 5/2/24: Resident has potential impairment to skin integrity related to hemiplegia, Below Knee Amputation (BKA), and diabetes; -Goals: Resident will maintain or develop clean and intact skin by the review date; -Interventions: Follow facility protocols for treatment of injury, educate resident/family/caregivers of causative factors and measures to prevent skin injury, identify/document potential causative factors and eliminate/resolve where possible; -Focus, undated: Resident has functional bladder incontinence related to physical limitations; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Goals: Resident will remain free from skin breakdown due to incontinence and brief use through the review date; -Interventions: Clean perineal area with each incontinence episode; -The presence of pressure ulcers not included in the care plan. Review of the resident's shower sheets, reviewed for the month of May 2024, showed perform a visual assessment of a resident's skin when giving the resident a shower. Report any abnormal looking skin to the charge nurse immediately. Forward any problems to the DON for review. Use this form to show the exact location and description of the abnormality. Using the body chart below, describe and graph all abnormalities: -On 5/2/24, refused hand written on the form; -On 5/6/24, no skin areas identified as abnormal looking; -On 5/8/24, bed bath written on the form. No skin areas identified as abnormal looking; -On 5/13/24, bed bath written on the form. No skin areas identified as abnormal looking; -On 5/15/24, no skin areas identified as abnormal looking; -On 5/18/24, no skin areas identified as abnormal looking; -On 5/23/24, refused shower and bed bath written on the form; -On 5/29/24, bed bath written on the form. A hand drawn star over the buttocks area of the body chart. Barrier cream applied, hand written on the form. The form was signed by the Certified Nursing Assistant (CNA) and charge nurse. Neither signature legible. The signature line for the DON was not signed. Review of the resident's skin assessments for May 2024, showed: -A skin assessment, dated 5/19/24, No new skin issues noted by this nurse; -A skin assessment, dated 5/25/24, Site: Sacrum (buttocks area), small break down on the sacrum. New suspected pressure ulcer/Deep tissue Injury (DTI, Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister). Applied triad cream (barrier cream) and foam dressing to sacrum. Review of the resident's progress notes, dated May 2024, showed: -A note, dated 5/25/24 at 11:23 A.M., showed CNA notified charge nurse of skin break down on sacrum. Charge nurse applied triad cream and covered with foam dressing; -No further documentation of wound care or assessment; (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's ePOS, dated May 2024, showed: -No physician order for the triad cream and/or foam dressing documented; -No treatment order obtained for the sacrum. Review of the resident's shower sheets, reviewed for the month of June 2024, showed perform a visual assessment of a resident's skin when giving the resident a shower. Report any abnormal looking skin to the charge nurse immediately. Forward any problems to the DON for review. Use this form to show the exact location and description of the abnormality. Using the body chart below, describe and graph all abnormalities: -On 6/4/24, no skin areas identified as abnormal looking; -On 6/8/24, no skin areas identified as abnormal looking; -On 6/11/24, no skin areas identified as abnormal looking; -On 6/14/24, no skin areas identified as abnormal looking; -On 6/18/24, no skin areas identified as abnormal looking; -On 6/22/24, no skin areas identified as abnormal looking; -On 6/25/24, no skin areas identified as abnormal looking; -On 6/29/24, no skin areas identified as abnormal looking. Review of the resident's skin assessments, for the month of June 2024, showed: -A skin assessment, dated 6/1/24, barrier cream applied to buttock and offered turning and repositioning during rounds; -A skin assessment, dated 6/8/24, no new skin issues; -A skin assessment, dated 6/15/24, skin intact; -No skin assessments documented for 6/22/24 or 6/29/24 and no further skin assessments documented in June. Review of the resident's ePOS, dated June 2024, showed no treatment orders for the buttocks/sacrum wound. Review of the resident's shower sheets, reviewed for the dates of July 1 through 20, 2024, showed perform a visual assessment of a resident's skin when giving the resident a shower. Report any abnormal looking skin to the charge nurse immediately. Forward any problems to the DON for review. Use this form to show the exact location and description of the abnormality. Using the body chart below, describe and graph all abnormalities: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Chestnut Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 10954 Kennerly Road Saint Louis, MO 63128	

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 0686 Level of Harm - Actual harm Residents Affected - Few	-On 7/2/24, no skin areas identified as abnormal looking; -On 7/6/24, no skin areas identified as abnormal looking; -On 7/9/24, no skin areas identified as abnormal looking; -On 7/13/24, no skin areas identified as abnormal looking; -On 7/16/24, no skin areas identified as abnormal looking; -On 7/20/24, no skin areas identified as abnormal looking. Review of the resident's progress notes, for the dates of July 1 through 19, 2024, showed: -A progress note, dated 7/3/24 at 2:58 P.M., the resident had an open area to his/her coccyx (buttocks area), plan of care ongoing. Measurements: 3 x 6 x 0.2. The resident expressed no other needs at this time. Physician and family notified; -No other progress notes regarding the wound were documented. Review of the resident's ePOS, dated for the dates of July 1 through 19, 2024, showed: -An order, dated 7/4/24, Santyl (collagenase, a topical medication used for removing damaged or burned skin) external ointment 250 unit/gram (gm) (Collagenase). Apply to coccyx topically one time a day for wound care. Clean the area with soap and water, Normal saline/pat dry, apply Santyl ointment with calcium alginate (absorbent dressing) to the wound base, do not put on skin, skin prep the perineal area, cover with border foam dressing daily and as needed until resolved. Review of the resident's skin assessments, for the dates of July 1 through 19, 2024, showed: -A skin assessment, dated 7/6/24, no new issues to report. -No further skin assessments documented. Review of the facility's Wound Rounds report, for the dates of July 3 through 16, 2024, showed the following for the resident: -On 7/3/24 at 2:47 P.M., facility acquired Stage III pressure ulceration on coccyx measures 3 cm by 6 cm by 0.30 cm; -On 7/9/24 at 8:04 A.M., facility acquired Stage III pressure ulcer 3 cm by 6 cm by 0.30 cm; -On 7/16/24 at 8:04 A.M., facility acquired Stage III pressure ulcer. 1 cm x 1.0 x 0.30 cm; -No documentation the resident had a pressure ulcer identified prior to 7/3/24. Observation on 7/19/24 at 1:00 P.M., showed Licensed Practical Nurse (LPN) E completed a skin assessment. A bordered dressing was present and intact on his/her sacrum dated 7/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Rehab and Nursing	10954 Kennerly Road Saint Louis, MO 63128

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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/19/24 at 1:15 P.M., LPN E said resident skin assessments are correlated with their shower days and completed by the assigned nurse or the wound nurse. During an interview on 7/19/24 at approximately 2:00 P.M., LPN G said he/she is the wound care nurse while the primary wound care nurse is out of town. The resident had a small pressure ulcer on his/her sacrum. The dressing was changed today and it was almost healed. The wound company Nurse Practitioner (NP) comes in on Monday. LPN G said he/she was not sure what happened or how the resident got the open area. During an interview on 7/23/24 at 9:45 A.M., the Administrator said she would have expected staff to complete and document skin assessments as ordered. Regarding when the area was identified in May, the treatment would depend on if the area was opened. It was just a red area and barrier cream was applied until it was later identified as a pressure ulcer and a treatment was ordered. There should have been a skin assessment completed and documented between 6/15/24 and 7/3/24. The staff are educated to document any red, open areas, and scars. She would expect the area to be identified and treated prior to being classified as a Stage III pressure ulcer. The wound nurse is currently not available to answer any questions. During an interview on 7/23/24 at 12:48 P.M., the wound care company NP said their company does not currently see the resident. He/She would expect by the time an open area becomes a Stage III that the facility would have the wound care company help them manage it. On 7/23/24 at 1:00 P.M., an attempt to interview the physician was made. No call back from the physician received. MO00237180