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	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Care at Sunset Hills	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to communicate and attempt to resolve one resident's refusal to take medications scheduled at 8:00 A.M., because he/she was sleeping. Review of the resident's 1/2026 medication administration record (MAR) from 1/1/26 through 1/26/26, showed the resident did not receive eight of eight medications scheduled at 8:00 A.M. on 10 separate days, and two of three doses of one medication scheduled at 8:00 A.M. every Wednesday (Resident #8). The facility also failed to ensure one resident (Resident #2) with a new order for Azithromycin (antibiotic) for pneumonia received the first dose timely. The antibiotic was available in the facility Electronic Emergency Kit (E-Kit, a dispensing system located at the facility containing commonly used medications) but the first dose was not administered for approximately 15 hours after being ordered. The facility also failed to ensure that same resident did not run out of two medications that required a physician's prescription before the pharmacy could deliver the medications. In addition, the facility failed to ensure one resident (Resident #1) promptly received Vancomycin (antibiotic) for clostridium difficile (C-diff, a bacterium that can cause severe diarrhea and colitis (inflammation of the colon)). The pharmacy delivered the Vancomycin to the facility on 1/20/26 at 11:00 A.M., but staff did not administer the first dose until 1/23/26. Eleven residents were sampled and problems were identified with three. The census was 84.Review of the facility's Electronic Emergency Kit For First Dose and Emergency Medications policy, dated 11/2021, showed:-Policy: The facility may use the E-Kit for first dose and emergency medications, where permitted by regulation or law;-Procedures: -The E-Kit may be used by authorized facility staff to access first dose and emergency medications, per regulation and applicable law;-Only authorized licensed facility personnel who have received training, have access to medications in the E-Kit;-Upon receipt of a new medication order, facility staff should obtain the total number of doses necessary to cover the period of time from the administration of the first dose until it is expected to become available from the pharmacy. Review of the facility Controlled Substance Prescriptions policy, dated 11/2021, showed:-Policy: Medications included in the Drug Enforcement administration classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations;-Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe;-Additional supplies of controlled drugs are ordered by the facility from the provider pharmacy. Re-orders for controlled substances should be made allowing appropriate time for the pharmacy to obtain the prescription and to assure adequate supply is on hand. Review of the facility's Medication Administration policy last reviewed 1/2024, showed:-Purpose: To administer the following: Right medication, right dose, right dosage form, right route, right resident and right time;Procedure: -Document the following as applicable: Administration of the medication on the MAR as soon as (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications are given. Omitted dose by circling your initials in the appropriate block on the MAR (the facility has an electronic MAR and omitted doses are number coded by the certified medication technician (CMT), licensed practical nurse (LPN) or registered nurse (RN)). Reason for omission in the Nursing Progress Notes or on the back of the MAR. PRN (as necessary/needed) medication, reason for administration, and effectiveness in the Nursing Progress Notes or on the back of the MAR;-Notify physician of changes in resident or with refusal of medication. Review of the facility Miscellaneous Special Situations - Unavailable Medications policy dated 11/2021, showed:-Policy: Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. The facility must make every effort to ensure that medications are available to meet the needs of each resident;-Procedures: -The pharmacy staff shall: Call or notify staff that the ordered product(s) is/are unavailable. Notify nursing when it is anticipated that the drug(s) will become available. Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance;-Nursing staff shall: Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. Obtain a new order and cancel/discontinue the order for the non-available medication. 1. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/31/25 and located in the electronic healthcare record (EHR), showed:-Makes Self Understood: Understood;-Ability To Understand Others: Understands;-Moderately impaired cognition;-Rejection of Care - Presence and Frequency: Behavior not exhibited;-Diagnoses of: High blood pressure, peripheral vascular disease (narrowing of the arteries causing poor circulation), renal (kidney) insufficiency/renal failure/or end-stage renal disease (ERSD), diabetes, hyperkalemia (high potassium level), stroke, and unspecified atrial fibrillation (A-Fib, irregular heart rate/rhythm);-Special Treatments, Procedures, and Programs: Hemodialysis (dialysis, a process of filtering the blood of a person whose kidneys are not working normally). Review of the resident's care plan, located in the EHR, showed: -7/2/24: Focus: Renal failure related to ERSD. Goal: Will have no signs/symptoms of complications related to fluid deficit. Interventions: Give medications as ordered by the physician. Monitor for signs/symptoms of hypervolemia (fluid overload often leading to symptoms like selling, high blood pressure and shortness of breath) or hypovolemia (fluid depletion that can cause weakness, fatigue and dizziness);-7/2/24: Focus: Dialysis related to renal failure. Goal: Will have no sighs/symptoms of complications from dialysis. Interventions: Encourage resident to go to scheduled dialysis appointments on Tuesday, Thursday and Saturday-7/2/24: Focus: Congestive Heart Failure (CHF, a chronic condition that affects the heart's ability to pump blood efficiently). Goal: Will be free from peripheral edema (swelling, usually in the lower limbs). Will have clear lung sounds, regular heart rate and rhythm. Interventions: Give cardiac medications as ordered;-7/2/24: Focus: Hypertension (high blood pressure). Goal: Will remain free from signs/symptoms of hypertension. Interventions: Give anti-hypertensive medications as ordered. Monitor for side effects such as increased heart rate;-7/2/24: Focus: Resistive to care related to refusing medications/care at times. Goal: Will cooperate with care. Interventions: Allow resident to make decisions about treatment regime, to provide sense of control. If possible, negotiate a time for activities of daily living so the resident participates in the decision-making process. Provide resident with opportunities for choice during care provision;-12/9/25: Focus: Impaired cognition. Goal: Will be able to communicate basic needs daily. Interventions: Communicate with the resident regarding capabilities and needs. The resident needs (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with decision making. Review of the resident's physician's order sheet (POS), located in the EHR, showed:-12/19/25: Carvedilol (used to treat high blood pressure) 3.125 milligrams (mg), one tablet every 12 hours;-12/19/25: Apixaban (used to prevent blood clots/strokes) 5 mg, one tablet two times a day;-12/19/25: Sodium bicarbonate (baking soda) 650 mg, one tablet daily for ESRD;-12/20/25: Amiodarone HCl (used to keep the heart beating normally) 200 mg, give one tablet daily for arrythmia (irregular heartbeat);-12/20/25: Atorvastatin Calcium (used to lower cholesterol) 80 mg daily for hyperlipidemia (elevated levels of lipids (fats, oils, waxes and certain vitamins));-12/20/25: Losartan Potassium (used to treat high blood pressure) 25 mg, one time a day;-12/20/25: [NAME]-Vite (a multivitamin specifically formulated for use by patients on dialysis), give one tablet daily;-12/23/25: Sevelamer (used to treat high phosphate levels in residents with chronic kidney disease who are on dialysis) 800 mg, give two tablets three times a day;-12/24/25: Cholecalciferol (vitamin D3, helps to absorb calcium and phosphorus) 1.25 mg, one time a day every Wednesday. Review of the resident's MAR, located in the EHR, showed CMT O documented a code 7 (sleeping) at 8:00 A.M. on 1/3/26, 1/5/26, 1/6/26, 1/7/26, 1/9/26, 1/10/26, 1/14/26, 1/15/26, 1/17/26, and 1/26/26, for the following medications: -Carvedilol, apixaban, sodium bicarbonate, amiodarone HCl, atorvastatin calcium, losartan potassium, [NAME]-Vite, and sevelamer;-CMT O documented a code 7 at 8:00 A.M on 1/7/26, and 1/14/26, for the Cholecalciferol. During an interview on 1/27/26 at 8:16 A.M., CMT O said he/she works mostly on the hall where the resident resides and administers his/her medications on the days he/she works. He/She works 7:00 A.M. until 3:00 P.M. and administers the resident's 8:00 A.M. medications. The resident is asleep a lot of the time when he/she passes the 8:00 A.M. medications. The resident prefers to sleep until around noon and does not want to take the 8:00 A.M. medications. The resident does not refuse his/her afternoon medications. He/She had told the nurse, but not the Director of Nursing (DON) or the physician about the resident frequently refusing to take the 8:00 A.M. medications CMT O had not asked the resident if he/she wanted his/her medications scheduled later in the day. CMT O did not know if the nurse had discussed the medication times with the resident. During an interview on 1/27/26 at 8:48 A.M., LPN H said he/she obtains the resident's blood glucose level and administers his/her insulin every morning around 8:00 A.M. The resident is usually asleep, but will wake up. LPN H had not been told by any CMT the resident was not taking his/her 8:00 A.M. medications. Had he/she been made aware the resident was not taking his/her medications, he/she would have tried to give the medications himself/herself when he/she takes his/her glucose level and administers the insulin. LPN H could also ask the resident if he/she would prefer his/her medications at a more suitable time for him/her. During an interview on 1/27/26 at 9:30 A.M., LPN B said if a resident does not take medications for any reason, he/she should be notified. If the resident does not take medications because he/she prefers to sleep, then he/she would contact the physician to see if the medication administration times could be changed to accommodate the resident. During an interview on 1/27/26 at 10:35 A.M., the DON said she was not aware the resident had been refusing to take his/her 8:00 A.M. medications. The CMT should have informed the nurse. Had she been made aware, she would have discussed adjusting the administration times to accommodate his/her sleeping schedule. If the resident agreed, she would contact the physician about changing the medication administration times. It's important for the resident to take his/her medications. 2. Review of Resident #2's quarterly MDS dated [DATE] and located in the EHR, showed:-Adequate hearing and vision;-Speech Clarity: Clear speech - distinct intelligible words;-Makes Self Understood: Understood;-Ability To Understand Others: Understands;-Cognitively intact;-Rejection of Care - Presence and Frequency: Behavior not exhibited;-Diagnoses of: Non-Alzheimer's dementia, anxiety, depression and bipolar disorder (a mental disorder (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characterized by periods of depression and abnormally elevated mood). Review of the resident's care plan, located in the EHR, showed:-Focus: Communication problem related to confusion, disorganized thought processes and speech patterns. Goals: Will improve communication function as evidenced by decrease in disorganized thoughts and ability to finish thoughts without cueing. Interventions: Anticipate needs. Allow adequate time to respond;-Focus: Delirium or an acute confusional episode. Goals: Will be free from signs/symptoms of delirium (changes in behavior, mood, cognitive function, communication, level of consciousness, restlessness). Interventions: Monitor/record/re[ort new onset signs/symptoms of delirium. Provide medications to alleviate agitation. Review of the resident's POS, located in the EHR, showed:-12/24/25: Valium (anti-anxiety medication) 2.5 mg every morning and bedtime-12/26/25: Amphetamine-dextroamphetamine/Adderall (used to treat ADHD (attention deficit hyperactivity disorder, a neurodevelopmental disorder characterized by symptoms of inattention, hyperactivity, impulsivity, and emotional dysregulation that are excessive and pervasive) 10 mg tablet one time a day for ADHD. Review of the resident's MAR, located in the EHR, showed:-Amphetamine-dextroamphetamine 10 mg at 6:00 A.M.: Staff documented a 9 (other/see progress notes, indicates the medication was not administered) on 1/19/26, 1/20/26, 1/21/26, and 1/22/26. The MAR was blank on 1/23/26;-Valium 0.25 mg at 8:00 A.M. and 8:00 P.M.: Staff coded a 9 on 1/20/26 and 1/21/26 at 8:00 A.M. and 8:00 P.M. Review of the resident's progress notes, located in the EHR, showed:-1/19/26 at 5:17 A.M.: Amphetamine-dextroamphetamine, medication on order;-1/20/26 at 5:54 A.M.: Amphetamine-dextroamphetamine, medication on order;-1/20/26 at 8:32 A.M.: Valium, need new script;-1/20/26 at 9:35 P.M.: Valium, on order, nurse is aware;-1/21/26 at 6:08 A.M.: Amphetamine-dextroamphetamine, awaiting pharmacy delivery;-1/21/26 at 8:15 A.M.: Valium, on order, need new script, nurse is aware;-1/21/26 at 9:01 P.M.: Valium, on order;-1/22/26 at 6:20 A.M.: Amphetamine-dextroamphetamine, awaiting pharmacy delivery. Review of a radiology report located, in the EHR, showed:-Examination Date: 1/21/26 at 8:32 A.M.;-Reported Date: 1/21/26 at 9:46 A.M.;-Impression: Focal pneumonia. Follow-up recommended. Review of the resident's progress note, dated 1/21/26 at 8:27 P.M., showed chest x-ray results reported to physician, positive for pneumonia. New order to start Azithromycin. Review of the resident's POS, showed:-1/22/26: Azithromycin 250 mg, give two tablets one time only on day one, then one tablet daily for four days, for infection. Review of the resident's MAR showed:-1/22/26: Azithromycin 250 mg two tablets one time only. Staff documented the Azithromycin was administered on 1/22/26 at 12:02 P.M., more than 15 hours after receiving the physician's order on 1/21/26 at 8:27 P.M. Review of medications in the facility E-Kit, showed the E-Kit contained 10 tablets of Azithromycin 250 mg. During an interview on 1/22/26 at 8:44 A.M., the resident said he/she had not been feeling too good because he/she had pneumonia, and staff told him/her they had not received his/her antibiotics yet. He/She had also been out of his/her Adderall for about five days. During an interview on 1/23/26 at 9:33 A.M., the DON said she expected staff to check the E-Kit when there is a new antibiotic ordered, and if it is available the antibiotic should be started. Azithromycin is available in the E-Kit. If the medication had been not available in the E-Kit, she would have expected the nurse to have contacted the physician to see if he wanted to start a different antibiotic that was available or wait until the pharmacy delivered the original antibiotic. This should all be documented in the resident's progress notes. During an interview on 1/24/26 at 7:00 A.M., LPN K said the resident did not receive his/her Valium and amphetamine-dextroamphetamine because his/her prescription ran out, and they needed a new prescription from the physician to be sent to the pharmacy. LPN K had not spoken to the pharmacy or the physician about the medications being out of stock, but he/she thought the day shift nurse had. During a telephone interview on 1/26/26 at 2:21 P.M., a pharmacy representative said when a facility notifies (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them a medication is running out, the pharmacy will inform the facility if a new prescription is needed before the medication can be refilled and delivered. The facility is responsible to contact the physician and have the prescription sent to the pharmacy so it can be delivered. The pharmacy did not receive the new prescription from the physician for amphetamine-dextroamphetamine until 1/23/26, and the medication was delivered to the facility on 1/24/26 at 8:00 A.M. The pharmacy received a new prescription for the Valium on 1/21/26, and the medication was delivered to the facility on 1/22/26 at 12:00 P.M. During an interview on 1/27/26 at 8:48 A.M., LPN H said if he/she had received the results of the resident's chest x-ray confirming pneumonia, he/she would contact the physician. If the physician ordered an antibiotic like Azithromycin, he/she would check the facility E-Kit and if available he/she would start the antibiotic at that time. Medications such as amphetamine-dextroamphetamine and Valium are sent to the facility by the pharmacy in bubble cards (each tablet is sealed in a plastic bubble and has to be popped out). When there are about 10 pills left in the card, he/she would contact the pharmacy and reorder the medication, so it does not run out. If the pharmacy says the medication will require a new prescription before it can be delivered, then the nurse is supposed to contact the physician so a new prescription can be sent to the pharmacy. Ideally, a resident should not run out of a medication. During an interview on 1/27/26 at 9:30 A.M., Nursing Supervisor LPN B, said they usually get chest x-ray results quickly after the chest x-ray is obtained. If the results showed an abnormal, like pneumonia, he/she would contact the physician right away. If the physician ordered an antibiotic, he/she would check the E-Kit and if available give the antibiotic. If it was available in the E-Kit, there would be no reason to wait until the next day to start the antibiotic. If a medication like amphetamine-dextroamphetamine or Valium is running out, he/she would contact the pharmacy when there are about 10 pills left in the card. If the pharmacy says a new prescription is required before the medication can be delivered, he/she would contact the physician at that time and request the new prescription be sent to the pharmacy so the medication wouldn't run out. During an interview on 1/27/26 at 10:35 A.M., the DON said there is a color change on the bubble card that should prompt the CMT or nurse to contact the pharmacy so a medication can be reordered and delivered before the medication runs out. The pharmacy will let the nurse know if the medication requires a new prescription and if so, she expected the nurse to contact the physician to have the new prescription sent to the pharmacy. She did not know why the prescriptions were not sent to the pharmacy prior to the amphetamine-dextroamphetamine and Valium running out. If the system worked as, it should, no resident should run out of their medication. 3. Review of Resident #1's admission face sheet, located in the EHR, showed an admission date of 12/19/25. Review of the resident's hospital admission orders, dated 12/19/25 and located in the EHR, showed the resident was admitted to the hospital on [DATE] with a diagnoses of C-diff and an order to administer Vancomycin 125 mg daily for four days. Review of the resident's MAR, located in the EHR, showed an order dated 12/20/25, for Vancomycin 125 mg, give one capsule daily at 6:00 A.M. for four days. Staff documented a code 9 (other/see progress notes) on 12/20/25 and 12/21/25. Review of the resident's progress notes, located in the EHR, showed:-No documentation as to why the resident did not receive his/her Vancomycin on 12/20/26;-12/21/26 at 6:31 A.M.: Vancomycin pending delivery. During a telephone interview on 1/26/26 at 2:21 P.M., a pharmacy representative said the pharmacy delivered 4 doses of Vancomycin 125 mg to the facility on [DATE] at 11:00 A.M. During an interview on 1/27/26 at 10:35 A.M., the DON said when a medication is coded as a 9, she expected staff to document the reason in the progress notes. When medications were delivered to the facility on a weekend, the pharmacy will normally take the entire delivery, for all the nurse's stations, to just one nurse's station. The nurse that receives the delivery (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should ensure any medications for residents on different halls are promptly delivered to those nurse's stations. If the Vancomycin was delivered on 12/20/25 at 11:00 A.M., she would have expected staff to have administered the medication that day. 2655549

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify one resident's physician and obtain treatment orders for skin issues/wounds they identified on a skin check upon the resident's admission on [DATE]. As of 12/23/25, when the resident passed away, the facility had not contacted the resident's physician regarding the skin issues/wounds, had not received treatment orders and had not documented the skin issues/wounds on the electronic treatment administration record (TAR) for on-going monitoring and assessment. Three residents were sampled for wounds, and problems were identified with one (Resident #1). The census was 84.Review of the facility's Skin Program Policy and Procedure revised 12/2023, showed:Purpose: The purpose of the skin program is to ensure that every resident's skin condition is observed/evaluated 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 observed/evaluated upon admission and PRN (as necessary/needed) 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 observation/evaluation is a full body audit and completion of the Braden Scale Pressure Risk Evaluation in Wound Rounds;-A Baseline Plan of Care is initiated and individualized by the Interdisciplinary Team (IDT) within 48 hours post admission;-Residents admitted to the facility with skin areas/pressure ulcers will have treatment orders initiated upon admission/re-admission;-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. Review of the facility LPN (Licensed Practical Nurse) Job Description, undated, showed:-Reports to: Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Supervisor;-Definition: The LPN is part of and functions in the context of the Nursing Department. The LPN is responsible for the direct and indirect care for residents experiencing medically complex conditions, general medical conditions, rehabilitation and/or wound care needs;-Responsibility and Tasks:-Documents on the delivery of health care and nursing process in accordance with specific unit standards and facility nursing policy;-Maintains accurate resident care records and documents pertinent data reflecting the use of the nursing process and critical thinking skills;-Performs administration and documentation of medication, internal nutrition, and performs treatments, as per physician's orders, and in accordance with policies, procedures, and licensure scope and standard of practice;-Keeps the DON informed of the residents' status and related matters;-Assures that each resident's attending physician is promptly notified of any significant change in the resident health condition. Review of the resident's admission face sheet, located in the electronic healthcare record (EHR), showed an admission date of 12/19/25. Review of Resident #1's Baseline Care Plan, completed by LPN N, dated 12/19/25 and located in the EHR, showed:-Dependent for: Toileting/hygiene, shower/bathing, personal hygiene, and roll left and right;-Level of Consciousness: Alert;-Cognitive Status: Cognitively impaired;-Always incontinent of bowel and bladder;-Current skin integrity issues: Yes;-Skin Risk: See skin assessment. Review of the resident's progress note's, located in the EHR, showed:-12/19/25 at 9:00 P.M., skin check documented by LPN N: Skin Issue #002: Location: Front right medial (toward the middle) lower leg. Issue Type: Open lesion. Length: 1.0 centimeter (cm) x Width: 1.0 cm. Skin Issue #003: Right lateral (to the side) calf. Issue type: Open lesion. 0.3 cm x 0.5 cm. Skin Issue #004: Location: Right great toe. Issue Type: Diabetic foot ulcer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	0.5 cm x 0.2 cm. Skin Issue #006: Location: Peri-anal (the skin between the genitals and surrounding the anus). Redness;-12/19/25 at 10:30 P.M.: Resident admitted to facility from hospital. Resident is alert and oriented x 3 (person, place, time). Body assessment done. Resident has some redness to groin, sheering (the skin moves in opposite direction causing friction or pressure leading to tissue damage). Areas noted to front right shin, back of right ankle and right big toe;-The progress notes showed no documentation the resident's physician was contacted for treatment orders for the skin issues identified on the right shin, back of right ankle and right big toe. Review of the resident's physician's order sheet (POS), located in the EHR, showed no treatment orders for the skin issues identified in LPN N's progress note dated 12/19/25 at 9:00 P.M. Review of the resident's treatment administration record (TAR, where nurses initial treatments are completed as ordered) dated 12/1/25 through 12/23/25, and located in the EHR, showed no documentation to monitor and/or treat the skin issues identified in LPN N's progress note dated 12/19/25 at 9:00 P.M. During an interview on 1/23/26 at 11:27 A.M., LPN N said he/she was the resident's admission nurse on Friday 12/19/25, and he/she documented the skin check in the progress note. He/She reviewed the skin check and said he/she documented skin issue #002 on the front right medial lower leg as open, but now he/she was not sure if it was open or not. There was a dressing on the area he/she removed, cleaned with soap and water and covered it with a dry dressing. Skin issue #003, the right lateral calf may have been open; it probably was open. Skin issue #004, the right great toe had a black necrotic (dead or dying tissue) area on the tip of the toe, on the skin, right below the toenail. Skin issue #006, the peri-anal area was red, but did not have any open areas. He/She applied protective dressings on the right lateral leg, the right lateral leg, and the right great toe. He/She applied barrier cream (a protective cream used to keep moisture/feces off the skin) to the peri-anal area. He/She should have documented each skin issue on the TAR for on-going monitoring but totally forgot. He/She attempted to contact the physician on 12/19/25, about the skin issues, but did not document that. He/She worked Saturday 12/20/25, and Sunday 12/21/25, as well, but did not attempt to contact the physician on those days. He/She did replace the resident's dressings on those days, but did not document that. He/She did not recall if he/she worked Monday 12/22/25. During a telephone interview on 1/24/26 at 7:10 A.M., LPN J said he/she worked the unit where the resident resided and remembered the resident. If a resident had a skin issue/treatment it should be on the TAR. The TAR is what prompts him/her to know a resident has a skin issue and/or treatment. He/She did not know the resident had any skin issues. During a telephone interview on 1/24/26 at 7:25 A.M., LPN K said when he/she looks at the TAR, it will tell him/her what residents have a skin issue that needs to be assessed or treated. If it is not on the TAR, he/she would not know about the skin issue. During an interview on 1/27/26 at 8:48 A.M., LPN H said if a resident is admitted with any abnormal skin areas or pressure ulcers, he/she would measure the areas, describe them and document it in the progress notes. He/She would contact the physician for new orders and document those in the progress notes, the POS and TAR. If the physician did not call back, he/she would cover the area with a basic dressing and pass it along in the shift report. He/She would document any attempts to contact the physician in the progress notes. If a treatment order is not on the TAR, he/she would not know to do the treatment or monitor the area. During an interview on 1/22/26 at 1:48 P.M., the facility Wound Care Nurse said the resident was admitted after she left on Friday 12/19/25. She was off Saturday, Sunday and Monday and returned to work on Tuesday 12/23/25. She was going to assess the resident's skin that morning, but the resident had just passed away. When she is not at the facility, the admitting nurse is responsible to complete the skin check upon admission. She reviewed the skin check completed by LPN N. The LPN should have contacted the physician (continued on next page)

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	265331	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Care at Sunset Hills	10954 Kennerly Road Saint Louis, MO 63128

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for treatment orders and documented the skin issues along with the treatment orders on the POS, TAR and in the progress notes. If the LPN attempted to contact the physician, it should have been documented. The LPN should have attempted to contact the physician on Saturday and Sunday as well. During an interview on 1/23/26 at 9:33 A.M., the DON said LPN N should have contacted the resident's physician and received treatment orders for each of the skin issues the resident had. Any new treatment orders should be documented on the TAR. The TAR prompts other nurses on other shifts to provide on-going assessment and treatment. She would have expected the LPN to have made more than one attempt to contact the physician and documented those attempts in the progress notes. 2699783

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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 - Minimal harm or potential for 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** Based on interview and record review, the facility failed to notify one resident's physician and obtain treatment orders for a pressure ulcer/injury (localized damage to the skin that usually occur over a bony prominence as a result of pressure) on one resident's coccyx (tailbone) that was identified on a skin check upon the resident's admission on [DATE]. As of 12/23/25, when the resident passed away, the facility had not contacted the resident's physician, had not received treatment orders and had not documented the pressure ulcer/injury on the electronic treatment administration record (TAR) for on-going monitoring, assessment and treatment. Three residents were sampled for wounds, and problems were identified with one (Resident #1). The census was 84.Review of the facility Skin Program Policy and Procedure revised 12/2023, showed:Purpose: The purpose of the skin program is to ensure that every resident's skin condition is observed/evaluated 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 observed/evaluated upon admission and PRN (as necessary/needed) 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 observation/evaluation is a full body audit and completion of the Braden Scale Pressure Risk Evaluation in Wound Rounds;-A Baseline Plan of Care is initiated and individualized by the Interdisciplinary Team (IDT) within 48 hours post admission;-Residents admitted to the facility with skin areas/pressure ulcers will have treatment orders initiated upon admission/re-admission;-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. Review of the facility's LPN (Licensed Practical Nurse) Job Description, undated, showed:-Reports to: Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Supervisor;-Definition: The LPN is part of and functions in the context of the Nursing Department. The LPN is responsible for the direct and indirect care for residents experiencing medically complex conditions, general medical conditions, rehabilitation and/or wound care needs;-Responsibility and Tasks:-Documents on the delivery of health care and nursing process in accordance with specific unit standards and facility nursing policy;-Maintains accurate resident care records and documents pertinent data reflecting the use of the nursing process and critical thinking skills;-Performs administration and documentation of medication, internal nutrition, and performs treatments, as per physician's orders, and in accordance with policies, procedures, and licensure scope and standard of practice;-Keeps the DON informed of the residents' status and related matters;-Assures that each resident's attending physician is promptly notified of any significant change in the resident health condition. Review of the resident's admission face sheet, located in the electronic healthcare record (EHR), showed an admission date of 12/19/25. Review of the resident's Baseline Care Plan, completed by LPN N, dated 12/19/25 and located in the EHR, showed:-Dependent for: Toileting/hygiene, shower/bathing, personal hygiene, and roll left and right;-Level of Consciousness: Alert;-Cognitive Status: Cognitively impaired;-Always incontinent of bowel and bladder;-Current skin integrity issues: Yes;-Skin Risk: See skin assessment. Review of the resident's progress note's, located in the EHR, showed:-12/19/25 at 8:10 P.M.: Braden Scale (an assessment tool used for predicting pressure injuries). Moisture (skin): Constantly moist. Activity: Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequent or significant changes independently. Friction and shear: Problem. Score of 11 (indicates is at a high risk to develop pressure sores/injuries);-12/19/25 at 9:00 P.M., skin check documented by LPN N: Skin Issue #005: Location coccyx. Issue Type: Pressure ulcer/injury. 4.0 centimeters (cm) x 0.3 cm x depth 0.5 cm. -12/19/25 at 10:30 P.M.: Resident admitted to facility from hospital. Resident is alert and oriented x 3 (person, place, time). Body assessment done. Resident has some redness to groin, sheering (the skin moves in opposite direction often caused friction or pressure leading to tissue damage) and opened area to coccyx. Areas noted to front right shin, back of right ankle and right big toe;-The progress notes showed no documentation the resident's physician was notified regarding the resident's coccyx pressure ulcer and/or if a treatment was obtained. Review of the resident's physician's order sheet (POS), located in the EHR, showed no treatment order for the pressure ulcer on the coccyx identified in LPN N's progress note dated 12/19/25 at 9:00 P.M. Review of the resident's TAR dated 12/1/25 through 12/23/25, showed no treatment order for the pressure ulcer identified in LPN N's progress note dated 12/19/25 at 9:00 P.M. During an interview on 1/23/26 at 11:27 A.M., LPN N said he/she was the resident's admission nurse on Friday 12/19/25, and he/she documented the skin check in the progress note. He/She reviewed the skin check and said he/she documented skin issue #005 on the coccyx. The pressure ulcer was red and open. He/She cleaned the pressure ulcer and applied barrier cream (a protective cream used to keep moisture/feces off the skin). He/She should have documented the pressure ulcer on the TAR for on-going monitoring but forgot. He/She attempted to contact the physician on 12/19/25, about the skin issues, but did not document that. He/She worked Saturday 12/20/25, and Sunday 12/21/25, as well, but did not attempt to contact and the physician on those days. He/She did replace the resident's dressings on those days, but did not document that. He/She did not recall if he/she worked Monday 12/22/25. During a telephone interview on 1/24/26 at 7:10 A.M., LPN J said he/she worked the unit where the resident resided and remembered the resident. If a resident had a pressure ulcer/treatment it should be on the TAR. The TAR is what prompts him/her to know a resident has a skin issue and/or treatment. He/She did not know the resident had a pressure ulcer on his/her coccyx. During a telephone interview on 1/24/26 at 7:25 A.M., LPN K said when he/she looks at the TAR, it will tell him/her what residents have a pressure ulcer that needs to be assessed or treated. If the pressure injury was not on the TAR, he/she would not know about it. During an interview on 1/27/26 at 8:48 A.M., LPN H said if a resident is admitted with any abnormal skin areas or pressure ulcers, he/she would measure the areas, describe them and document it in the progress notes. He/She would contact the physician for new orders and document those in the progress notes, the POS and TAR. If the physician did not call back, he/she would cover the area with a basic dressing and pass it along in the shift report. He/She would document any attempts to contact the physician in the progress notes. If a treatment order is not on the TAR, he/she would not know to do the treatment or monitor the area. During an interview on 1/22/26 at 1:48 P.M., the facility Wound Care Nurse said the resident was admitted after she left on Friday 12/19/25. She was off Saturday, Sunday and Monday and returned to work on Tuesday 12/23/25. She was going to assess the resident's skin that morning, but the resident had just passed away. When she is not at the facility, the admitting nurse is responsible to complete the skin check upon admission. She reviewed the skin check completed by LPN N. LPN N should have contacted the physician for treatment orders and documented the pressure ulcer along with the treatment order on the POS, TAR and in the progress notes. If the LPN attempted to contact the physician, it should have been documented. The LPN should have attempted to contact the physician on Saturday and Sunday as well. During an interview on 1/23/26 at 9:33 A.M., the DON said LPN N should have contacted the resident's physician and received treatment orders for the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer on the coccyx. Any new treatment order should be documented on the TAR. The TAR prompts other nurses on other shifts to provide on-going assessment and treatment. She would have expected the LPN to have made more than one attempt to contact the physician and documented those attempts in the progress notes. 2699783