STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265338	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester House, The	550 White Road Chesterfield, MO 63017

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' personal possessions were kept safe from loss or theft and failed to maintain inventory sheets for four sampled residents (Residents #1, #8, #9 and #10). The census was 90. Review of the facility's Inventory of Personal Belongings policy, dated [DATE], showed: -The facility will reduce the potential for lost clothing and ensure that residents receive all of their personal clothing once it has been laundered; -The Laundry Department will be notified of each new resident admission, take the resident's clothing, mark it and account for each item on an inventory sheet, with description for each article of clothing; -The same procedure will be done each time new clothing is brought into the facility; -If any clothing is missing, the Laundry Department will make every possible attempt to find the clothing before the resident's discharge. Review of the facility's Closet Search-Lost and Unmarked Clothing policy, dated [DATE], showed: -Every attempt will be made to ensure lost clothing is found. All personal clothing will be handled in a manner to ensure that clothing is given back to the appropriate resident; -A concern and comment form should be completed, as appropriate, and turned into the Environmental Services Director or Social Services; -Using the descriptions given for the lost article of clothing, the Laundry Department will go to each room and search through every closet; -Once the article of clothing has been found, the resident/family will be notified; -If the article of clothing cannot be located, the Environmental Services Director and Social Services will work together to resolve the issue to the satisfaction of the resident. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Cognitively intact; -Impairment on both sides of lower body; -Dependent on staff for transfers; -Diagnoses included heart failure, kidney disease, respiratory disease and diabetes mellitus. Review of the resident's inventory sheet, undated, showed there was no documentation listing any belongings. Review of the resident's handwritten inventory sheet, undated, showed: -One brown faux fur blanket; -There was no documentation showing two makeup bags with products, three bottles of perfume, pants, or an electric toothbrush were listed. Review of the resident's progress notes, dated [DATE] through [DATE], showed no documentation the resident reported missing items or missing items were found or replaced by the facility. During an interview on [DATE] at 10:10 A.M., the resident said: -He/She was missing $700.00 worth of personal belongings, including an expensive faux fur blanket, three bottles of perfume, an electric toothbrush, pairs of pants and two bags full of makeup; -The resident spilled water on his/her faux fur blanket and instead of letting it dry on a chair, a staff member took it to the laundry to get washed; -The resident has asked for the faux fur blanket back and it was not returned; -He/She did not feel the facility was taking him/her seriously and had not updated him/her on the missing items. During an interview on [DATE] at 12:08 P.M., the Administrator said: -She was made aware sometime in February, the resident was missing two or three pairs of pants. At that time, she thought the pants were located in laundry and returned to the resident; -She could not find any documentation the resident's pants were ever returned and if they were still missing, the facility was responsible for reimbursing the resident for the missing items; -She saw an online review recently saying the resident was missing $700.00 worth of items; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was not aware the resident was missing $700.00 worth of items and was currently investigating the matter with the resident. 2. Review of Resident #8's inventory sheet, dated [DATE], showed no documentation found listing a gold wedding band. Review of the resident's admission MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included dementia and Parkinson's Disease (a movement disorder of the nervous system). Review of the resident's progress notes, dated [DATE] through [DATE], showed: -On [DATE] at 9:53 A.M., the resident entered the building via stretcher, escorted by two Emergency Medical Technicians (EMT). The resident was alert but lethargic, was easily understood and denied pain. The resident was part of his/her own care plan decisions and a family member was there to confer with hospice nurse to sign paperwork and confirm care; -On [DATE] at 10:58 A.M., the resident was able to make needs known. The resident was newly admitted to hospice care; -On [DATE] at 11:37 A.M., the resident was observed moaning this morning, medication was administered for anxiety and pain; -On [DATE] at 4:11 P.M., resident deceased ; -On [DATE] at 4:38 P.M., during 3:00 P.M. rounds,. The resident was found with cessation of all vital signs. Confirmed by another nurse. Hospice, Primary Care Physician (PCP) and family notified. Director of Nursing (DON) and coroner made aware. Post mortem care provided. Family arrived at 4:10 P.M.; -On [DATE] at 5:39 P.M., the resident's remains were picked up by the mortuary; -There was no documentation the resident was wearing a gold wedding band or that the resident was missing a gold wedding band. During an interview on [DATE] at 12:15 P.M., Registered Nurse (RN) A said: -He/She worked with the resident on [DATE], [DATE], [DATE] and [DATE]; -He/She did not admit the resident when he/she returned from the hospital; -He/She remembers the resident was wearing his/her gold wedding band on [DATE] and on [DATE] after the resident returned from the hospital; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE], he/she cannot recall seeing the resident wearing his/her gold wedding band as the resident had his/her arms under the covers and was actively dying during his/her shift. RN A was more concerned about the resident's rapid decline of health at the time; -On [DATE], RN A checked on the resident after report, at approximately 3:00 P.M., and found the resident deceased . The resident was not wearing his/her gold wedding band; -On [DATE], the resident's son made RN A aware the resident's gold wedding band was missing after the resident's remains were picked up by the funeral home. He/She immediately searched the resident's room for the gold wedding band. It was not located. During an interview on [DATE] at 12:25 P.M., Certified Nurse Aide (CNA) B said: -He/She worked with the resident on [DATE], [DATE] and [DATE]; -He/She could not remember seeing the resident wearing a gold wedding band during his/her shifts; -He/She provided post mortem care for the resident on [DATE] and did not recall the resident wearing a gold wedding band; -On [DATE], the resident's son made him/her aware the resident was missing his/her gold wedding band while the resident's remains were still in his/her room; -CNA B searched the room, the bed, and the resident's clothes for the gold wedding ring and could not locate it. 3. Review of Resident #9's inventory, dated [DATE], showed: -$5.00 with change was listed; -There was no documentation found showing a wallet was listed. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive issues; -Diagnoses included Parkinson's disease, anxiety and depression. Review of the resident's progress notes, dated [DATE] through [DATE], showed no documentation regarding the resident's wallet or money was in his/her possession or was reported lost or missing. During an interview on [DATE] at 12:07 P.M., the Administrator said: -The resident called the police and reported she/he was missing his/her coin wallet with $60 in it; -The resident reported to a staff member he/she last saw it on [DATE] under his/her pillow; (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident then changed his/her story and said it was in his/her wheelchair beside him/her when the resident last saw the wallet. During an interview on [DATE] at 12:05 P.M., CNA C said: -He/She last worked with the resident on [DATE], when the CNA helped the resident to the bathroom; -The resident had his/her wallet located on the side of his/her wheelchair when CNA C helped the resident to the bathroom; -CNA C worked with the resident consistently and the resident was very on his/her wallet making sure it was beside him/her while the resident was in his/her wheelchair or underneath his/her pillow when the resident went to lay down in the bed; -CNA C made sure the resident always had his/her wallet when working with the resident; -CNA C was not sure how much money was in the resident's wallet; -The resident was fully cognitive and was able to report when he/she was missing property. 4. Review of Resident #10's inventory sheet, dated [DATE], showed a pocketbook, a wallet and $13.00 with change was listed. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included heart failure, anxiety and depression. Review of the resident's inventory sheet, dated [DATE], showed no documentation listing any denomination of money was listed as missing. Review of the resident's progress notes, dated [DATE] through [DATE], showed no documentation the resident had a wallet with cash money in his/her room or that the resident refused to keep the money in a resident trust account. There was not documentation the resident reported money missing from his/her wallet. During an interview on [DATE] at 12:07 P.M., the Administrator said: -The resident reported to the police today, that on [DATE], time unknown, $100 out of $200 was missing from his/her wallet; -The resident refused to keep the money in the resident trust account. 5. During an interview on [DATE] at 12:08 P.M., the Administrator said she expected residents to have inventory sheets in their electronic medical records and was not sure if each resident had inventory sheets or if they were complete. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:05 P.M., CNA C said: -CNA C made sure residents' personal property was kept safe from loss or theft by ensuring the residents who were cognitively aware had their personal property with them during his/her shift, following the residents' preferences and if a resident was not cognitively aware, CNA C would inform the nurse of any personal property so it would be secured; -Both nurses and CNAs were responsible for making sure inventory sheets were filled out upon resident admissions or when new items were brought in the facility. During an interview on [DATE] at 12:15 P.M., RN A said: -Nurses and/or family members filled out inventory sheets when residents were admitted and the form was kept in the residents' medical record; -Nurses would either lock up personal valuable items or send the valuables home with family to keep them safe from loss or theft. During an interview on [DATE] at 4:08 P.M., the DON said: -She expected nursing staff and the laundry department to fill out the inventory sheets with resident belongings upon admission; -She expected families to update nursing staff with any new items they bring in or remove from the residents' room so inventory sheets could be updated by staff; -The facility would look for any missing items once they were reported; -The facility would reimburse items if they were reported lost at the facility if they were not listed on the inventory sheet, providing a receipt was given by the resident or the residents' family; -They ensured residents' personal property was kept safe from lost and/or theft by maintaining inventory sheets; -The facility had the resident or the resident's family sign a clause in the Admissions Agreement showing they were responsible for any monies, jewelry, or other valuable items if they were kept in the resident's room; -She expected facility staff to have knowledge of and to follow facility policies. MO00253623 MO00254154 MO00254157 MO00254090

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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. Based on observation, interview and record review, the facility failed to complete weekly skin assessments and to identify an open wound caused by cellulitis (a serious bacterial infection) for one resident (Resident #1) and failed to notify the resident's physician of the wound and obtain orders for the wound care. The facility also failed to discontinue wound care orders for the resident's right medial distal thigh and documented falsely in the resident's Treatment Administration Record (TAR). The sample size was four. The census was 90. Review of the facility's Skin Integrity and Pressure Ulcer/Prevention and Management Policy, dated 7/9/24, showed: -Policy: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy (surgically created opening in the body to allow waste to exit the body) Continent Nurses Society); -A comprehensive skin inspection/assessment is completed on admission and re-admission to the center; -A skin assessment/inspection should be performed weekly by a licensed nurse. Skin observations also occur throughout points of care provided by Certified Nurse Assistants (CNA) during activities of daily living (ADL) care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed; -When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. Review of Resident #1's Physician Order Sheets (POS), showed: -An order, dated 4/2/25, for wound care company to evaluate and treat; -There were no orders for weekly skin checks; -There were no orders for treatment to the resident's left thigh. Review of the resident's assessments, showed: -A weekly skin integrity data collection, dated 4/9/25, showed skin alterations included Moisture Associated Skin Damage (MASD) on the resident's perineal area (region between the anus and the genitals), open area/wound with a wound vacuum (wound vac, a medical device used to help heal wounds using negative pressure) present on the resident's right thigh and other was used to describe buttock. None of the areas were new; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation of weekly skin integrity data collection assessments found after 4/9/25 through 5/12/25. Review of the resident's shower sheets, showed; -On 4/16/25, the body diagram with the right front thigh was circled with a handwritten note of wound vac and the back of the right and left buttocks circled with a handwritten note of redness, scabs. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/2/25, showed: -Cognitively intact; -Impairment on both sides of lower body; -Dependent on staff for toileting, showers, lower body dressing, bed mobility and transfers; -Incontinent of bowel and bladder; -Surgical wounds present; -Diagnoses included heart failure, kidney disease, respiratory disease and diabetes mellitus. Review of the resident's care plan, undated, showed: -Problem: Resident was admitted with multiple wounds with worse one on his/her right thigh; -Interventions included: Treatment as ordered, weekly skin checks, and pressure reducing mattress. Review of the resident's progress notes, dated 5/1/25 at 10:05 P.M., showed the resident had areas to the left leg that were warm, red and painful to the touch. Notified the physician on call. Received new orders for antibiotics and a blood test. Continue to monitor the area. Review of the resident's shower sheets, showed: -On 5/3/25, a handwritten note said (he/she) didn't feel good. There was no other documentation found. Review of the resident's TAR, dated May 2025, showed: -An order, dated 4/4/25, for right inner thigh wounds, apply Santyl (an ointment used to debride ulcers) and Calcium Alginate (dressing used for exudating wounds) and cover with right dry dressing every Monday, Wednesday and Friday during day shift. Documentation showed the facility administered the treatment as ordered on 5/2, 5/5, 5/7 and 5/9; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 4/28/25, for treatment to right medial (closest to center of body) distal (site furthest away from center) thigh. Cleanse wound with wound cleanser, apply Hydrofera Blue (dressing provides wound protection and addresses bacteria and yeast) to wound bed and dry dressing every Monday, Wednesday and Friday during day shift. Documentation showed the facility administered the treatment as ordered on 5/2, 5/5, 5/7, and 5/9. -An order, dated 5/5/25, for Collagen-Antimicrobial (dressing used to absorb exudate (drainage)) external sheet; cleanse right medial distal thigh with wound cleanser, apply collagen powder (powder used to absorb exudate) and Hydrofera Blue, cover with a dry dressing every shift Monday Wednesday and Friday. Documentation showed the facility administered the treatment as ordered on evening shift and resident sleeping during night shift for 5/9; administered on day shift, held for evening shift and other for 5/7; and administered on day, evening and night shifts for 5/9/25. Review of the resident's wound care company wound assessment, dated 5/5/25, showed: -Trauma (caused by mechanical force) wound located on right thigh, medial distal, measuring 8.1 centimeters (cm) by 11.3 cm by 0.3 cm deep, with 45% granulation tissue (red, new tissue), 25% slough (dead tissue separating from living tissue) and 30% eschar (dead tissue) in wound bed with a moderate amount of serosanguineous (composed of serum and blood) exudate present; -Wound orders and plan of care included: Cleanse wound with Hypochlorous acid (slightly acidic solution used to fight infections), apply collagen powder, 1 gram (gm) to base of clean wound bed, cover with Hydrofera Blue, then cover with a dry dressing every Monday, Wednesday and Friday. All orders will remain in effect until discontinued, revised, or replaced with additional orders. Ok to continue current treatment orders until able to obtain supplies/medications for updated orders; -Visit specific information: Rounded with the facility Wound Nurse, recommended change to plan of care to add collagen powder; -Medical Necessity for this encounter: After evaluating the wound/skin issues at this encounter, a change to the plan of care was required. Orders and instructions were left with the care facility and/or nursing staff. Bedside nurse was instructed on proper dressing changes or dressing change techniques to enhance wound healing; -There was no documentation of a wound assessment or plan of care for the resident's left thigh. Review of the resident's shower sheet, dated 5/7/25, showed no documentation found. The Certified Nurse Assistant (CNA) nor the nurse signed the document. Review of the resident's progress notes, showed no documentation a new wound was found on the resident's left posterior thigh with notification to the Primary Care Physician (PCP) for new orders. Observation on 5/9/25 at 10:10 A.M., showed: -The resident lay on a pressure reducing mattress, in a gown, wearing anti slip socks with a call light in reach; -There was a white dressing present on the resident's left posterior thigh, dated 5/7/25; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a white dressing present on the resident's right medial distal thigh, dated 5/7/25. Observation on 5/9/25 at 10:45 A.M., showed; -The Wound Nurse provided care to the resident; -The Wound Nurse removed a treatment, dated 5/7/25, from the resident's right medial distal thigh; -The Wound Nurse treated the wound on the resident's right medial thigh by cleansing the wound with sterile water and gauze, put Collagen-Antimicrobial sheet in the wound base, then Hydrofer Blue over it and covered the wound with a dry dressing, dated 5/9/25; -The Wound Nurse removed a treatment, dated 5/7/25, from the resident's left posterior thigh. The bandage had a moderate amount of purulent (thick, yellowish-green or yellowish fluid that is often associated with infection) drainage; -The Wound Nurse treated the wound on the resident's left posterior thigh by cleansing the wound with sterile water and gauze, put Xeroform gauze (dressing with petrolatum used to maintain moisture in wound) in the wound base and covered the wound with a dry dressing, dated 5/9/25; -The Wound Nurse explained she used sterile water to cleanse the wounds as the Hypochlorous acid stung and hurt the resident, making the resident resistant to wound care. It was the resident's preference. During an interview on 5/12/2, at 8:49 A.M., the wound care company Nurse Practitioner (NP) said: -She evaluated and treated wounds for the facility-identified residents; -She came once a week and did rounds with the facility's Wound Nurse; -She assessed residents' wounds, gave verbal recommendations to the Wound Nurse during rounds and then submitted a wound assessment report to the facility the day after her visit; -She expected the Wound Nurse to update the residents' POS in the electronic medical record (EMHR) with her new wound treatment orders after receiving the wound report; -She expected the Wound Nurse to discontinue any existing wound treatment orders when new wound treatment orders were received; -She expected the Wound Nurse to notify her if a product was unavailable so she could make new treatment orders; -She was aware the Wound Nurse was using Collagen-Antimicrobial dressing instead of collagen powder and sterile water instead of Hypochlorous acid during wound care; -She expected the facility to follow her wound treatment orders to facilitate wound healing. Observation on 5/12/25 at 9:03 A.M., showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester House, The	550 White Road Chesterfield, MO 63017

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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	-CNAs were expected sign the shower sheets, turn shower sheets into the nurse for their signature and then the nurse kept the shower sheets; -CNAs were expected to notify the nurse of any new skin issues so the nurse could evaluate and treat the resident. During an interview on 5/12/25 at 12:55 P.M., the Wound Nurse said: -She rounded with the wound care company NP once a week on residents who had orders for the NP to evaluate and treat their wounds; -The wound care company NP would tell him/her of any new wound treatment orders during rounds and the Wound Nurse would put the new wound treatment orders in residents' POS in the EMHR after the wound care during the NP's visit, on the same day; -She completed a weekly wound assessment in residents' EMHR after she received the wound care company NP submitted her wound report. The Wound Nurse received the NP's wound reports the day after service; -The weekly wound assessment included the wound description, measurements, whether or not the wound improved and the plan of care, including any new orders; -The Wound Nurse was responsible for discontinuing an existing wound treatment order when there was a new wound treatment order; -She was expected to assess any new wounds, document his/her findings in a wound assessment in the EMHR, notify the PCP for new orders, notify the DON the resident and the resident's responsible party; -The wound assessments generated a progress note automatically with a summary; -It was important to document the wound assessment when a wound was first found so there was a record of what was done, the date it was found and the condition of the wound for tracking purposes. It was also important to have the baseline wound assessment to see if the wound was improving or declining so changes in the plan of care could be made; -The residents were at risk of further breakdown of their skin, deterioration of the wound and/or infection if the PCP was not informed of the new wounds to get appropriate treatment orders; -She referred to the wound treatment orders found in the residents' EMHR when she administered their treatments; -She was responsible for completing weekly wound assessments for residents with existing wounds; -Nurses were responsible for completing weekly skin assessments for residents; -She was responsible for auditing residents' EMHR for completed weekly skin assessments once a week; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was expected to notify the DON if a nurse did not complete a weekly skin assessment during their assignment; -She was not sure the last time she ran an audit for completed weekly skin assessments. She thought it might have been a week or two ago; -She expected the CNAs or nurses to notify him/her of any new skin issues immediately or during the next worked shift, so she could evaluate and get orders to treat the new wounds; -She was not made aware of any new skin issues on the resident prior to 5/9/25; -She did not have an order for the wounds on the resident's left posterior thigh on 5/9/25. When she saw the wound, she put a treatment on it; -She could not remember when she first the wound on the resident's left posterior thigh; -She should have discontinued the previous wound treatment orders for the right medial distal thigh when she put in the new treatment order on 5/5/25; -The Wound Nurse was not aware she had documented that she had administered the treatment orders dated 4/4/25, 4/28/25 and 5/5/28 for the resident's right medial distal thigh. It was inaccurate documentation and contradicting information. It did not accurately reflect that she was only administering the wound treatment order dated 5/5/25; -She should have notified the PCP of the new wounds found on 5/9/25 for new treatment orders, documented the wound assessment, notified the DON and resident responsible party before she left her shift on 5/9/25. She had every intention to do so but was taking care of other residents; -She was aware of the facility policies and had access to them. During an interview on 5/12/25 at 7:29 A.M. and at 1:48 P.M., the DON said: -The Wound Nurse was responsible for completing wound treatments for the residents; -Nurses were responsible for completing weekly skin checks, documenting the assessments in the residents' EMHR; -The Wound Nurse was responsible for overseeing the weekly skin assessments, ensuring they were completed by nurses; -She expected the Wound Nurse to tell the nurse to complete a skin assessment or the Wound Nurse to complete a skin assessment if the wound nurse found during her audit nurses did not complete residents' weekly skin assessment; -The Wound Nurse was expected to report to the DON the nurses who failed continually to complete resident weekly skin assessments; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Wound Nurse was responsible for completing weekly wound assessments, documenting in the residents' EMHR; -The facility had a wound care company who came out once a week to evaluate and treat residents with open wounds, other than skin tears; -The Wound Nurse was responsible for rounding with the wound care company Nurse Practitioner every Monday, put in new orders, discontinue old orders and update the residents' EMHR with the new wound assessment; -The wound care NP sent in complete wound assessments every Tuesday and the Wound Nurse was expected to review them and make changes to the residents' orders as needed; -Failure to discontinue wound treatment orders when new wound treatment orders were received was confusing to any other nurse who tried to administer treatment to the wound as they would not sure which treatment order was accurate; -Documenting on three different orders was falsification of medical records and did not reflect what was actually administered to the residents; -She expected the Wound Nurse to complete a wound assessment, notify the PCP for new treatment orders, notify the resident and/or resident responsible party when a new skin issue was found. -Residents were at risk of further skin breakdown, deterioration of the new wound and/or infection if new orders were not received upon discovery of the new wounds -She expected nursing staff to have knowledge of and to follow facility policies. Review of the resident's wound care company wound assessment, dated 5/12/25 at 10:42 P.M., showed: -Visit specific Information: Rounded with facility Wound Nurse. Resident was diagnosed with cellulitis last week and was started on antibiotics with new wounds to left posterior thigh. Start Santyl and Calcium Alginate to posterior thigh wounds; -Trauma wound located on right thigh, medial distal, measuring 7.0 cm by 11.6 cm by 0.2 cm deep with 60% granulation tissue, 15% slough and 15% eschar tissue present in wound bed with a moderate amount of serosanguineous exudate present; No new treatment order listed; -Cellulitis wound on left thigh, posterior (back), first date wound recognized on 5/7/25, measuring 1.5 cm by 2. 3 cm by 0.1 cm deep, 50% granulation, 30% skin and 20% eschar tissue present in wound bed with a moderate amount of Serosanguineous exudate present. Wound order: Cleanse wound with Hypochlorous acid, apply Santyl nickel thick to wound bed, edge to edge, apply calcium alginate inside wound base and cover with a super absorbent dressing. Change dressing daily and as needed. MO00253623

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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 observation, interview and record review, the facility failed to complete weekly skin assessments and to identify a Stage II (partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue) or eschar (non-viable, dark brown or black tissue). May also present as an intact or open/ruptured blister) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for one resident (Resident #1) and failed to notify the resident's physician of the pressure ulcer and obtain orders for the wound care. In addition the facility failed to assess, document and obtain treatment orders for a pressure ulcer identified on admission (Resident #7). The sample size was four. The census was 90. Review of the National Pressure Ulcer Advisory Panel (NPUAP), prevention and treatment of pressure ulcers: quick reference guide, Washington DC: National Pressure Ulcer Advisory Panel 2014 showed the following: -Assess the pressure ulcer initially and re-assess it at least weekly; -With each dressing change, observed the pressure ulcer for signs that indicate a change in treatments as required (e.g., Wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications); -Address the signs of deterioration immediately. Review of the facility's Skin Integrity and Pressure Ulcer/Prevention and Management Policy, dated 7/9/24, showed: -Policy: Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy (surgically created opening in the body to allow waste to exit the body) Continent Nurses Society); -Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. -A comprehensive skin inspection/ assessment is completed on admission and re-admission to the center; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A skin assessment/inspection should be performed weekly by a licensed nurse. Skin observations also occur throughout points of care provided by Certified Nurse Assistants (CNA) during activities of daily living (ADL) care (bathing, dressing, incontinent care, etc). Any changes or open areas are reported to the nurse. CNAs will also report to nurse if topical dressing is identified as soiled, saturated, or dislodged. Nurse will complete further inspection/assessment and provide treatment if needed; -Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services; -When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. 1. Review of Resident #1's Physician Order Sheets (POS), showed: -An order, dated 4/2/25, for wound care company to evaluate and treat; -There were no orders found for weekly skin checks; -There were no orders found for treatment to buttocks. Review of the resident's assessments, showed: -A weekly skin integrity data collection, dated 4/9/25, showed skin alterations included Moisture Associated Skin Damage (MASD) on the resident's perineal area (region between the anus and the genitals), open area/wound with a wound vacuum (wound vac, a medical device used to help heal wounds using negative pressure) present the resident's right thigh and other was used to describe buttock. None of the areas were new; -There was no documentation found showing there were weekly skin integrity data collection assessments found after 4/9/25 through 5/12/25. Review of the resident's shower sheets, showed; -On 4/16/25, the body diagram with the right front thigh circled with a handwritten note of wound vac and the back of the right and left buttocks circled with a handwritten note of redness, scabs. The nurse signed off. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/2/25, showed: -Cognitively intact; -Impairment on both sides of lower body; -Dependent on staff for toileting, showers, lower body dressing, bed mobility and transfers; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Incontinent of bowel and bladder; -At risk for pressure ulcers; -One Unstageable pressure ulcer (slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined) present; -Surgical wounds present; -Diagnoses included heart failure, kidney disease, respiratory disease and diabetes mellitus. Review of the resident's care plan, undated, showed: -Problem: At risk for unavoidable pressure injury development or decline of skin integrity; -Interventions included: Pressure redistribution mattress and weekly skin checks. Review of the resident's shower sheet, showed: -On 5/3/25, a handwritten note said (he/she) didn't feel good. There was no other documentation found. Review of the resident's Braden scale assessment (for predicting pressure ulcer risk) dated 5/4/25, showed staff documented a score of 13 (moderate risk). Review of the resident's shower sheet, showed: -On 5/7/25, there was no documentation found. Neither the CNA nor the nurse signed the document. Observation on 5/9/25 at 10:10 A.M., showed the resident lying on a pressure reducing mattress, in a gown, wearing anti slip socks with a call light in reach. During an interview on 5/9/25 at 10:12 A.M., the resident said: -His/Her buttocks were painful and he/she thought there might be an open area; -The nursing staff applied a cream to his/her buttocks after every incontinence episode. Observation on 5/9/25 at 10:45 A.M., showed; -The Wound Nurse assisted the resident to roll over to his/her right side; -The Wound Nurse removed the resident's dry brief, exposing his/her left buttock; -The resident's brief had a minimal amount of reddish, brown exudate (drainage) present where it was against the resident's left buttock; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were three small open areas present on the resident's left buttock. The wound base on all three open areas appeared shiny and red; -The Wound Nurse cleansed the wounds with sterile water, placed Xeroform (dressing with petrolatum used to maintain moisture in wound) in the wound base and covered the wound with a dry dressing; -The Wound Nurse replaced the resident's brief and repositioned him/her on the bed. During an interview on 5/9/25 at 11:31 A.M., the Wound Nurse said: -The wounds on the resident's left buttock were new and she was not aware of them until the observation; -She was not sure what type of wounds were present on the resident's left buttock; -She was a new wound nurse, and started in the position a month ago. Review of the POS, showed no new orders dated 5/9/25. Review of the progress notes, showed no documentation staff notified the physician or resident's responsible party (RRP) of the wounds. During an interview on 5/12/25 at 8:49 A.M., the wound care company Nurse Practitioner (NP) said: -She evaluated and treated wounds for the facility-identified residents; -She came once a week and did rounds with the facility Wound Nurse; -She assessed residents' wounds, gave verbal recommendations to the Wound Nurse during rounds and then submitted a wound assessment report to the facility the day after her visit; -She expected the Wound Nurse to update the residents' POS in the residents' electronic medical health record (EMHR) with her new wound treatment orders after receiving the wound report; -She expected the facility to follow her wound treatment orders to facilitate wound healing. Observation on 5/12/25 at 9:03 A.M., showed: -The wound care company NP and the facility Wound Nurse providing care to the resident; -The Wound Nurse informed the wound care company NP the resident had a new skin issue located on his/her left buttock; -The resident was rolled over and the Wound Nurse removed a treatment, dated 5/9/25, from the resident's left buttock; -The wound care company NP said the open areas on the resident's left buttock were Stage II pressure ulcer, assessed the wound, took pictures and gave treatment instructions to the Wound Nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, on 5/12/25 at 10:23 A.M., showed: -There was no documentation the Wound Nurse notified the Primary Care Physician (PCP) of the new wounds found on the resident's left buttock to obtain new orders; -There was no documentation the Wound Nurse notified the resident's responsible party (RRP) or the Director of Nurses (DON) of the new wounds found on the resident's left buttock. Review of the resident's assessments, on 5/12/25 at 10:23 A.M., showed: -There was no documentation found showing a skin assessment or wound assessment was completed on the resident from 5/9/25 through 5/12/25. During an interview on 5/12/25 at 10:25 A.M., CNA D said: -He/She was not assigned to the resident's care; -CNAs were expected to fill out shower sheets when providing bath or showers to residents; -CNAs were expected to document if a resident refused a bath or shower, any existing or new skin issues by marking on the body diagram the location and description of what was found; -CNAs were expected to notify the nurse immediately of any new skin issue so the nurse could immediately assess the residents' skin and provide treatment; -CNAs were expected sign the shower sheets, turn shower sheets into the nurse for their signature and then the nurse kept the shower sheets; -CNAs were expected to notify the nurse of any new skin issues so the nurse could evaluate and treat the resident. During an interview on 5/12/25 at 12:55 P.M., the Wound Nurse said: -She rounded with the wound care company NP once a week on residents who had orders for the NP to evaluate and treat their wounds; -The wound care company NP would tell her of any new wound treatment orders during rounds and the Wound Nurse would put the new wound treatment orders in residents' POS in the EMHR after the wound care NP's visit, on the same day; -She completed a weekly wound assessment in residents' EMHR after she received the wound care company NP submitted her wound report. The Wound Nurse received the NP's wound reports the day after service; -The weekly wound assessment included the wound description, measurements, whether or not the wound improved and the plan of care, including any new orders; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Wound Nurse was responsible for discontinuing an existing wound treatment order when there was a new wound treatment order; -She was expected to assess any new wounds, document her findings in a wound assessment in the EMHR, notify the PCP for new orders, notify the DON, the resident and the resident's responsible party; -The wound assessments generated a progress note automatically with a summary; -It was important to document the wound assessment when a wound was first found so there was a record of what was done, the date it was found and the condition of the wound for tracking purposes. It was also important to have the baseline wound assessment to see if the wound was improving or declining so changes in the plan of care could be made; -The residents were at risk of further breakdown of their skin, deterioration of the wound and/or infection if the PCP was not informed of the new wounds to get appropriate treatment orders; -She referred to the wound treatment orders found in the residents' EMHR when she administered their treatments; -She was responsible for completing weekly wound assessments for residents with existing wounds; -Nurses were responsible for completing weekly skin assessments for residents; -She was responsible for auditing residents' EMHR for completed weekly skin assessments once a week; -She was expected to notify the DON if a nurse did not complete a weekly skin assessment during their assignment; -She was not sure the last time she ran an audit for completed weekly skin assessments. She thought it might have been a week or two ago; -She expected the CNAs or nurses to notify her of any new skin issues immediately or during the next worked shift, so she could evaluate and get orders to treat the new wounds; -She was not made aware of any new skin issues on the resident prior to 5/9/25; -She should have notified the PCP of the new wounds found on 5/9/25 for new treatment orders, documented the wound assessment, notified the DON and resident's responsible party before she left her shift on 5/9/25. She had every intention to do so but was taking care of other residents; -She was aware of the facility policies and had access to them. During an interview on 5/12/25 at 7:29 A.M. and at 1:48 P.M., the DON said: -The Wound Nurse was responsible for completing wound treatments for the residents; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses were responsible for completing weekly skin checks, and documenting the assessments in the residents' EMHR; -The Wound Nurse was responsible for overseeing the weekly skin assessments, ensuring they were completed by nurses; -She expected the Wound Nurse to tell the nurse to complete a skin assessment or the Wound Nurse to complete a skin assessment if the wound nurse found during her audit nurses did not complete residents' weekly skin assessment; -The Wound Nurse was expected to report to the DON the nurses who failed continually to complete resident weekly skin assessments; -The Wound Nurse was responsible for completing weekly wound assessments, documenting in the residents' EMHR; -The facility had a wound care company who came out once a week to evaluate and treat residents with open wounds, other than skin tears; -The Wound Nurse was responsible for rounding with the wound care company Nurse Practitioner (NP) every Monday, put in new orders, discontinue old orders and update the residents' EMHR with the new wound assessment; -The wound care NP sent in complete wound assessments every Tuesday and the Wound Nurse was expected to review them and make changes to the residents' orders as needed; -She expected the Wound Nurse to complete a wound assessment, notify the PCP for new treatment orders, notify the resident and/or resident responsible party when a new skin issue was found. -Residents were at risk of further skin break down, deterioration of the new wound and/or infection if new orders were not received upon discovery of the new wounds -She expected nursing staff to have knowledge of and to follow facility policies. Review of the resident's wound care company wound assessment, dated 5/12/25 at 10:42 P.M., showed: -Visit specific Information included: Rounded with facility Wound Nurse. Resident had a new wound to left buttock, diagnosed as a Stage II Pressure Ulcer; -Stage II pressure ulcer, located on Left Buttock, first date wound recognized on 5/7/25, measuring 3.3 centimeters (cm) by 1.9 cm by 0.1 cm deep, with 70% epithelial (new skin, light pink) and 30% skin present in wound bed and a minimal amount of frank blood exudate (drainage) present; -Wound orders and plan of care included: Cleanse wound with Hyprochlorous acid (slightly acidic solution used to fight infections), cleanse wound with saline, protect peri-wound (area surrounding wound) with Skin Protectant, apply collagen powder (used to absorb exudate) one gram (gm) to clean wound bed, apply hydrogel gel (gel used to debride wound) and cover with silicone bordered foam dressing. Change dressing every Monday, Wednesday, Friday and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #7's entry MDS, showed an admission date of 4/7/25. Review of the resident's progress note, dated 4/7/25 at 5:30 P.M. showed the following: -admitted to facility from the hospital. Reddened at groin (area on each side of the body where the belly joins the legs); -Buttocks noted with a pressure ulcer to the sacrum (a large, triangular bone at the base of the spine) and gluteal (buttocks); -Protective ointment applied to all reddened areas; -Dressing was replaced to sacrum, clean and dry; -Feet noted with pressure ulcers to bilateral heels; -Orders verified; -No documentation of measurement of the pressure ulcers. Review of the resident's POS, dated 4/7/25, showed no orders for treatment to the buttocks, sacrum and bilateral heels. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 4/7/25, showed no treatment orders for reddened areas, sacrum and gluteal pressure ulcers. Review of the resident's progress note, dated 4/8/25 at 11:00 A.M., showed the resident was sent to the hospital. Review of the resident's hospital discharge record, dated 4/11/25, showed the following: -Diagnoses of urinary tract infection and changes in mental status; -Wound care discharge orders: Sacral/Coccyx: Unstageable pressure ulcer (wound not stageable due to wound bed covered with slough (soft dead tissue) and/or eschar (hard dry dead tissue)). Cleanse skin with soap and water, pat dry, apply Calmoseptine (topical medication used to treat and prevent minor skin irritations) to periwound (area surrounding wound), place Triad ointment (medication used to break down necrotic tissue) and cover with gauze; -Apply Aquacel dressing to callus on bilateral great toes, change every 3 to 5 days and as needed. Continue heels boots. Review of the resident's POS, dated 4/11/25, showed no orders for treatment to the buttocks, sacrum and bilateral heels. Review of the resident's progress notes, showed the following: (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 - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation regarding the resident's pressure ulcer until 4/13/25; -4/13/25 at 11:51 P.M.: Skilled nursing note: showed a diagnosis of unstageable pressure ulcer of the sacral region. No further documentation regarding the unstageable pressure ulcer to the sacral region until 4/16/25; -4/16/25 at 3:33 A.M.: Skilled nursing note: showed a diagnosis of unstageable pressure ulcer of the sacral region. No further documentation regarding the unstageable pressure ulcer to the sacral region until 4/17/25. Review of the resident's admission MDS, dated [DATE], showed the following: -Diagnoses of high blood pressure, diabetes and stroke; -Short and long term memory loss; -Required total assist of staff for all activities of daily living; -Incontinent of bowel and bladder; -Skin: one unstageable pressure ulcer present upon admission. Review of the resident's progress note, dated 4/17/25 at 3:05 P.M., showed an unstageable pressure ulcer to the sacrum, covered in slough. Physician notified, new order for referral to outside wound company for treatment and potential debridement (removal of dead skin), dry dressing applied. Order to apply and monitor daily until seen by wound care company. Review of the resident's POS, dated 4/17/25, showed the following: -Wound Care Company to evaluate and treat sacrum wound; -Order dated 4/17/25: Apply bordered gauze dressing to sacrum daily until seen by wound company. Clean with wound cleaner, apply bordered gauze daily and as needed if soiled or damaged. Review of the progress note, dated 4/18/25 at 2:03 PM., showed the resident was sent to the hospital. During an interview on 5/12/25 at 10:22 A.M., CNA D said he/she had taken care of the resident., The resident required total care. He/she doesn't recall resident having a pressure ulcer on his/her buttocks. He/she would notify the charge nurse if he/she had seen a open area. During an interview on 5/13/25 at 12:25 P.M., RN E said he/she was the charge nurse on the resident's hall and took care of the resident. The pressure ulcer on the resident's buttocks was discovered during a skin assessment by the wound nurse. The skin assessment was initiated after management reviewed the resident's hospital paperwork. Staff had not reported any changes in the resident's skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265338	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester House, The	550 White Road Chesterfield, MO 63017

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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	During an interview on 5/12/25 at 12:55 P.M., the Wound Nurse said 4/17/25 was the first time she was made aware of the resident's pressure ulcer. Staff should have made her aware of the pressure ulcer when the resident was admitted . During an interview on 5/12/25 at 10:10 A.M., the Director of Nurses said she expected the nurse to complete and document the assessment, notify the physician and complete the physician's order upon admission. In addition, staff are to notify the Wound Nurse of any wounds upon admission. MO00253623 MO00251251