STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265417	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherbrooke Village	4005 Ripa Avenue Saint Louis, MO 63125

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 46888 Based on observation, interview and record review, the facility failed to ensure one resident's (Resident #1's) feet were free from dry skin and failed to ensure skin assessments were accurate. The facility also failed to address the resident's foot care needs on the care plan. The sample was four. The census was 92. Review of the facility's skin integrity policy, dated 7/5/25, showed: -Purpose: To establish best practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate; -Policy: Skin evaluations shall be completed upon admission and routinely, as per the care plan, to monitor skin integrity. Skin integrity risk factors will be evaluated upon admission and routinely, as per the care plan. Appropriate interventions will be initiated based on the risk factors identified. Lotion and moisture barrier products shall be available and applied as per the care plan. Minimize, as much as possible, any friction or vigorous rubbing of the skin while providing care. Any skin abnormalities noted shall be communicated to the licensed nurse. The licensed nurse shall notify the provider as needed for appropriate skin care orders. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/1/25, showed: -Cognitively intact; -Diagnoses included vascular dementia, chronic obstructive pulmonary disease (COPD, lung disease), and chronic kidney disease (CKD, impaired kidney function). Review of the resident's Physician Order Summary (POS), showed: -An order, dated 12/3/24, for head to toe skin assessment to be completed every Thursday on evening shift; -An order, dated 1/15/25, cleanse Left plantar (sole) foot, apply xeroform (non-adherent dressing), cover with Abdominal gauze pad (ABD) and wrap with kerlix (sterile gauze bandage) every night shift; (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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No orders for any lotion or preventive ointments for the resident's dry skin. Review on 1/17/25, of the resident's skin monitoring bathing reviews, showed: -On 12/10/24, no skin concern areas noted; -On 12/17/24, no skin concern areas noted; -On 12/24/24, no skin concern areas noted. Review on 1/17/25, of the resident's most recent skin observation tool, showed: -Skin observation completed on 12/31/24, noted a blister on the left foot covering 3/4 of the foot; -Skin observation completed on 1/9/25, noted no new skin issues. Review on 1/17/25, of the resident's most recent shower sheets, showed: -The resident received a shower on 1/13/25. Dry skin on the resident's feet not documented; -The resident received a shower on 1/16/25. Dry skin on the resident's feet not documented. Review of the resident's care plan, dated 10/8/24, showed: -Focus: The resident has potential for pressure ulcer development; -Goal: The resident will have intact skin, free of redness, blisters or discoloration by/through review date; -Intervention: Administer treatments as ordered and monitor for effectiveness. Reposition for comfort throughout day and night. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaks from blood vessels); -The resident's care plan was not updated for the resident's foot blistered, discovered on 12/20/24, or dry skin on the resident's feet. Observation on 1/17/25 at 8:02 A.M., showed the resident lay in his/her bed. The resident's left foot had a pressure relieving boot on. A bandage on the resident's left foot was dated 1/16/25. The resident's right foot had a pea size amount of skin peeling off the great toe. The right heel was dry and flaky. Dry skin flakes were on the resident's mattress near the resident's feet. Observation on 1/17/25 at 10:45 A.M., of the resident's left foot, showed: -The sole of the resident's foot had a reddened, raw like area covering approximately 3/4th of the sole of the foot. The area was a large, circular area in the middle of the sole of the foot and down the right side of the sole of the foot; (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Blood was observed in various areas along with peeled skin; -The skin on the resident's foot was dry and flaky. During an interview on 1/17/25 at 11:15 A.M., Certified Nursing Assistant (CNA) B said he/she was made aware of the resident's foot wound on 12/20/24. Skin assessments were done on the resident once a week. He/She was aware of the resident's dry skin. He/She would expect the resident's skin assessments to include his/her dry skin. During an interview on 1/17/25 at 11:57 A.M., Licensed Practical Nurse (LPN) A said he/she was made aware of the resident's left foot wound on 12/20/24. He/She was aware of the resident's dry skin on his/her feet. He/She did not know if the dry skin was being treated with anything. The resident has skin assessments completed every week. He/She would expect the resident's shower sheets and skin assessments to be complete and accurate. During an interview on 1/17/25 at 12:48 P.M., the Director of Nursing (DON) and Administrator said they were not aware of the resident's dry skin on his/her feet. The DON said she was made aware of the wound on the resident's left foot on 12/20/24. She contacted the wound doctor and set the resident up with wound clinic services. They would expect the resident's dry skin to be documented in the resident's skin assessments and shower sheets. They would expect nursing staff to put lotion on the resident's feet if they notice dry skin and to alert the charge nurse. She would expect for shower sheets and skin assessments to be complete and accurate. MO00247280