STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265439	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barnes-Jewish Extended Care	401 Corporate Park Drive Saint Louis, MO 63105

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide treatment and care in accordance with professional standards of practice, for six of twelve residents sampled. Two residents (Residents #5 and #8) did not have orders for wound care, three residents (Residents #6, #7, #9) wound care orders were not followed, and five residents (Residents #4, #6, #7, #8, #9) wound dressings were not dated or initialed per facility policy. The facility census was 62. Review of the facility's policy and procedure for Physician Order, revised 4/2025, showed:-Purpose: To establish guidelines for properly obtaining physician orders and processing these orders;-Policy: Telephone and verbal orders should be documented in the resident's electronic medical record then read back to the ordering physician or independent practitioner for verification;-It is the responsibility of the licensed nurse and Certified Medical Technician (CMT) to understand and comply with this procedure;-It is the responsibility of the Nurse Manager to maintain, enforce and monitor the procedure. Review of the facility's policy and procedure for Wound Care, revised 6/25/2025, showed:-To provide guidelines for use in wound assessment, treatment, and documentation;-Policy: A physician's order is required for all wound treatment;-Responsibility: It is the responsibility of the Director of Nursing (DON) to oversee this policy and procedure;-Practice: All dressings will be dated and initialed by the nurse applying the dressing. 1. Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/27/25, showed:-Cognitively intact;-Medical diagnoses and treatments: Right knee fracture, history of hip and knee fractures, obesity, heart failure, surgical wound, intravenous (IV) antibiotics. Review of resident's care plan, in use at the time of the investigation, showed:-Surgical incision at risk for skin impairment due to immobility. Reposition resident frequently. Keep resident clean and dry. Check resident skin daily with care and inform the nurse of any skin issues. Please let the nurse know if resident dressing is not intact or any new areas of redness/skin breakdown. Treatments as ordered by physician;-Goal is to reduce the risks factors that could contribute to skin impairment and/or optimize wound healing through this next review period;-No care plan for skin tears or fragile skin. Review of resident's physician orders, reviewed on 7/7/25, showed no order for left lower leg/calf dressing. Review of the resident's physician and nursing progress notes, showed no documentation of orders received for a skin tear to the left calf. Observation and interview with the resident on 7/7/2025 at 8:23 A.M., showed the resident had a wound dressing to the left lateral (outer side) of his/her calf, dated 7/4/25 and staff initials labeled on it. The resident said he/she thinks it gets changed every couple of days. 2. Review of Resident #8's admission MDS, dated [DATE], showed:-Intact cognition;-Medical diagnoses and treatments: surgical wound, skin tears, anemia, heart failure, and history of falls. Review of resident's care plan, in use at the time of the investigation, showed:-Surgical incision on right hip/thigh and right elbow skin tear;-Reposition frequently, check skin daily with care and inform the nurse of any skin issues. Let the nurse know if dressing is not intact or any new areas of redness or skin breakdown. Review of the resident's physician's orders, showed the following:-Wound care order dated 7/2/25: Skin tear on the left arm, leave Tegaderm (transparent dressing) in place for 21 days and change as needed, monitor daily for signs and symptoms of infection;-No order for Tegaderm dressing to right elbow. Observation and interview with the resident on 7/7/25 at 10:15 A.M., showed the resident had Tegaderm dressings to the right elbow and left wrist, both dated 7/2/25, no staff initials. The resident said he/she thinks they get changed every few days but is not sure. 3. Review of Resident #6's admission MDS, dated [DATE], showed:-Moderate cognitive impairment;-Medical diagnoses and treatments: heart disease, history of falls, kidney disease, and diabetes. Review of resident's care plan, in use at the time of the investigation, showed:-Surgical incision to right ankle. Risk for skin impairment due to immobility. Reposition frequently. Keep resident clean and dry. Check skin daily with care and inform the nurse of any skin issues. Let the nurse know if dressing is not intact or any new areas of redness or skin breakdown. Treatments as ordered by physician;-Risk for bleeding due to anticoagulant use. Monitor urine for blood and monitor body for excessive bleeding or bruising and contact nurse with changes;-No care plan for skin tears or fragile skin. Review of the resident's physician orders, showed the following:-Wound care order dated 7/6/25: Left arm skin tear, apply adherent film (a type of wound dressing that has an adhesive layer or border, allowing it to stick to the skin and stay in place for up to seven days), change every seven days and as needed if soiled. Monitor daily;-Wound care order dated 6/26/25: Right ankle surgical incision, cleanse with wound cleanser, pat dry and apply a dry gauze dressing

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to provide appealing meal options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice, by failing to provide alternate meals per resident preference (Residents #10, #11, and #12). The sample size was 12. The facility census was 62. Review of the facility's menu for the week of 7/7/25 through 7/13/25, showed:-Breakfast for 7/7/25: Oatmeal, scrambled eggs, pancake with maple syrup;-Lunch for 7/7/25: Tomato Florentine soup, maple glazed ham, rice pilaf, green beans, blonde bar;-Breakfast for 7/8/25: Grits, scrambled eggs, bacon strips, biscuit;-Lunch for 7/8/25: Garden vegetable soup, beef sirloin steak, green peas, wheat roll, chocolate pudding;-Breakfast for 7/9/25: Oatmeal, scrambled eggs, orange bread;-Breakfast for 7/10/25: Grits, scrambled eggs, pancake with maple syrup, minestrone;-Breakfast for 7/11/25: Oatmeal, scrambled eggs, biscuit and gravy;-Breakfast for 7/12/25: Grits, scrambled eggs, cinnamon muffin;-Breakfast for 7/13/25: Oatmeal, scrambled eggs, bacon strips, French toast. Review of the facility's Always Available menu, showed:-Center of Plate: Classic cheeseburger, Hot dog on bun, Chicken tenders, Grilled Cheese sandwich, Deli sandwich, Grilled chicken breast;-Lighter Fare: Chef salad, fruit & cottage cheese plate, yogurt parfait;-Sides: French fries, side salad, cottage cheese, fresh fruit;-Beverages: Milk, water, coffee, iced tea, fruit juice, soda. Review of the facility's posted menu and menu substitution, showed: -When menu items are unavailable substitutions of comparable nutritional value are made;-Menus should include daily choices available for each meal;-Menu changes or substitutions for situations such as an emergency event, food unavailability or special dining events will be posted or otherwise communicated prior to meal service;-Menus for resident advanced ordering will be delivered to the resident;-Completed menus are collected and reviewed by dietary staff for diet congruency and honored. 1. Review of Resident #10's medical record, showed the following:-No cognitive impairment;-Consistent carbohydrate diet (CCHO) with Regular texture;-Diagnoses includes stroke and diabetes. Observation and interview on 7/7/25 at 10:05 A.M., showed the resident lay in bed with his/her breakfast tray that contained scrambled eggs, one pancake and a bowl of oatmeal, untouched with the lid half on that exposed half of the plate, on the resident's bedside table. Various different cereals and snacks were stored on the resident's windowsill. The resident said he/she just woke up and pushed the call light for the certified nurse aid (CNA) to reheat his/her breakfast tray. The resident said, I hate those powered eggs and oatmeal, but I do like the pancakes. The resident said although he/she continues to tell the facility that he/she dislikes oatmeal or grits he/she continues to get it every morning. At 10:10 A.M., CNA E said he/she could not reheat the breakfast tray because it would be considered cross contamination but would ask the kitchen for another breakfast tray. The CNA removed the breakfast tray and exited the room. At 10:20 A.M., CNA E returned to the room and said the kitchen could only offer a sandwich. The resident said he/she did not want a sandwich and if the CNA could please bring some milk so he/she could eat the cereal that was sitting on his/her windowsill. The resident said this was why he/she had to personally buy his/her own food to keep in his/her room. He/She has just given up on making requests because the facility never listens, so he/she just has his/her family bring food. 2. Review of Resident #11's medical record, showed the following:-No cognitive impairment;-Consistent Diet Therapy (CDT) and Low Concentrated Sweets (LCS);-Diagnosis includes Diabetes and cancer. Observation and interview on 7/7/25 at 1:10 P.M., showed the resident sat up in bed being fed by his/her spouse. The lunch tray contained two slices of ham and a large portion of green beans. A separate plate contained what appeared to be a blondie bar that was approximately two-inches by two-inches square and one mid-size cup of liquid. On the table a diet ticket showed the following:-Tomato Florentine soup, crossed out in blue ink;-Maple glazed ham;-Rice pilaf, crossed out with the wording mash potatoes in blue ink. Above the wording rice pilaf in a different handwriting and in black ink was do not have;-Seasoned green beans, crossed out in blue ink;-Blondie bar;-Saltine crackers;-Ice water;The spouse said he/she continues to voice frustration with the staff over not following the resident's requests or providing an acceptable alternative. The resident shook his/her head in acknowledgement. The spouse said all that happens when the facility does not have an alternative, they will double up on something else verses offering a comparable alternative. Filling out the diet tickets is pointless. They had filled out the diet ticket requesting the resident not have rice or green beans because these items upset the resident's stomach. However, all the facility did was write do not have above where he/she wrote mash potatoes and gave the resident a double amount of ham and green beans. He/She is very concerned for the resident nutrition needs. His/Her other concern was since the