

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Barnes-Jewish Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident with a pressure wound/injury (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) had necessary treatments and services to promote healing (Resident #30). The sample size was 18. The census was 69. Review of the facility's Wounds: Treatment of Pressure and Non-Pressure policy, revised 6/25/25, showed: -Purpose: To provide guidelines for use in wound assessment, treatment, and documentation; -Policy: The facility's Wound Product Selection Guide will be used as guidelines to determine appropriate treatments. A physician's order is required for all wound treatment; -Interventions should be taken to reduce edema and pressure related to the wound such as offloading heels (critical practice of removing or redistributing pressure from a wound site) and repositioning; -All dressings will be dated and initialed by the nurse applying the dressing. Review of Resident #30's Comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/2/26, showed: -Cognitively intact-Diagnosis included: Diagnosis included paranoid schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder, and benign prostatic hyperplasia (enlarged prostate gland). Review of Resident's care plan, in use at the time of survey, showed: -Focus: Resident has pressure ulcers and is at risk for skin impairment due to immobility and incontinence; -Goal: Goal is to reduce the risk factors that could contribute to skin impairment and optimize wound healing through the next review period; -Interventions included: Reposition frequently. Keep resident clean and dry. Low air loss mattress for weight distribution and gel cushion when up in chair. Check skin daily with care and inform the nurse of any skin issues. Let the nurse know if his/her dressing was not intact or any new areas of redness and/or skin breakdown. Treatments as ordered by physician. The care plan failed to show his/her heels should be always floated. (A care technique that involves elevating a bedridden patient's heels off the mattress surface to prevent or treat pressure ulcers). Review of the resident's Braden Scale (a tool used to assess a resident's risk of developing a pressure wound), dated 2/11/26, showed the resident scored 16, indicating at mild risk. Review of the resident's daily skilled assessments, dated 2/18/26 through 2/20/26, showed: -On 2/18/26 at 10:28 P.M., the resident's skin color assessment was usual for ethnicity, skin temperature warm and dry, and skin integrity intact. -On 2/20/26 at 11:53 P.M., the resident's skin color assessment was usual for ethnicity, skin temperature warm, and skin integrity localized abnormality. Review of the resident's wound progress notes dated 2/24/26, showed: -History of Present Illness (HPI): admitted after hospitalization for repeated falls after Lumbar (L) 4-5-disc herniation status post-surgery (a surgical procedure to treat a herniated disc located between the 4th and 5th lumbar vertebrae) 12/29/25. Sacral (sacrum-large triangular bone at the base of the spine, located between the two hip bones) DTI (developing deep tissue pressure injury)- evolving, appears fairly extensive and Right buttock DTI- continue zinc barrier cream and offloading. Left heel serosanguinous (a thin and watery fluid with a pink color) blister-continue skin prep (protective dressing) and floating. Has low air loss mattress (a specialized therapeutic support surface designed to prevent and treat pressure ulcers by combining, controlling, and managing skin moisture and pressure, honeycomb wheelchair cushion (a flexible, gel-like, or plastic seating pad designed to evenly distribute weight, reduce pressure points, and promote (continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>airflow). Braden originally reported as 16 (inaccurate) recalculated as 13 on 2/23/26. A score of 13 indicates a moderate risk for developing pressure injuries;-Wound #1 status is open. Original cause of wound was Pressure Injury. The date acquired was: 2/20/2026. The wound is currently classified as an unstageable/unclassified (an obscured full-thickness skin and tissue loss) wound with etiology of Pressure Ulcer (what was the cause) and is located on the sacrum. The wound measures 11cm length x 9.5cm width; -Wound #2 status is Open. Original cause of wound was Pressure Injury. The date acquired was: 2/20/2026. The wound has etiology of pressure ulcer and is located on the right gluteus (buttock muscle). The wound measures 2.5cm length x 0.8cm width; -Wound #3 status is open. Original cause of wound was pressure Injury. The date acquired was: 2/20/2026. The wound has etiology of pressure ulcer and is located on the left calcaneus (heel bone). The wound measures 3.3cm length x 5.5cm width. Review of the resident's re-admission nursing assessment, dated 1/21/26 at 9:43 P.M., showed a skin assessment was completed, and skin was intact. Review of the resident's physician order sheet (POS), showed:-An order, dated 2/20/26, wound care pressure, left buttock extending to bilateral gluteal cleft, clean with wound cleanser, pat dry, apply barrier cream every shift and as needed;-An order, dated 2/20/26, wound care pressure, left heel, apply skin prep daily and float heels at all times;-An order, dated 2/20/26, wound care pressure, right buttock, clean with wound cleanser, pat dry, apply barrier cream every shift and as needed. Observations on 3/2/26 through 3/5/26, showed:-On 3/2/26 at 6:34 A.M., resident lay flat on his/her back in bed; heels rested on bed with no elevation; -On 3/2/26 at 10:19 A.M., resident lay flat on his/her back in bed; heels rested on bed with no elevation; -On 3/3/26 at 9:15 A.M., resident lay flat on his/her back in bed; heels rested on bed with no elevation; -On 3/3/26 at 9:20 A.M., Certified Nurse Aide (CNA) H entered the room to provide morning care;-On 3/3/26 at 11:00 A.M., the head of the bed was slightly elevated, and the resident lay on his/her back; heels rested on bed with no elevation;-On 3/4/26 at 11:30 A.M., the head of the bed was elevated at a 45-degree angle and foot of bed slightly elevated, and resident lay on his/her back at an angle with head wedged between the mattress and bedrail against the wall; heels rested on bed with no elevation; -On 3/4/26 at 3:32 P.M., the head of the bed was elevated at a 45-degree angle and the foot of bed slightly elevated, and the resident lay on his/her back; heels rested on the bed with no elevation;-On 3/5/26 at 8:50 A.M., the head of the bed was slightly elevated, and resident lay on his/her back; heels rested on the bed with no elevation. Observation and interview on 3/5/26 at 10:15 A.M., showed the resident in bed. CNA H rolled the resident onto his/her side. There was a dressing on the resident's sacrum area extending down each buttock. The dressing had a brownish discoloration of the inner edges. The dressing was dated 3/3/26. CNA H said he/she did not know the resident had drainage like that. On the left heel was a roundish shaped dollar size blister. The blister was approximately half filled with fluid. The resident's heels were positioned on the mattress, there was no pillow under the resident's heels, and he/she did not have heel protectors on. Observation and interview on 3/5/26 at 12:30 P.M., showed the Director of Nursing (DON) checked the dressing on the sacrum and said the dressing was dated 3/3/26. Observation on 3/6/26 at 8:48 A.M., showed the head of the bed was elevated at a 45-degree angle. The resident had scooted down and was laying on his/her back at an angle with his/her chin touching his/her chest. The heels rested on the bed with no elevation. During an interview on 3/4/26 at 6:21 P.M., CNA I said when resident first moved in, he/she was able to use a walker and walk around but now the resident is incontinent and sleeps a lot. The resident was dependent on staff with all his/her activity of daily living (ADLs, grooming, dressing, toileting, and bathing) and now he/she had a pressure ulcer. He/she was not sure when it was discovered. CNA I said if he/she saw an issue with the wound dressing while providing personal care, he/she was to report it to the nurse. He/She was unaware of any special instructions needed for the resident's wound other than keeping the resident clean and dry. During an interview on 3/5/26 at 9:45 A.M. and at 1:56 P.M, the Wound Nurse said both her and the floor nurse was responsible for providing wound care. She made a list daily of residents who she will provide wound care to, and this was communicated to the floor nurse. If the floor nurse was unable to complete the (continued on next page)</p>		

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