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	03/06/2026

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

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Based on observation, interview and record review, the facility failed to follow their policy regarding visitation and failed to ensure residents could receive visitors when the facility locked the front door entrance at 8:30 P.M. and did not allow resident families/visitors to freely enter and exit the facility. The census was 69.Review of the facility's Resident Right to Access and Visitation policy, reviewed 9/22, showed:-Purpose: To outline resident's rights regarding visitation practices within the communities to see that proper compliance with CMS (Centers for Medicare and Medicaid Services) guidelines exists;-Responsibility: It is the responsibility of the Administrator to see that all staff members follow the visitation guidelines within this policy;-Policy: It is the policy of this organization to support and facilitate the resident's right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable and in a manner that does not impose on the rights of another resident;-The community must provide immediate access to any resident by:-Any representative of Federal Human Health Services;-Any representative of the State; -Any representative of the Office of the State Long Term Care Ombudsman;-The resident's individual physician;-Any representative of the agency responsible for the protection and advocacy system for the developmentally disabled individuals or those with mental disorders;-The resident representative;-The community must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at the time;-The community must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;-The community will inform each resident and/or resident representative of his or her visitation rights and related policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner he or she understands;- The community will inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation;-The community will not restrict, limit, otherwise deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation or disability;-The community will see that all visitors enjoy full and equal visitation privileges consistent with resident preferences;-The community shall provide 24-hour access to other non-relative visitors who are visiting with the consent of the resident. During a group interview on 3/3/26 at 10:30 A.M., three out of four residents who represented the resident council, said the facility did not allow visitors after 8:30 P.M. They said the staff would make announcements twice before 8:30 P.M., stating all visitors needed to leave and the front doors will be locked. During an interview on 3/4/26 12:11 P.M., Visitor E said he/she visited a resident every day for several hours but just needed to make sure he/she leaves before 8:30 P.M. in the evening because the facility locks the door. There are no other access doors for coming in and going out in the facility for visitors. He/She was told visiting hours were from 7:00 A.M. to 8:30 P.M. Observation on 3/5/26 at 3:05 P.M., showed a sign by the front doors, stated, Building Hours 7:00 A.M. - 8:30 P.M. If you need assistance, please use the intercom on the brick wall behind you. The sign was inside the building and seen after entering the first double-doors, and before the second double doors entering the lobby, to the receptionist desk. During an interview 3/5/26 at 3:10 P.M., Receptionist D said he/she worked when (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the front doors were open from 7:00 A.M. through 3:30 P.M., and another receptionist worked from 3:30 P.M. until 8:30 P.M. He/She said the facility's visiting hours were from 7:00 A.M., to 8:30 P.M. The front doors closed after the receptionist leaves. No visitors were allowed after the hours. The evening shift receptionist would make overhead announcements twice before 8:30 P.M., first at around 8:00 P.M., then at around 8:20 P.M., to let visitors know they needed to leave, unless they were spending the night. If visitors were unable to leave on time, and the front doors were locked, they would be escorted by staff to exit in the back door. The back door was for employees' access only. The receptionist said strictly no visitors were allowed after 8:30 P.M. unless permitted to stay overnight. The intercom in the front doors would not be accessible after 8:30 P.M. because both doors would be locked. If visitors arrived after the set time, they may call the facility but would still not be allowed to enter the facility. The receptionist said the visiting hours information was provided to the residents and family or whoever was with them upon admission or arrival to the facility. They would also remind the visitors of the visiting hours when they come in. During an interview on 3/6/26 at 3:48 P.M., the Corporate Director of Clinical Services (CDCS) said there should not be visiting hours. The visitors were allowed to enter the building at any time. The front doors were to be locked after 8:30 P.M., but the back door should be accessible to visitors. She expected the staff to follow the facility's visitation policy.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to accommodate the needs of one resident (Resident #30) by failing to ensure the resident's call light was plugged in and accessible to the resident. The sample was 18. The census was 69. Review of the facility's Call Lights: Accessibility and Timely Response policy, revised 8/2024, showed:-Purpose: To establish a procedure to which the community adequately equips call lights at each residents' bedside, toilet and bathing areas to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response;-Policy: Each resident shall have access to summon assistance lights are answered timely;-Practice: Special accommodations will be identified on the resident's person-centered plan of care and provided accordingly. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. Review of the facility's Nursing Policy - A.M. and P.M. Care, revised 10/2022, showed the procedure during P.M care included attach call bell to bedside rail or within the resident's reach. Review of Resident #30's medical record, showed:-admission date 12/31/25;-Diagnosis included history of stroke, need for assistance with personal care, unspecified fall, generalized muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, cognitive communication deficit, paranoid schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and anxiety disorder. Review of the resident's care plan, in use at the time of survey, showed: -Focus: High risk for falls;-Goal: Reduce the risk factors that may contribute to falls and minimize injuries related to falls;-Interventions included: Call light within reach. Remind to use call light. Observations on 3/2/26 at 11:05 A.M., 3/3/26 at 9:15 A.M. and 3/4/26 at 11:33 A.M., showed the resident in bed. His/Her call light was unplugged to the right of the foot of the bed. Observation and interview on 3/4/26 at 12:26 P.M., showed the resident awake in bed with his/her head in between the mattress and bedrail, and body positioned at a diagonal angle on the mattress. His/Her call light was unplugged and to the right side of the foot of the bed. During an interview, the resident said he/she didn't know what happened to his/her call light but would be more comfortable if he/she was repositioned. Observation on 3/4/26 at 3:32 P.M., showed resident in bed with eyes closed. His/Her call light was unplugged and to the right side of the foot of the bed. During an interview on 3/4/26 at 6:21 P.M., Certified Nurse Aid (CNA) I said the resident depends on staff for assistance with all his/her activity of daily living (ADLs). Sometimes the resident has behaviors and yells out for help. The resident knows how to use the call light and is known to pull out his/her call light. During an interview on 3/4/26 at 6:24 P.M., Licensed Practical Nurse (LPN) C said the resident knows how to use his/her call light but has behaviors and yells out a lot for help and is known to pull the call light off the wall. Observation on 3/6/26 at 8:48 A.M., showed the resident scooted down toward the foot of the bed with his/her body positioned at a diagonal angle and his/her chin touching his/her chest. The call light was unplugged and sat in open view on top of the resident's dresser. During interview on 3/6/26 at 8:55 A.M., CNA J said the resident was unable to get out of bed without assistance and was dependent of staff for ADL care, but he/she knew how to use the call light to call for assistance. CNA J did not know why the call light was unplugged, or who unplugged it, but thought maybe nursing staff unplugged it because the resident was to be discharged later that day. It was important for residents to have access to their call lights so they could request assistance when needed. He/She did not know the facility's protocols when residents are being discharge and believes that's why staff unplugged it. During interview on 3/6/26 at 9:00 A.M., LPN B said the resident usually screams out for help or bangs on the wall for help. He/She is known to use the call light excessively and someone probably just unplugged it because they became annoyed. During an interview on 3/6/26 at 3:49 P.M., the Director of Nursing (DON) said she expected the staff to follow their policies and to ensure all residents had access to their call lights. It is not acceptable practice to remove a resident's call light.

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	265439	A. Building B. Wing	03/06/2026

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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 interview and record review, the facility failed to ensure services provided met professional standards when staff failed to identify one resident's burn on admission which resulted in the treatment orders not being obtained for four days (Resident #101) and staff failed to identify/document one resident's wound on admission (Resident #53). The sample was 18. The census was 69. Review of the facility's admission of a Resident policy, date revised 2/26, showed:-The nurse should interview and assess the resident upon admission to determine high risk areas based on the resident's admission diagnosis. Assessment findings will be used to provide appropriate equipment or monitoring required. Nursing assessments include but are not limited to skin condition;-When assessing a resident and obtaining orders for a new admit the nurse should refer to the admission checklist and consider the following: skin and wound prevention protocol;-Review and discuss with resident/resident representative current medication orders present upon admission and reconcile discrepancies with most recent home or transferring facility medications by clarifying with the admitting physician what medications he/she wants the resident to be on;-Transcribe the physician's orders to the appropriate places;-The Nurse Manager should review all admissions 24 hours post admission, or Monday following weekend admissions for follow-up completion using the admission audit tool. Review of the facility's Assessments and Documentation Requirements policy, date revised 10/24, showed:-It is the responsibility of each licensed nursing employee to abide by this policy. It is the responsibility of each Nurse Manager to monitor his/her employees regarding completion of required assessments;-The following documentation requirements will be completed on all residents: admission assessment for the skilled resident, head to toe assessment daily. Daily skilled head to toe assessment on every rehab and therapy patient;--Assessment for Long Term Care Resident: Head to toe assessment including vital signs daily for first 72 hours after admission and monthly thereafter. 1. Review of Resident #101's medical record, showed:-admitted on [DATE];-Alert and oriented times four (person, place, time and situation);-Diagnoses included: Urinary tract infection (UTI), atrial fibrillation (irregular heart rhythm), high cholesterol, and anemia (decreased number of red blood cells). Review of the admission Observation, dated 2/19/26, showed: Does resident have any alteration in skin? Burn was not checked. Review of the progress notes, dated 2/19/26 through 2/24/26, showed:-On 2/20/26 at 2:49 P.M., on 2/21/26 at 3:40 P.M., on 2/22/24 at 1:09 P.M., on 2/23/26 at 12:54 P.M., on 2/24/26 at 1:47 P.M. skin temperature was warm, skin integrity was intact; mucous membranes color: Pink, and mucous membrane description: Pink;-On 2/24/26 at 4:44 P.M., resident reported dressing to his/her left side was peeling off. No order for a treatment or care for this wound site. Office Manager notified, went with nurse to assess wound. Old dressing removed with moderate amount of serosanguineous drainage (yellowish drainage will small amounts of blood) with mild odor. Wound bed noted with 2nd degree burn (affects the outer most layer of skin and extends to the middle layer of skin) that resident reported occurred three weeks ago at home from hot grease while cooking French fries. The doctor was notified with new wound care orders. Cleanse wound with wound cleanser, pat dry, apply to wound, 4x4 (gauze), secure with tape every day for seven days. Nurse medicated resident with oxycodone (pain medication) 15 milligrams (mg) by mouth for side pain from dressing change. Review of the care plan in use at the time of survey, showed:-Problem: Resident had a burn to his/her left flank (side of the body between the upper abdomen and the back), dated 2/27/26;-Goal: To reduce the risk factors that could contribute to skin impairment and optimize wound healing through the next review period;-Interventions included: Please check the resident's skin daily with care and inform the nurse of any skin issues, new areas of redness, or skin breakdown. Let the nurse know if the dressings are not intact. Treatments as ordered by Medical Doctor (MD). During an interview on 3/5/26 at 12:30 P.M. the Director of Nursing (DON) said the resident did not obtain a burn at the facility. If the resident had a dressing on when (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she was admitted to the facility, the nurse should have removed the dressing and documented what the skin looked like, and staff should have called the Physician to review the wound with him. If the resident did not have a dressing on when he/she was admitted , staff should have documented what the skin looked like. If a resident was admitted with a burn/wound, staff should tell the Wound Nurse, call the on-call Physician for guidance or they could call the wound doctor to obtain orders. 2. Review of Resident #53's medical record, showed:-admitted on [DATE];-Alert and oriented times four;-Incontinent of bowel and bladder;-Diagnoses included: partially blind, high blood pressure, pressure ulcer of sacral region (the triangular region at the base of the spine, located between the lumbar vertebrae and the tailbone (coccyx), stage III (full-thickness wound extending through the skin into the subcutaneous fat layer, but not exposing muscle, tendon, or bone). Review of the care plan in use at the time of survey, showed:-Problem: Resident had a pressure ulcer to his/her coccyx and surgical incision to his/her neck, dated 2/27/26;-Goal: To reduce the risk factors that could contribute to skin impairment and optimize wound healing through the next review period;-Interventions included: Please check the skin daily with care and inform the nurse of any skin issues, new areas of redness, or skin breakdown. Let the nurse know if the dressings were not intact. Treatments as ordered by MD. Review of the physician order sheet, in use at the time of survey showed:-A physician order for left buttocks wound, cleanse area with soap and water, apply Calvida (barrier) every 12 hours and as needed every shift, dated 2/20/26;-A physician order for sacrum, clean with wound cleanser, pat dry. Apply Calvida every shift and as needed, dated 2/23/26. Review of the progress notes dated 2/20/26 through 2/24/26, showed:-On 2/20/26 at 6:37 A.M., resident arrived at facility via ambulance. Wound at the back of his/her neck. The note did not show the resident had a wound on his/her sacrum;-On 2/22/26 at 1:47 A.M., skin integrity: Localized abnormality, abnormality location: neck; note did show area on sacrum;-On 2/23/26 at 4:05 P.M., sacrum pressure injury noted in hospital, was unable to be assessed this date due to resident refusal. Wound consult placed. Educated patient on importance of repositioning every two hours;-On 2/24/26 at 4:00 P.M., sacrum pressure injury noted in hospital, was seen by wound doctor this date and renamed as stage III pressure injury to coccyx. Measured 1.3 centimeters (cm) x 7 cm x 0.1cm. Orders to continue barrier cream twice a day and as needed. Review of the hospital records, showed:-Wound 2/9/26, gluteal cleft (vertical crease between buttocks): On 2/18/26, site assessment: Dry and intact; -Wound 2/17/26, sacrum pressure injury: Pressure injury stage: Deep tissue pressure injury (persistent non-blanchable deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters caused by damage to the underlying soft tissues);-Recommendations: Cleanse sacrum/bilateral buttocks, pat dry and apply a thin layer of barrier or zinc spray twice daily and as needed for soiling/stooling. Review of the admission Observation, dated 2/20/26, showed the form was blank. Review of the wound doctor note, dated 2/24/26, showed this was the wound doctor's initial assessment, and the information was provided by the caregiver. Wound #1 status was open. Original cause of wound was pressure injury. The date acquired was: 2/20/2026. The wound was currently classified as a category/stage III wound with etiology of pressure ulcer and is located on the coccyx. During an interview on 3/5/26 at 9:45 A.M. and at 1:56 P.M, the Wound Nurse said the nurse on the floor was responsible for completing the admission and weekly skin assessments. Both the floor nurse and the Wound Nurse provided wound care. During an interview on 3/5/26 Unit Manager K said when she went to print the admission assessment, she invalidated the assessment, since she helped with the admission, she entered the assessment in today. Review of the admission observation dated 3/5/26 showed: Does the resident have a pressure skin injury or any pressure ulcer injury? No was marked. 3. During an interview on 3/6/26 at 12:30 P.M. the Director of Nursing (DON) said when a resident was admitted to the facility, the nurse on the floor was responsible for completing all the assessments that pop up in the computer system. A head-to-toe assessment is one of the assessments that pops up. Staff should document any bruises, rashes or wounds the resident may have. Wounds should be documented in the progress notes and should include a description of (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wound, if there was drainage, anything out of the ordinary. The wound nurses usually measure and stage the wounds. The DON did not know anything about Resident #53's wound on the sacrum. 4. During an interview on 3/6/26 at 3:49 P.M., the DON said she expected staff to follow the facility's policies and procedures.

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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	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 observation, interview and record review, the facility failed to provide care and services in accordance with professional standards when the facility staff failed to complete/document neurological checks (neuro-checks, an assessment completed by nursing staff to monitor for changes in the resident's neurological (nervous system) status) post fall per the facility's policy for four out of six residents sampled for falls (Residents #14, # 16, #10 and #15). In addition, staff failed to follow a physician order to monitor one resident's blood pressure (B/P) and notify the physician per the physician's order (Resident #14). The sample size was 16. The census was 63.Review of the facility's Fall Management/Reduction Program policy, last revised 9/24, showed:-It is the responsibility of all staff to know and follow this policy;-Once a fall occurs, it is important that an assessment and investigation occur to determine possible cause of the fall utilizing the designated form within the resident's medical record. The charge nurse will conduct a post fall huddle including all involved that witnessed the fall or had care responsibilities. Upon gathering the facts of the fall, current and proposed intervention(s) will be reviewed and implemented as necessary to attempt to reduce the potential for a subsequent occurrence;-A post-fall evaluation is to be completed after any resident fall. Additionally, Neuro checks per neuro check policy will also be completed;-Post Fall interventions will be developed and implemented after each fall and noted in the medical record;-Neuro Checks are to be completed with any fall at the following intervals: All unwitnessed falls or witnessed falls in which the head was struck: Initial assessment; Then every (Q) 15 minutes x (times) four; Then Q 30 minutes x two; Then Q hour x two; Then once per shift for 72 hours;-Nurses will document in the medical record routinely for seventy-two (72) hours after the fall to describe the post-fall condition, injury, interventions, etc. 1. Review of Resident #14's face sheet, showed:-readmitted [DATE];-Diagnoses included: malignant neoplasm (cancerous tumor), unsteadiness on feet, muscle weakness and needed assistance with personal care. Review of the Resident's progress notes, dated 3/24/26 through 3/25/26, showed:-On 3/24/26, no progress note entry that provided detail of the resident's unwitnessed fall;-On 3/25/26 at 12:29 A.M., a telemedicine physician from out of state was contacted regarding the resident being found at bedside uninjured after an unwitnessed fall. Assessment/plan for neuro checks as per facility protocols;-On 3/25/26 at 3:25 A.M., neuro check was performed. Review of the Resident's Medication Administration Record (MAR), dated 3/24/2026 through 3/26/26, showed:-A physician order, with a start date of 3/25/26 and stop date of 3/25/26, for neuro checks Q15 minutes x four, then every 30 minutes x two, Q one hour x two, then Q shift x 72 hours;--Documentation showed: at 10:45 A.M., vitals (temperature (T), pulse (P), respiration (R), blood pressure (B/P), and oxygen saturation (O2 sat)) and pain level were documented. No other vitals signs were documented. Review of the Resident's Event Report, dated 3/24/26 at 10:45 P.M. and completed on 3/27/26 at 12:19 P.M., showed:-Description: Unwitnessed fall from bed;-Neurological (neuro) check (level of consciousness, facial muscle, upper extremity movement, lower extremity movement, pupil size -reactive): showed a neuro check complete;-Nurse manager / Interdisciplinary Team (ITD) review note, showed resident had a history of muscle weakness, unsteadiness on feet, and cognitive communication deficit with increased confusion related to metastatic cancer. Client had been noted to roll out of bed. Staff encouraged to keep bed in lowest position;-Vitals signs completed, showed::--On 3/24/26 at 10:45 P.M.,11:00 P.M., 11:15 P.M., 11:30 P.M.;--On 3/25/26 at 12:00 A.M., 12:30 A.M., 1:30 A.M., 2:30 A.M. A B/P was recorded on 3/25/26 at 2:57 A.M;-Orders: Fall: Start date 3/25/26 and discontinue on 3/28/26, to:--Fall unwitnessed - neuro checks Q 15 minutes (mins) x four, then every 30 mins x two, Q one hour x two, then Q shift x 72 hours. Special instructions: Complete Neuro check progress note;-Notes: dated 3/25/26 at 3:25 A.M., showed a neuro check was completed. No other neuro checks were documented. Review of the Resident's vital signs tab in the medical record, dated 3/26/26, showed:-At 4:59 A.M. B/P as 97/68;-At 7:52 A.M. B/P was 87/62;-At 4:17 P.M. (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B/P was 120/62;-No other B/Ps were documented. Review of the Resident's Event Report, dated 3/26/26 at 4:15 A.M. and completed 3/27/26 at 12:17 P.M., showed:-Description: Unwitnessed fall;-Neurological Check: was completed;-Vitals: were completed on 3/26/26 at 4: 59 A.M.;-Orders: Start date 3/26/26 and discontinue on 3/28/26 to:--Fall unwitnessed - neuro checks Q 15 minutes (mins) x four, then every 30 mins x two, Q one hour x two, then Q shift x 72 hours. Special instructions: Complete Neuro check progress note;--Fall witnessed- neuro checks initially, then Q shift for 72 hours. Special instruction: Complete neuro check progress note. Review of the Residents' progress notes, dated 3/26/26 through 3/27/26, showed:-On 3/26/26 at 5:01 A.M., The nurse was called to patients' room by Certified Nurse Aide (CNA) patient was seen by the nurse laying on the floor on his/her stomach. Patient stated, I fell out of bed. Assessments, vitals, and range of motion are within normal limits for this patient. Patient was assisted to his/her recliner chair and is watching tv in the common area. Patients denied any pain or discomfort and show no signs and symptoms of distress at this time;-On 3/26/26 at 5:53 A.M., a telemedicine physician from out of state was contacted regarding resident's fall:-Vital Signs: heart rate: 114 beats per minute (bpm) (normal is 60 through 100) ; blood pressure: multiple readings taken - 95/68 millimeters of mercury (mmHg) (normal 120/80 through 90/60), 96/62 mmHg, 94/63 mmHg, 84/59 mmHg;-Physical Examination, Alert, awake, and oriented times two, at baseline;-Assessment & Plan, patient who experienced a fall and is being evaluated for associated complications including hypotension (abnormally low blood pressure, defined as reading below 90/60 mmHg) and tachycardia (an abnormally fast resting heart rate, defined as over 100 beats per minute);-Plan: Monitor blood pressure and vital signs every hour, call back if further decline in blood pressure occurs;-Orders given / Nursing instructions: Perform neurological checks for monitoring; monitor blood pressure and vital signs every hour; Call back if further decline in blood pressure occurs. Review of the undated physician's order sheet, in use at the time of survey, showed there was no order to monitor blood pressure and vital signs every hour and to call back if further decline in blood pressure. Review of the Resident's progress notes, dated 3/26/26 through 3/27/26, showed there was no documentation showing the blood pressure was documented hourly or the physician was notified when the blood pressure fluctuated from 97/68 to 87/62, and there was no documentation showing the physician monitoring the blood pressure hourly was discontinued. Review of the Resident's MAR, dated 3/26/26 through 3/28/26, showed:-A physician order for Fall: Unwitnessed- Neuro checks Q15 minutes x four, then every 30 minutes x two, Q one hour x two, then Q shift x 72 hours;-Documentation showed: day shifts on 3/26 and 3/28 were blank;-A physician order for Fall: Witnessed- Neuro checks Initially, then Q shift x 72 hours;-Documentation showed: day shift on 3/26 and 3/28 were blank;-There was no physician to check the blood pressure and vital signs hourly to notify the physician if further decline in blood pressure occurred. Review of the vital signs tab dated 3/27/26, showed:-On 3/27/26 at 6:29 A.M. B/P was 98/58;--At 8:35 A.M., B/P was 98/67;--At 9:11 A.M. B/P was 98/61;--At 6:30 P.M., B/P was 90/61;--At 11:02 P.M., B/P was 100/68;--At 11:03 P.M. B/P was 100/64;-On 3/28/26 at 6:38 A.M. B/P was 100/64. Review of the Resident's care plan, in use at the time of the survey, showed:-Focus: Resident is at risk for falls due to unsteadiness on feet, muscle weakness and poor safety awareness, edited on 3/27/26;-Goal: Reduce the risk factors that may contribute to falls and minimize injuries related to falls;-Interventions: Ensure proper footwear while up, adequate lighting, call light within reach and low bed. Review of the progress notes dated 3/27/26 through 3/28/26, showed:-On 3/28/26 at 5:15 A.M., resident was sent to the hospital for rectal bleeding. Blood pressure 100/64;-There was no documentation showing the physician was notified when the blood pressure fluctuated from 98/61 to 90/60 and no documentation showing the physician order for hourly blood pressure and vital signs were discontinued. 2. Review of Resident #16's face sheet, showed:-readmitted : 4/8/26;-Diagnoses included dementia, glaucoma (a group of eye diseases that damage the optic nerve), diabetes, and chronic urinary retention (inability to completely or partially empty the bladder) with indwelling catheter (a sterile tube inserted into the bladder to drain urine). Review of the Resident's progress (continued on next page)

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	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note, showed on 4/9/26 at 8:08 P.M., the CNA informed the nurse that patient was on the floor in dining room. Upon entering room patient was sitting on his/her left side, in front of his/her recliner. The nurse and CNA assisted patient to recliner, range of motion and body assessment performed with no injuries noted. T 97.9, P-71, R-16, B/P-102/52, O2 Sat 96% on room air. Placed call to on call doctor, instructed to continue with facility fall protocol. Review of Resident's MAR, dated 4/1/26 through 4/9/26, showed:-A physician order with a start date of 4/9/26 and stop date of 4/11/26 for neuro checks initially, then Q shift x 72 hours.-The record failed to reflect the pupil size - reactive. Review of the Resident's progress note, dated 4/11/26 at 7:13 A.M., showed neuro checks: Left Pupil Size: 3 millimeters (mm), Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive. Review of the Resident's care plan, dated 4/16/26, and in use at the time of the survey, showed:--Focus: Resident is at risk for falls due to poor safety awareness;--Goal: Reduce the risk factors that may contribute to falls and minimize injuries related to falls;--Interventions: Falls mat at bedside. Grip mat in chair to prevent sliding. Frequent rounding and may sit at nursing station for closer monitoring. Call light in reach and low bed. Review of the Resident's progress note, dated 4/16/26 through 4/22/26, showed:-On 4/16/26 at 5:11 A.M., resident crawled out of bed and was found by nurse squatting down on the floor. Resident confused and not able to communicate the circumstances of his/her unwitnessed fall;-On 4/16/26 at 8:25 P.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive;-On 4/18/26 at 10:57 P.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive;-On 4/21/26 at 4:30 P.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive;-On 4/21/26 at 5:24 P.M., resident found on the floor next to bed. Physician notified, order to continue monitoring resident for any change in condition and continue neuro checks;-On 4/21/26 at 8:42 P.M., post fall, no delayed injuries noted, neuros in process; neuro check details not included;-On 4/22/26 at 10:48 P.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive. Review of the Resident's undated POS, in use at the time of survey, showed an order with a start date of 4/21/26 and end date 4/24/26. Unwitnessed fall, neuro checks Q15 minutes x four, then every 30 minutes x two, Q one hour x two, then Q shift x 72 hours. Special instructions: Complete neuro check progress notes every shift, day and night. Review of the Resident's MAR, dated 4/2026, showed a physician order with a start date of 4/21/2026 and stop date of 4/24/2026, for neuro checks Q15 minutes x four, then every 30 minutes x two, Q one hour x two, then Q shift x 72 hrs. The record failed to reflect the pupil size-Reactive. 3. Review of Resident #10's face sheet, showed:-admitted : 4/7/26;-Diagnoses: high cholesterol, high blood pressure, hypothyroidism (the thyroid is not making enough thyroid hormone), peripheral arterial disease (narrowed arteries reduce blood flow to the arms or legs) and left clavicular fracture (broken collar bone), cervical spine fractures, sternal fractures and rib fractures due to a motor vehicle collision (MVC). Review of the Resident's care plan, dated 4/8/26, and in use at the time of the survey, showed:--Focus: Resident at risk for falls with history of falls and impulsive movement;--Goal: Reduce the risk factors that may contribute to falls and minimize injuries related to falls;--Interventions: Fall mat, adequate lighting, call light within reach, keep items that are used frequently within reach for example- television remote and water pitcher, room free of clutter and low bed. Review of the Resident's progress notes, dated 4/8/26 through 4/11/26, showed:-On 4/8/26 at 8:28 A.M., Patient found on the floor by the nurse in a seating position sliding down the room towards the door. Assisted back to bed, patient confused and not able to communicate how he/she got on the floor. Treated as unwitnessed fall. Neuro checks within normal limit. No injuries noted and patients moved all extremities with no signs of pain.-On 4/9/26 at 1:53 P.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive.- On 4/11/26 at 7:12 A.M., neuro checks: Left Pupil Size: 3 mm, Left pupil reaction: Reactive, Right Eye - Pupil Size: 3 mm, Right pupil reaction: Reactive. Review of Resident's MAR, dated 4/1/26 through (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/24/26, showed:-A physician order with a start date 4/8/2026 and stop date of 4/8/26 for neuro checks and vitals every hour (x2);-The record failed to reflect the pupil size - reactive;-A physician order with a start date 4/8/26 and stop date of 4/11/26 for neuro checks and vitals every 12 hours X six;-The record failed to reflect the pupil size - Reactive. 4. Review of Resident #15's face sheet, showed diagnoses included acute kidney failure (the kidneys suddenly can't filter waste products from the blood), dementia, muscle weakness, unsteadiness on feet and epilepsy (brain condition that causes recurring seizures). Review of the Resident's care plan, created 3/25/26, in use at the time of survey, showed:-Problem: Resident was at risk for falls. Last fall 4/2/26;-Goal: Reduce the risk factors that may contribute to falls and minimize injuries related to falls;-Interventions: Adequate lighting. Call light within reach. Keep items that are used frequently within reach. Low bed. Remind the resident to use call light. Keep room free of clutter. Geri (medical reclining chair) chair in common area for increased monitoring. Review of the Resident's progress notes, dated 4/3/26, showed:-At 12:14 A.M. orientation: disoriented; memory/recall: none of the above were recalled.-At 5:43 P.M., showed the nurse was charting when he/she heard a loud noise, looked up patient was on the floor next to recliner. Patients could not recall what happened. No complaint of pain or discomfort. Patient assessed and assisted back to recliner. No open areas. No bleeding. Notified physician, nurse manager and family. B/P 125/72, Pulse (P, normal 60 through 100) 100, Respirations (R, normal 12 through 18) 18, Temperature (T, normal 97.8 through 99.1) 98.4, Oxygen Saturation (O2 sat, normal 95% through 100%) 96% room air. In bed resting with call light in reach. Review of the Resident's MAR, dated 4/1/26 through 4/26/26, showed:-A physician order, dated 4/3/26 through 4/5/26, for Fall: Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall.--No documentation on 4/3/26. Documentation showed status for only 4/4 and 4/5;-A physician order, dated 4/3/36 through 4/6/26, for Fall: Unwitnessed- Neuro checks every 15 minutes x four; then every 30 minutes x two; then every one-hour x two; then Q shift X 72 hrs. Special instructions: Complete neuro check progress note;--Documentation showed: Day Shift: T, P, R, BP, O2 sat were documented once on 4/4, 4/5 and 4/6. Night Shift: T, P, R, BP, O2 sat were documented on 4/5 and 4/6. On 4/4, it was blank on night shift. Review of the Resident's progress notes, dated 4/3/26 through 4/6/26, showed:-On 4/3/26, neuro checks every 15 minutes x four, then every 30 minutes x two; then every one-hour x two, were not documented;-On 4/5/26, no vital signs or neuro checks were documented. Observation and interview on 4/24/26 at 4:25 P.M., showed the resident was up in a Geri Chair (reclining wheeled chair) sitting at the nurse's station. The nurse brought the resident to his/her room. The resident had a yellow bracelet around his/her wrist that showed he/she was a fall risk. The residents said he/she did not recall any recent falls. When the surveyor finished talking with the resident, he/she moved his/her legs over the side of the chair as he/she attempted to sit up. The nurse entered the room and repositioned the resident into his/her chair and moved the resident back to the nurse's station. 5. During an interview on 4/24/26 at 4:45 P.M., Certified Nurse Aide (CNA) A said if a resident fell, he/she would stay with the resident and tell the nurse. The nurse would assess the resident then they would get the resident up in a chair. If the residents hit their head they would do vital signs every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, then every eight hours. CNAs did the vital signs, but they also teamed up to get the vitals done. The CNA said Quality would notify staff if any new interventions were put into place post fall. 6. During an interview on 4/26/26 at 4:50 P.M., Licensed Practical Nurse (LPN) B said if a resident fell, he/she would assess the resident and ask the resident if he/she was hurt or if they hit their head. Falls were documented on the incident report and in the progress notes. The physician and family should be notified. Neuro checks were completed for any unwitnessed fall or if the residents hit their head. Neuro checks were done per protocol every 15 minutes X one hour, then every 30 minutes X two, then every hour X three days. Neuro checks included checking vital signs, pupils and range of motion. Neuro checks were documented in the computer. Once the order was entered into the computer, it would automatically pop up under tasks when the neuro check should be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. 7. During an interview on 4/26/26 at 5:00 P.M., the Nurse Manager C said if a resident fell, the CNA would yell out for help and the nurse would assess the resident. The assessment included checking the pupils, Range of Motion (ROM), if there were breaks for pain, if there was head trauma, did the resident need to go to the emergency room or if they were safe to get up. Neuro checks were done for all unwitnessed falls or if the residents hit their head. Neuro checks popped up in the computer when it was due. Falls were documented under events, and it populated a note in the progress notes. She would also try to figure out why the residents fell to see if new interventions needed to be put into place. 8. During an interview on 4/24/26 at 5:34 P.M. the Director of Nursing (DON) said she did not know the fall policy off the top of her head. If a resident fell, the CNA should report it to the nurse. The nurse should do a fall assessment, and the template would guide the nurse through anything they needed to do. Neuro checks should be done for unwitnessed fall, a change in condition or if the residents hit their head. Neuro checks were completed in the computer, under the events tab. The physician and the resident representative should be notified. The facility utilized a telehealth service from 7 P.M. to 7 A.M. If the physician wrote orders in their notes, those orders would be communicated to the nurse, and the nurse would enter the orders into the computer. If the physician ordered vital signs, it would be documented under the vital signs tab. If the vital signs were not documented in the computer, she did not have the information. She would expect staff to follow the facility's policy and procedures.

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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. 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 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 measures11cm 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 wound care, they could report it to the wound nurse or pass it on to the next shift to complete. During an interview on 3/6/26 at 1:45 P.M., Unit Manager (Unit Mgr.) A said she would expect the staff to follow the physician orders to float the heels, which is ensuring the resident's heels are elevated off the surface to relieve pressure on the heels. During an interview on 3/6/26 at 3:49 P.M., the DON said if a resident had an order to float their heel or for off-loading, she would expect the resident's heels to be elevated off the mattress, even if the resident had an air loss mattress. She would expect for staff to follow physician orders and the facility's policies and procedures. 2692303

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to evaluate and address the hydration needs for one of 18 sampled residents (Resident #30). The census was 69.Review of the facility's Nursing Policy-A.M. and P.M. Care, revised 10/22, showed the procedure during A.M. and P.M care to be sure water is within reach. Offer and encourage fluid intake with care. 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-Diagnoses included paranoid schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder, and benign prostatic hyperplasia (enlarged prostate gland);-Independent of eating. Review of most current care plan, showed:-Focus: Resident is at risk for weight loss;-Goal: Minimize the risk factors that could contribute to weight loss;-Interventions included: Allow adequate time to eat, assist with positioning during meals, house supplements and snacks, and report to nurse if meal intake decreases. Review of resident's progress notes, showed:On 2/12/26 at 3:22 P.M. the physician note said last admission, per registered nurse (RN), patient (pt) drank excessive amounts of water. Pt is uncertain how much he/she is drinking. Will ask Nurse Sup if we are able to do urine na (NA, urine sodium, urine test to evaluate kidney function, fluid balance, and the cause of abnormal blood sodium levels) and urine osm (OSM, Urine osmolality, urine test to measures the concentration of all particles in urine, indicating how well kidneys balance water in the body). Will do a trial of fluid restriction 1500cc/day and repeat Na in 2-3 days. UA (urine analysis) pending and to notify physician of any changes;-On 2/13/26 - Unable to collect urine patient voided prior to collection;On 2/19/26 at 10:16 A.M., the physician note said he do not see a fluid restriction in resident's orders; however, patient no longer needs fluid restriction. Review of the resident's medication administration record dated 2/1/2026 through 2/28/2026, showed an order dated 2/12/26 and was discontinued on 2/19/26, for 1500cc fluid restriction daily every shift order. Observation on 03/2/26 at 11:05 A.M., showed resident lay on his/her back in bed that was in the lowest position. The resident's call light was unplugged and lay at the right side of the foot of the bed, a pitcher of water was on the bedside table that was approximately four feet from the ground out of resident's reach. The resident could be heard saying, Please, I am so thirsty. Please give me some water. Observation on 03/3/26 at 9:15 A.M., showed resident lay on his/her back in bed that was in the lowest position. The resident's call light was unplugged and lay at the right side of foot of the bed. On the resident's bedside table sat a small cup with approximately four ounces of light brown liquid and an empty pitcher. The bedside table was approximately four feet from the ground, out of resident's reach. The Resident could be heard saying, Please, I want some water. Observation and interview on 03/4/26 at 6:10 P.M., showed resident's bedside table with a half full pitcher of water, placed at the end of the room next to resident's closet in front of the window. The resident said he/she would like a bottle of water because he/she was thirsty. During an interview on 3/4/26 at 6:21 P.M., Certified Nurse Aid (CNA) I said when the 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 depends on staff with all his/her activity of daily living (ADLs). The CNA said he/she knows the resident does not eat much and is on a fluid restriction, but the nurse would have more detail. During an interview on 3/4/26 at 6:24 P.M., Licensed Practical Nurse (LPN) C said the resident has behavior and yells out a lot for help but nine of out ten times, the reason is the resident wants something to drink. The LPN C said the resident is on fluid restrictions because the resident urinates a lot, so the resident is given sips of water throughout the day. During an interview on 03/6/26 at 3:49 P.M., the Director of Nursing said she would expect the staff to follow their policies and ensure all residents receive proper hydration by assisting those who are dependent on staff by offering fluid intake during care or when entering the room.

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	03/06/2026

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two residents were free from significant medication errors when staff failed to administer medications per physician orders and failed to notify the physician when the medications were not administered (Resident #10 and #30). The sample was 18. The census was 69.Review of the facility's Medication Administration Policy, dated revised on 6/23, showed: -Only a licensed nurse or Certified Medication Technician (CMT) may prepare, administer and/or record the administration of medications. Medications must be administered in accordance with a physician's orders (i.e., the right resident, the right medication, the right dosage, the right route and the right time). Medications must always be prepared, administered and recorded by the same nurse/CMT;-Each resident will have his/her own supply of medications, excluding stock medications;-Initial on Medication Administration Record (MAR) after each dose is administered;-Reorder (medication) when three-to-five-day supply remains;-Reordering and refilling is a daily task for the nurse/CMT at the end of each medication pass. The day shift shall have the primary responsibility for re-ordering medications. Other shifts need to reorder medications that might be given only on their shift and as needed medications, as needed.-If a medication is needed immediately, add need by time to the pharmacy refill sheet and fax (do not scan) to pharmacy;-If the medication is unavailable any time, the nursing supervisor should be contacted and may obtain medication from the emergency drug supply (e-kit, a secured, on-site container or electronic cabinet holding a limited supply of pre-approved medications to allow nurses to immediately administer essential, time-sensitive medications to residents without waiting for a, pharmacy delivery) or contact the physician to try to obtain an alternate order. Review of the facility's Medication-Related Error policy, dated 04/00, showed:-Definitions: medication error will be defined as a departure from the accepted standards of practice for medication use, which includes transcription, dispensing and administration;-Significant medication error as one causing a resident discomfort or jeopardizing his/her health and safety;-Examples of medications errors include, but are not limited to: errors may be by commission or omission;-When a medication error is discovered, the employee noting the error must notify the supervisor, the physician, the resident and, when applicable, the resident's representative. 1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/24/26, showed:-Cognitively intact-Diagnoses included: diabetes, hypertensive heart and chronic kidney disease with heart failure. Review of Resident's care plan, in use at the time of survey, showed:-Focus: Patient observed hoarding medication at the bedside;-Goal: Patient will not hoard medications during the review period;-Interventions included: Medication times will be changed and will reevaluate at a later date. Review of the physician order summary, in use during the survey, showed:-A physician order dated 11/7/25, for insulin lispro pen 100 unit/milliliter (ml) (rapid acting insulin), subcutaneously (under the skin) three times daily with meals, for type 2 diabetes mellitus; If Blood Sugar is less than 70, call physician ; If Blood Sugar is 150 to 200, give 2 Units; If Blood Sugar is 201 to 250, give 4 Units; If Blood Sugar is 251 to 300, give 6 Units;If Blood Sugar is 301 to 350, give 8 Units ;If Blood Sugar is 351 to 400, give 10 Units;If Blood Sugar is greater than 400, call physician. Review of the MAR, dated 2/13/26 through 3/4/26, showed:-A physician order, dated 11/7/25, for insulin lispro pen 100 unit/milliliter (ml) (rapid acting insulin), subcutaneously (under the skin) three times daily with meals, for type 2 diabetes mellitus; If Blood Sugar is less than 70, call physician; If Blood Sugar is 150 to 200, give 2 Units; If Blood Sugar is 201 to 250, give 4 Units; If Blood Sugar is 251 to 300, give 6 Units;If Blood Sugar is 301 to 350, give 8 Units ;If Blood Sugar is 351 to 400, give 10 Units;If Blood Sugar is greater than 400, call physician.-Documentation showed: -On 2/13/26 at 11:30 A.M., insulin was not administrated; reason resident was asleep;-On 2/18/26 at 11:30 A.M., insulin was not administered; reason resident refused;-On 2/27/26 at 11:30 A.M., was not administered; reason blank;-On 2/27/26 (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 4:22 pm, blood sugar was 456; -On 3/2/26 at 8:03 am blood sugar was 413; -On 3/4/26 at 4:22 pm blood sugar was 401. During an interview on 3/6/26 at approximately 12:32 P.M., the resident said he/she has never refused to take his/her insulin because he/she knew how important this medication was, and he/she could become very ill without it. During an interview on 3/6/26 at approximately 12:02 P.M., the License Practical Nurse (LPN) B said residents should receive their insulin as ordered, he/she did not know why the insulin was not administered. During an interview on 3/6/26 at approximately 1:45 P.M., the Unit Manager A said he/she was not aware Resident #10 missed insulin.2. Review of Resident #30's comprehensive MDS, dated [DATE], showed:-Cognitively intact-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 care plan, in use at the time of survey, showed:-Focus: The resident displays behaviors related to paranoid schizophrenia;-Goal: Reduce the risk factors that lead to behaviors;-Interventions included: Notify the nurse and/or physician if his/her behaviors increase or interfere with his/her care. Review of the physician order summary, in use during the survey, showed:-A physician order, dated 1/21/26, for clozapine 100 mg tablet, take two at bedtime for paranoid schizophrenia;-A physician order, dated 1/21/26, memantine 10 mg tablet, one tablet twice a day for schizophrenia;-A physician order dated 2/2/26 and discontinued on 2/15/26, for Diazepam 5mg, take one tablet two times a day, for anxiety;-A physician order dated 2/15/26 and discontinued on 2/21/26, for Diazepam 5mg, 1 tablet two times a day; -A physician order dated 1/22/26 for finasteride 5 mg tablet once a day for enlarged prostate gland; -A physician order dated 2/5/26 and discontinued on 2/21/26, for Hydroxyurea 500 mg, two tablets every other day for chronic myeloproliferative disease (overproduction of blood cells which could cause blood clots, strokes, or organ damage);-A physician order dated 2/6/26 and discontinued on 2/21/26, for Hydroxyurea 500 mg, two tablets every three days. Review of the MAR dated 2/6/26 through 3/4/26, showed:-A physician order, dated 1/21/26, for clozapine 100 mg tablet, take two at bedtime for paranoid schizophrenia; -Documentation showed: on 2/6, 2/7, 2/8, 2/9, 2/10, 2/11 and 2/12/26 medication was not administered; reason medication was unavailable;-A physician order, dated 1/21/26, memantine 10 mg one tablet twice a day for schizophrenia; -Documentation showed: -A.M.: on 2/22/26 through 3/2/26 medication was not administered; reason not available. -P.M.: on 2/24, 2/25, and 2/28 through 3/2/26 medication was not administered; reason not available;-A physician order dated 2/2/26 and discontinued on 2/15/26, for Diazepam 5mg, take one tablet two times a day, for anxiety; -Documentation showed: on 2/4/26 through 2/15/26 the medication was not administered; reason medication was unavailable.-A physician order dated 2/15/26 and discontinued on 2/21/26, for Diazepam 5mg, 1 tablet two times a day; -Documentation showed: on 2/15, 2/16 and 2/17/26 the medication was not administered; reason medication was unavailable;-A physician order dated 1/22/26 for finasteride 5 mg tablet once a day for enlarged prostate gland; -Documentation showed: -On 2/23, 2/24 and 2/27 medication were not administered; reason resupply. On 2/28 medication was not administered; reason called pharmacy to reorder; -On 2/25, 2/26, 3/2 and 3/4 medication was not administered; reason unavailable;-A physician order dated 2/5/26 and discontinued on 2/21/26, for Hydroxyurea 500 mg, two tablets every other day for chronic myeloproliferative disease; -Documentation showed: on 2/5 and 2/9/26 the medication was not administered; reason medication was unavailable; -A physician order dated 2/6/26 and discontinued on 2/21/26, for Hydroxyurea 500 mg, two tablets every three days; -Documentation showed: -On 2/6 and 2/8/26 the medication was not administered; reason unavailable; -On 2/21/26 discontinued duplicate order; -Documentation showed the Hydroxyurea was documented as administer on 2/15/26 for both every other day dose and every 3 days dose. Review of the list of medications available in the facility's e-kit, provided by the facility, dated 9/29/25, showed, the e-kit had five tablets of Finasteride 5 milligrams (mg) tablets. No other medications were in the e-kit. During an interview on 3/6/26 at approximately 1:45 P.M., the Pharmacy Technician said the pharmacy records reflect the following:-The pharmacy sent 60 tablets (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of clozapine on 1/21 and 2/13/26;-The pharmacy sent 60 tablets of Memantine 10 mg, on 1/21/26 and 3/2/26. The pharmacy attempted to refill the medication on 2/18 and 2/28/26 but the medication was suspended. There was no reason showing why the medication was suspended; -The pharmacy sent 60 tablets of Diazepam 5mg on 2/15/26. The order was changed to a half tablet on 2/21/26 and the pharmacy sent 30 half tablets. -The pharmacy sent 30 tablets of Finasteride 5mg on 12/31/25. The order changed on 1/21/26 and 30 tablets were sent. On 3/4/26 the pharmacy sent a 14-day supply; -The pharmacy sent 15 tablets of Hydroxyurea on 12/31/25 and on 1/21/26. On 2/21/26 a new order wasn't filled because it was suspended until 3/2/26. No notes on why. During an interview on 3/6/26 at approximately 12:02 P.M., the License Practical Nurse (LPN) B said medications should be documented after they were administered. If a resident refused their medications, it should be documented on the MAR. If a medication was unavailable, he/she would check the overflow. If the medication was not there, he/she would check to see if the medication was in the pyxis (e-kit). If the medication was not in the e-kit, he/she would call the pharmacy to check the status of the medication and order the medication to be sent out immediately, if needed. If the pharmacy was called, it would be documented in the progress notes. During an interview on 3/6/26 at 12:44 P.M., Unit Manager K said staff should click on complete after they administer the resident's medications to document the medication was administered. If a resident refused, he/she would talk to the resident and if they were their own responsible party he/she would educate the resident, ask a peer to try, if the resident continued to refuse, he/she would call the family to see if they could talk to the resident. If the resident continued to refuse, he/she would notify the physician and the resident representative, if the resident was their own responsible party, and monitor if anything needed to be monitored such as a blood pressure if a blood pressure medication was missed. He/she would document why the medication was not administered and what interventions she had attempted and what was said to the physician and any orders the physician may have given. All nurses can order/reorder medications. Medication can be order through the computer or the nurse can call the pharmacy. He/she would expect for staff to check the pyxis if a medication was unavailable. The nurse usually notified the unit manager when a medication was not available. Then, he/she would check the bottom of the cart to see if the medication was in the overflow and if not, he/she would try to figure out what happened. During an interview on 3/6/26 at approximately 1:45 P.M., Unit Manager A said he/she was not aware Resident #30's medications were unavailable or there was an issue with obtaining his/her medications. If a resident missed his/her clozapine or diazepam it could cause an increase in behaviors. During an interview on 3/6/26 at 3:49 P.M., the Director of Nursing (DON) said she would expect for staff to follow physician orders and the facility's policy's and procedures.

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	265439	A. Building B. Wing	03/06/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure drugs and biologicals were stored in accordance with acceptable standards of practice. The facility identified two medication rooms, six medication carts, and six treatment carts. Both medication rooms, five medication carts and one treatment cart were checked for medication storage. Issues were found in one medication room and two medication carts. Staff failed to double-lock the emergency kit for controlled substances. In addition, staff failed to dispose of expired over-the-counter (OTC) medications. The census was 69.Review of the facility's Delivery, Receipt, Storage, and Inventory of Facility Products policy, reviewed 8/2022, showed:-Subject and Addendum: Storage and expiration date of medications, biologicals, syringes and needles;-The policy failed to provide guidance regarding ensuring medication rooms and medication carts were free from expired medications, or storage of controlled substances under double lock, in accordance with State regulations. 1. Observation on 3/4/26 at 11:33 A.M., showed a controlled substance e-kit drawer in the medication room. The drawer was unlocked. During an interview, Unit Manager L said the key broke off the day prior. He/She said the medication room door was always locked but the e-kit drawer has been unlocked since the key broke off. Controlled substances should be double-locked. The maintenance staff was aware of the broken key, and a replacement was to be provided the following day, 3/5/26. There was no alternative lock or a locked container for the controlled substances while waiting for the replacement key. During an interview on 3/4/26 at approximately 3:00 P.M., Unit Manager L said the key to the controlled substances e-kit drawer has been replaced. Observation on 3/5/26 at 12:57 P.M., showed Unit Manager L obtained the medication room key from the nurse's station top drawer. The drawer was unlocked. No staff was at the nurse's station. Unit Manager L opened the medication room, then the controlled substances e-kit drawer, using keys from the set of keys he/she obtained from the nurses' station unlocked drawer. 2. Observation on 3/4/26 at 12:50 P.M. of the third floor medication cart, showed:-Three open bottles of acetaminophen (Tylenol) 650 milligrams (mg) with an expiration date of 12/2025;-One bottle of Vitamin B-12 1000 micrograms (mcg) (supplement) opened with an expiration date of 11/2025;-One bottle of sodium chloride 1 gram (gm) (supplement) opened with an expiration date of 12/2025;-One bottle of oyster shell calcium 500 mg (supplement) opened with an expiration date of 7/2025;-One bottle of aspirin extended release 81 mg opened with an expiration date of 10/2025;-One bottle of Geri-Dryl 25 mg (antihistamine) opened with an expiration date of 12/2025;-One bottle of high potency multivitamin opened with an expiration date of 10/2025. 3. Observation on 3/4/26 at approximately 1:00 P.M. of the third floor medication room, showed three bottles of Ferric X-150 (iron supplement) opened with an expiration date of 2/2026. 4. During an interview on 3/3/26 at 1:00 P.M., Licensed Practical Nurse (LPN) C said nurse management and the floor nurse were responsible for checking expiration dates on the medication carts. 5. During an interview on 3/6/26 the Director of Nursing (DON) said she expected staff to follow the facility's policies and procedures on proper medication storage. Controlled substances should be double-locked. 6. During email correspondence on 3/9/26 at 5:05 P.M., the Administrator said all policies related to medication storage had been provided.

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	265439	A. Building B. Wing	03/06/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to provide choices for meals and to offer substitutions for two residents (Residents #2 and #128). The sample was 18. The census was 69.Review of the facility's Menu Posting and Menu Substitution policy, dated 1/2025, showed: -Menu Posting:-Menus should include daily choices available for each meal;-An always available or a la carte menu is posted or made available to all residents;-Menu Substitutions:-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;--Menu substitute should be consistent with the usual and/or ordinary food items provided.Review of the facility posted menu, dated 3/2/26 through 3/5/26, showed:-Any additional request for lunch on the same day must be submitted before 10:00 A.M. and dinner request submitted before 2:00 P.M.;-Breakfast entree consisted of scrambled eggs for three out of four days, with oatmeal and grits alternating on each day of the week;-No information regarding evening snack availability or choices. Review of the facility's substitution Always Available Menu, undated, showed:-Center of the plate: Classic cheeseburger, hot dog on a bun, chicken tenders, grilled cheese sandwich, deli sandwich (turkey or ham), grilled chicken breast;-Lighter fare: Chef salad, fruit and cottage cheese plate, yogurt parfait;-Sides: French fries, side salad, cottage cheese, fresh fruit;-Beverages: Milk, water, coffee, ice tea, hot tea, fruit juice, and Shasta. 1. Review of Resident #2's medical record, showed:-admission date 2/1/26;-Diagnoses included chronic kidney disease and diabetes. Review of the resident's care plan, in use at the time of survey, showed:, -Focus: Resident is at risk for weight loss;-Goal: Resident to meet 75 to 100% of needs for majority of admission. During an interview on 3/4/26 at 10:45 A.M., the resident said he/she did not receive a menu, so he/she never knew if he/she would like what was being served at meals. Sometimes when he/she called down to the kitchen for a substitution, he/she was told it was too late and the kitchen was closed. This is why he/she saves half of his/her morning sandwich to eat later in the day when he/she gets hungry. During an interview on 3/4/26 at 11:45 A.M., Dietary Aide (DA) R said he/she met with all the residents on the resident's floor and completed each of their individual meal tickets for 3/5/26. Review of the resident's meal ticket for 3/5/26, showed:-Under breakfast, X marked for orange juice, grits, hashbrowns, bacon strips, orange muffin, and salted margarine;-Under lunch, a check mark next to tomato Florentine soup, pork tenderloin, brown rice, brussels sprouts, biscuit and pineapple;--Under dinner, a check mark next to catfish, tartar sauce, potato wedges, coleslaw, cornbread, and peanut butter cookies. During an interview on 3/4/26 at 11:50 A.M., the resident said he/she had not seen or spoken with anyone from dietary that morning. When shown the meal ticket dated 3/5/26, he/she denied giving input and said the meal ticket showed a check mark by brussels sprouts and brown rice, which he/she dislikes greatly and would never eat. He/She said he/she would have requested an alternative, if given the option. 2. Review of Resident #128's medical record, showed:-admission date 3/3/26 ;-Diagnoses included chronic kidney disease, high blood pressure, and heart disease. Observation and interview on 03/6/26 at 8:05 A.M., showed the resident said he/she is unaware of an Always Available Menu and he/she has not been given a menu since he/she was admitted on [DATE]. He/She spoke with someone about meals on his/her first day, but not since then. He/She would like a menu so he/she would know what to expect at meals, and to have a choice if substitution was available. He/She has been a coffee drinker his/her whole life and really missed drinking coffee at breakfast and in the evening. He/She has asked for coffee every day but is told the staff are waiting for more cups or they will bring some, but it never comes. Observations of breakfast on 3/6/26, showed:-At 8:14 A.M., the resident's breakfast tray delivered to the resident with one pancake, scrambled eggs, a bowl of oatmeal, and one cup of juice, with no coffee;-At 8:45 A.M., the resident's oatmeal untouched. The resident's meal ticket showed decaf coffee indicated (continued on next page)

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	265439	A. Building B. Wing	03/06/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	under Beverages. During an interview, the resident said he/she requested coffee and was told it was coming but it still hasn't come. He/She did not like oatmeal or grits and would have eaten cold cereal if given the choice. 3. During an interview on 3/6/26 at 2:22 P.M., the Dietary Manager (DM) said every morning, a member of the dietary department is to go to each floor with each resident's individual meal ticket and meet with each resident to go over the next day's menu. The dietary employee should mark any changes the resident requested on the resident's meal ticket. The meal tickets would be entered into the facility's software program to reflect the next day's meal changes or requests. He expected the staff to ensure each resident was given a menu along with the substitution, Always Available Menu, to ensure the residents' choices are honored.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS)), for one resident who required EBP for Intravenous (IV) medications (Resident #59) and when staff positioned one resident's urinary drainage bag (a medical device designed to collect urine from a catheter (a tube that is inserted into the bladder, allowing your urine to drain freely) on the rim of the trash can (Resident #39). In addition, clean linens were transported in an uncovered cart to the hall linen closets. The sample was 18. The census was 69.Review of the facility's EBP policy, revised on 2/24, showed: -Purpose: To provide direction for the implementation of precautions to prevent transmission of novel or targeted multidrug-resistant organisms utilizing guidelines from CDC; -Policy: To implement enhanced barrier precautions to prevent transmission of novel or targeted multidrug-resistant organisms as defined by CDC to residents, staff, volunteers, visitors or any other individuals providing services under a contractual agreement; -EBP - refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (such as, residents with wounds or indwelling medical devices); -EBP shall be implemented for residents with any of the following: -Wounds (such as, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO; -Infection or colonization with any resistant organisms targeted by the CDC and epidemiologically important MDRO when contact precautions do not apply; - High-contact resident care activities are dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). Review of the facility's Catheter, Insertion of Indwelling and Straight Catheter policy, date revised 5/23, did not show how the drainage tubing should be positioned. Review of the facility's Linen, Infection Control policy, date revised 5/23, showed, clean linen on carts must be covered before the carts are moved out of the clean linen room. All carts must remain covered at all times during transportation. Clean linen carts must be covered on the top and bottom as well as all four sides during transportation. 1. Review of Resident #59's medical records, showed: (continued on next page)

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	03/06/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted on [DATE]; -Diagnoses included infection following a procedure with surgical site, squamous cell carcinoma (skin cancer); -On 2/14/26, an order of micafungin (antifungal medication) 200 milligrams (mg) in 0.9% sodium chloride, to give intravenous piggyback (IVPB) daily for 11 days; -On 3/1/26, an order of heparin (blood thinner) lock flush, 10 unit per milliliter (unit/ml) solution, give intravenous twice a day, via peripherally inserted central catheter (PICC line, a thin, flexible tube inserted into an upper arm vein and advanced to a large vein near the heart for long-term IV access.) Review of the resident's care plan in use at the time of survey, showed: -Problem: Resident on EBP isolation due to PICC line; -Goal: Provide guidance to the resident, family and staff providing care; -Approaches included: Educate the resident and family on precautions, follow the precaution directives posted outside of the resident's room: I am on isolation per policy. Please ensure to keep my door closed as much as possible. Please ensure to use the proper hand hygiene and personal protective equipment (PPE) during my care. Please ensure that I wear a mask during my care. Observation on 3/2/26 at 10:21 A.M., showed the resident's IV pump was beeping. License Practical Nurse (LPN) O entered the resident's room with no PPE on. He/She adjusted the IV tubing and touched the resident's IV site. During an interview on 3/6/26 at 3:45 P.M., the Director of Nursing (DON) said the resident was on contact and EBP precautions. The staff should be wearing PPE when providing care to residents with an IV line. Staff should not be touching the IV or PICC line sites without the required PPE. 2. Review of Resident #39's medical record, showed: -admitted on [DATE]; -Diagnoses included multiple myeloma (cancer of plasma cells, a type of blood cell, affecting bone & bone marrow), diabetes and urinary retention (the inability to fully or partially empty the bladder). Review of the resident's care plan in use at the time of survey, showed: -Problem: Resident required an indwelling urinary catheter related to urinary retention, dated 3/2/26; -Goal: Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma; -Approach included: Position bag below level of bladder and store collection bag inside a protective dignity pouch. Observation on 3/3/26 at 1:15 P.M., showed the resident was sitting up in his/her wheelchair in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her room eating lunch. The catheter drainage bag was not inside a protective dignity pouch and was hanging on the rim of the trash can next to the resident. During an interview on 3/6/26 at 9:42 A.M. the Infection Control Preventionist (ICP) said catheter drainage bags should not be hanging on the rim of the trash can. There was a place on the wheelchair where the drainage bag could be attached. If the drainage bags were not positioned correctly, there could be a risk for infection. 3. Observation on 3/2/26 at 7:17 A.M., showed Housekeeper F, pushing a blue cart with linens and gowns in it, in the hallway, to the second-floor linen closet. The cart was uncovered. Observation on 3/3/26 at 7:20 A.M., showed Housekeeper G pushing an uncovered linen cart down Blueberry Hill Hall to the linen closet. He/She stocked the linen closet, then pushed the uncovered linen cart to Sunshine Lane linen closet. At 7:30 A.M., he/she pushed the uncovered cart to the elevator. During an interview on 3/6/26 at 9:43 A.M., the ICP said laundry should be transported per the facility's policy. During an interview on 3/3/26 at 8:45 A.M., the Housekeeping Manager said the linen carts should be covered. 4. During an interview on 3/6/26 at 3:49 P.M., the Director of Nursing (DON) said she expected staff to follow the facility's policies and procedures.