STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. Building B. Wing	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards. One resident (Resident #4) did not have his/her treatments completed as per physician orders to his/her vascular wounds, and one resident (Resident #3) did not have a treatment on his/her breasts and no follow up skin assessments were completed to ensure the resident's wound was healing. The sample was five. The census was 87. Review of the facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management Policy, review date, 3/31/23, showed: -Based on the comprehensive assessment of a resident, the facility must ensure that: -A skin assessment/inspection occurs on admission/readmission. Skin observations also occur throughout points of care provided by Certified Nursing Assistants (CNA) during Activities of Daily living (ADL, bathing, dressing and incontinent care). Any changes or open areas are reported to the nurse; CNAs will also report to the nurse if a topical dressing is identified as soiled, saturated or dislodged. The nurse will complete further inspection/assessment and provide treatment if needed; -A skin assessment/inspection should be performed weekly by a licensed nurse; -When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. Review of the facility's Physician Order Policy, revised 3/10/24, showed: -A physician must personally approve in writing a recommendation that an individual be admitted to a facility. A physician, physician assistant or nurse practitioner (NP) must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. 1. Review of Resident #4's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/13/23, showed: -Mild cognitive impairment; (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No rejection in care; -Total number of venous and arterial ulcers: Two; -Applications of dressings to feet with and without topical ointments. Review of the resident's face sheet, undated, showed diagnoses that included: Diabetes, muscle weakness, spinal stenosis (narrowing of the spine that causes pain), traumatic ischemia (restricted blood flow) of the muscle and malnutrition (lack of proper nutrition). Review of the resident's care plan, in use at the time of survey, showed it did not address resident's vascular leg ulcers. Review of the resident's physician order sheets (POS), dated 2/13/24, showed an order dated 1/17/24, start date 1/18/24, cleanse bilateral lower extremities (BLE) with normal saline or wound cleanser, apply wound gel, apply Xeroform (Vaseline based non- adherent dressing) then apply non-adherent dressing and wrap with Kerlix (a type of mesh like dressing used to wrap wounds, daily; Review of the resident's Treatment Administration Record (TAR), dated 1/1/24 through 1/31/24 showed: -An order dated 1/17/24, cleanse BLE with normal saline or wound cleanser, apply wound gel, apply Xeroform then apply non-adherent dressing and wrap with Kerlix daily; -No documentation treatment was administered, and boxes were blank on 1/18/24, 1/28/24, and 1/31/24. Review of the resident's TAR, dated 2/1/24 through 2/13/24, showed: -An order dated 1/17/24, cleanse BLE with normal saline or wound cleanser, apply wound gel, apply Xeroform, then apply non-adherent dressing and wrap with Kerlix, daily; -No documentation treatment was administered, and boxes were blank on 2/3/24, 2/4/24, 2/7/24, 2/8/24, and 2/12/24. Review of the resident's wound progress notes dated 2/7/24, showed: -Location: Bilateral lower extremities [NAME] (the area extending from just above the malleolus (ankle region) to below the knee); -Type: Vascular; -Right lower extremity and left lower extremity, much improved, no open excoriation; -Granulation (new tissue development) tissue pale pink. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 2/13/24 at 9:31 A.M., showed the resident lay in bed with BLE dressings dated 2/11/24 and initialed by staff. The resident said he/she thought the staff have been changing his/her dressings daily but was not sure. Observation and interview on 2/13/24 at 10:45 A.M., showed Licensed Practical Nurse (LPN) D removed the resident dressings to the resident's BLEs. The resident had vascular wounds to both lower legs that were healing, with no drainage or odor. LPN D said the vascular BLE dressings are to be changed daily and verified that the dressing on the BLE was dated 2/11/24. 2. Review of Resident #3's MDS information, showed an a entry tracking record, dated 11/23/23 (no further MDS assessments available to review). Review of the resident's face sheet, undated, showed diagnoses that included: Stroke, tracheostomy (an airway surgical formed into the windpipe to assist with breathing), hemiparesis (numbness or tingling of one side of the body), hemiplegia (paralysis or weakness to one side of the body), dysphagia (difficulty swallowing) and aphasia (difficulty speaking). Review of the resident's care plan, in use at the time of survey, showed: Focus: At risk for break in skin integrity; Interventions: Treatments as ordered; Weekly skin checks; The resident uses a pillow between his/her leg and Inter-dry (a fabric type dressing that absorbs moisture on the skin) between breasts and arms. Review of the resident's Braden score (an assessment that is completed to determine the level of risk the resident has to develop a pressure wound), dated 1/20/24, showed the resident was high risk. Review of the resident's wound observation tool, dated 1/26/24, showed: -Acquired at the facility 1/23/24; -Right breast blister; -Granulation tissue present; -No drainage; -Measurements: Length 0.5 centimeters (cm), Width 0.5 cm, Depth 0.1 cm.; -Treatment plan: Skin prep (a skin wipe to dry up potentially moist wounds) and Inter-dry. Review of the resident's record, showed no further wound assessments completed. Review of the resident's CNA bath sheet/skin check sheet, dated 2/12/24, showed on the body diagram, the right breast circled and labeled area. Review of the resident's POS, dated, 2/13/24, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 1/22/24, start date 1/23/24, cleanse bilateral breasts with normal saline, pat dry, apply skin prep, and apply Inter-dry between breasts and arms daily; -An order, dated 1/24/24, start date 1/25/24, Cleanse right breast open areas with normal saline and cover with dry dressing daily. Do not use tape. May hold in place with cloth garment. Observation on 2/13/24 at 9:10 A.M., showed the resident lay in bed with his/her eyes closed. LPN E and CNA F assisted the resident with turning. The resident had a small, closed, healed area on his/her right breast. No dressing or Inter-dry was in place on the resident's arms or breasts. Observation on 2/14/24 at 9:35 A.M., showed the Assistant Director of Nursing (ADON) completed a skin assessment of the resident's chest area. A small, closed, healed area to the right breast was noted. No dressing or Inter-dry dressing was noted in place on the resident arms or breasts. During an interview on 2/14/24 at 9:45 A.M., LPN A said the resident cannot have any adhesive to his/her skin because the resident develops blisters. LPN A was not aware the dressing and Inter-dry were not in place but verified it was a current order. All residents should have weekly skin assessments. 3. During an interview on 2/14/24 at approximately 2:00 P.M., the Director of Nursing (DON) said staff were expected to follow physician orders, complete the treatments as ordered and document the treatments on the TAR. A blank box on the TAR means the treatment was not completed. Weekly skin assessments should be completed on every resident. There is a glitch in the system where the skin assessments are not showing up for the nurses to complete.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to ensure two residents (Resident #5 and Resident #1) with pressure wounds (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) received the necessary treatments and services to promote healing. The sample size was five. The census was 87. Review of the facility's Skin Integrity and Pressure Ulcer/Injury Prevention and Management Policy, review date, 3/31/23, showed: -Based on the comprehensive assessment of a resident, the facility must ensure that: -A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; -A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; -Procedure: -A comprehensive skin inspection/assessment on admission and re-admission to the center may identify pre-existing signs of possible deep tissue damage already present; -A skin assessment/inspection occurs on admission/readmission. Skin observations also occur throughout points of care provided by Certified Nursing Assistant's (CNA) during Activities of Daily living (ADL, bathing, dressing and incontinent care). Any changes or open areas are reported to the nurse; -A risk assessment tool, Braden Scale or Norton Scale determines the resident's risk for pressure injury development. The score is documented on the tool and placed in the resident's medical record using the appropriate form; -Many clinicians utilize a standardized pressure ulcer/injury risk assessment tool to assess a resident's pressure ulcer/pressure risks upon admission, weekly for the first four weeks after admission, then monthly or whenever there is a change in the resident's condition; -A skin assessment/inspection should be performed weekly by a licensed nurse; -Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need of rehabilitation services; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident. Review of the facility's Physician Order Policy, revised 3/10/24, showed: -A physician must personally approve in writing a recommendation that an individual be admitted to a facility. A physician, physician assistant or nurse practitioner (NP) must provide orders for the resident's immediate care and ongoing care of the resident. The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. 1. Review of Resident #5's quarterly minimum data set (MDS, a federally mandated assessment instrument completed by facility staff), dated 10/3/23, showed the resident cognitively intact. Review of the resident's face sheet (undated), showed; -admitted , 12/16/23; -Diagnoses included: Diabetes, pressure ulcers, sepsis (a body's extreme response to an infection), chronic (long term) pain syndrome, osteomyelitis (infection within the bone) of the ankle and foot, and muscle weakness. Review of the resident's care plan, in use at the time of survey, showed: Focus: The resident has pressure ulcer injuries; Interventions: Administer treatments as ordered; observe dressing daily and report loose dressing to the nurse; document progress in wound healing on ongoing basis; assess wound weekly and as needed (PRN). Review of the resident's wound progress notes, dated 2/7/24, showed: -Location: Right posterior (back) heel; -Type: Pressure ulcer stage 2 (partial thickness of skin loss with exposed dermis, the middle layer of the skin, presenting as a shallow ulcer) reopened, -Size: Length 1.0 centimeters (cm), width 2.5 cm and depth 0.1 cm; -Odor: Absent; -Wound bed: Beefy red; -Moderate amount of bleeding; -Necrotic (tissue that is non-viable and appears black): 0%. -Location: Right lateral (side) heel; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Type: Pressure ulcer, stage 2; -Size: 0 cm; -Size: Epithelized (healing) tissue: 100 %; -Necrotic tissue: 0%; -Peri-wound (area around the wound) maceration (a softening and breaking down of skin resulting from prolonged exposure to moisture). Review of the resident's physician order sheets (POS), dated 2/13/24, showed an order, dated 1/17/24, start date 1/18/24, cleanse right heel with wound cleanser/normal saline, pat dry, apply Aquacel AG (an absorbent and antimicrobial dressing), cover with ABD pad (a thick dressing), wrap with Kerlix (a type of mesh-like dressing used for wrapping wounds), every other day. Review of the resident's treatment administration record (TAR), dated 1/17/24 through 1/31/24 showed: -An order, dated 1/17/23, cleanse right heel with wound cleanser/normal saline, pat dry, apply Aquacel AG, cover with ABD pad, wrap with Kerlix, every other day. -No documentation of treatment administered, and boxes were blank on 1/20/24, 1/22/24, and 1/26/24. Review of the resident's TAR, dated February 2024, showed: -An order, dated 1/17/23, cleanse right heel with wound cleanser/normal saline, pat dry, apply Aquacel AG, cover with ABD pad, wrap with Kerlix, every other day. -No documentation of treatment administered, and boxes were blank on 2/7/24, 2/9/24, and 2/11/24. Observation and interview on 2/13/24 at 10 :22 A.M. showed the resident in bed and his/her right foot with Kerlix dressing, undated, wrapped around it. The resident said the dressing to his/her foot had not been changed in several days. He/She always must remind staff that it is time to do his/her dressing. He/She had already placed his/her call light on that day to complete the dressing changes, and no one has come in yet. The resident said he/she is anxious to go home, and when his/her dressings are not changed in a timely manner as ordered, it delays his/her discharge. Observation on 2/13/24 at 12:45 P.M., showed the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) A removed the undated dressing to the resident's right foot and a posterior heel pressure wound and lateral heel pressure wound were observed. The posterior heel wound was bleeding a moderate amount and the would bed was noted pink in color with no odor. The lateral heel wound was pink in color, flat, no drainage and no odor. LPN A measured the lateral heel wound, and posterior heel wound. The posterior heel wound measured approximately, length 0.4 cm, width 2.0 cm and no depth. The lateral heel wound measured approximately, length 0.5 cm, width 2.0 cm, no depth. 2. Review of Resident #1's entry tracking MDS, showed an admitted [DATE] (no further MDS assessments were available to review). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's face sheet, undated, showed: -Diagnoses included: Diabetes, stroke, hemiparesis (numbness and tingling to one side of the body), hemiplegia (paralysis or weakness to one side of the body), speech and language deficits related to stroke, chronic (long term) kidney disease, absence of left lower leg below the knee, and anxiety disorder. -discharge date : 2/3/24; Review of the resident's admission assessment tool dated, 12/15/23, showed: Skin: -Intact: No; -Rash and open area boxes checked; -Site: -Groin: Red rash resembles moisture rash; -Sacrum: Small red open area to sacrum; -Abdomen: Right lateral upper abdomen area looks like staples were pulled. Review of the resident's care plan, undated, showed: Focus: The resident has a break in skin integrity, initiated 12/16/23; Plan: Pressure reducing mattress and treatments as ordered. Review of the resident's Braden score, dated 12/16/23, showed the resident was at high risk for developing pressure sores. Review of the resident's wound observation tool dated 12/18/23, showed: Observation: -Resident admitted with wound; -Location: Sacrum; -Type: Pressure; -Stage: Blank; -Viable tissue: First observation, no reference box: checked; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Date physician notified: the physician was present on admission on 12/15/23; -Date family or responsible party notified: Blank; -Epithelial (a layer of the skin) pink tissue present; -Drainage: none; -Wound measurements: Blank. Review of the resident's record, showed no further wound observation tools documented. Review of resident's progress notes, showed on 1/3/24 at 9:30 A.M., the resident was found on floor next to bed by the CNA, no visible injuries per skin assessment, buttocks remain excoriated and scrotal area reddened. Review of the resident's CNA bath sheet/skin check sheets dated 1/4/24, 1/15/24, 1/18/24, and 1/29/24, showed no documentation of visual skin checks. Review of the resident's POS, dated 12/15/23 through 12/31/23, 1/1/24 through 1/31/24, and 2/1/24 through 2/3/24, showed no orders for skin or wound treatments. During an interview on 2/14/24 at 11:00 A.M., CNA B said he/she assisted another CNA with getting the resident out of bed because the resident required a lot of assistance getting out of the bed. He/She remembered the resident complained that his/her bottom was hurting but he/she never looked at it or told anyone about the resident having pain. All skin issues are to be documented on the resident's shower sheets and the nurse should be notified. During an interview on 2/13/24 at approximately 2:00 P.M., LPN A said he/she was not aware the resident had any open areas on the coccyx or buttocks. He/She would expect the CNAs to notify him/her if there was a skin issue. Review of the resident's hospital nursing emergency triage progress note dated 2/3/23 at 9:23 P.M., showed the resident presented to the emergency department with an area of non-blanching (discoloration of does not fade when pressure is applied to the area) redness noted to coccyx (tailbone) and open area to left buttocks. 3. During an interview on 2/14/24 at 10:20 A.M., LPN C said all residents should have weekly skin assessments. On admission, the resident is assessed from head-to-toe and the physician is to be contacted as soon as possible for treatment orders. All treatments are to be dated and documented in the resident's TAR. The floor nurse is responsible for completing the treatments since the facility no longer has a wound nurse during the week and on weekends. If the box is blank, the treatment was not completed. The nurses should attempt to measure and describe the wound as best as they can anytime a skin issue develops. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 2/14/24 at approximately 2:00 P.M., the Director on Nursing (DON) said skin assessments are to be completed weekly on all residents. There is a glitch in the system to where the skin assessments are not showing up for the nurses to be completed. All treatments should be completed per the physician orders and documented in the TAR. The dressings should be dated once they are changed. A blank box on the TAR means the treatment was not administered. A head-to-toe skin assessment is to be completed on admission. All skin issues should be addressed with the physician and orders are expected to be obtained. The CNAs are expected to let the nurse know if a skin issue develops. If the nurse is unsure how to measure or describe a wound, the nurse is expected to reach out to the DON or immediate nursing supervisor. MO00231346 MO00231625