STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure facility staff provided two residents (Residents #1 and #4), who were unable to perform their own activities of daily living, the necessary services to maintain good personal hygiene when staff did not administer incontinence care in a timely manner. The facility also failed to ensure appropriate perineal care (Peri-care, washing the front and back of the hips, genitals, anal area and buttocks) was provided for infection control. The sample size was three. The census was 82. Review of the facility's Activities of Daily Living, Supporting policy, dated November 2024, showed: -Policy: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with toileting. Review of the facility's Peri-Care In-Service, dated 5/7/25, showed: -Peri-care, or perineal care, is the process of cleaning a patient's genital area; -Regular peri-care helps prevent urinary tract infections, bladder infections, kidney infections, and odor; -Peri-care should be performed daily, and more often if the patient has incontinence; -Always wash hands before and after performing peri-care; -Wear clean gloves to protect yourself and the patient; -Infection Prevention included: Follow all standard precautions, including hand hygiene and proper disposal of soiled linens. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/3/25, showed: -Severe cognitive deficiency; -Impairment on both sides of lower body; -Dependent on staff for toileting, lower body dressing, and transfers; -Maximal assistance required from staff for bed mobility; -Incontinent of bowel and bladder; -At risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction); -Moisture Associated Skin Damage (MASD) present; -Diagnoses included traumatic spinal cord dysfunction, heart failure, kidney disease, peripheral vascular disease (PVD, poor circulation), diabetes mellitus and dementia. Review of the resident's care plan, undated, showed: -Problem: ADL self-care performance deficit related to dementia, decreased mobility, generalized weakness and history of PVD. The resident is incontinent of bladder and bowel and required staff to provide toileting hygiene and perineal care after incontinent episode; -Interventions included: Check and change the resident at least every two hours and as needed for incontinence care. Observation on 6/13/25 at 11:42 A.M., showed the resident sat in a wheelchair, at a dining room table, preparing to each lunch. The resident was neatly groomed and had a slight odor of urine. The resident was not able to answer questions. During an interview on 6/13/25 at 11:55 A.M., Certified Nursing Assistant (CNA) B said: -CNAs were expected to round on residents every two hours to check for incontinence, give incontinence care if needed, apply barrier creams, and reposition residents to prevent skin breakdown; -CNAs were expected to report any skin breakdown to nurses so they could assess the resident and get orders for treatment. Observation on 6/13/25 at 1:02 P.M., showed,: -CNA B and CNA C giving care to the resident in his/her room, while the resident was lying in his/her bed; -Both CNAs donned gloves without sanitizing their hands; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B rolled the resident to his/her right side, pulled the resident's pants down and pulled the resident's brief to one side. The brief, heavily soaked with urine, was visibly wet up to the waistband of the brief. There was a strong smell of urine present; -CNA B, with soiled gloves, rolled the resident onto his/her back and pulled the brief down in between the resident's legs; -The brief was heavily soaked with urine and there was a strong smell of urine present; -CNA B, with soiled gloves, wiped the resident's inner thighs and lower abdomen with a wet washcloth, sprayed with no rinse perineal solution, changing the area of the washcloth with each wipe; -CNA B, with soiled gloves, rolled the resident back over to his/her right side, removed the urine soaked brief and placed it in a trash bag, then blotted the resident's coccyx with a towel wet with water and no rinse peri-care solution; -CNA B, with soiled gloves, put a new brief in place under the resident, and with assistance from CNA C, rolled the resident to the left and right side to secure the clean brief on the resident, while removing the soiled chuck (absorbent pad) and the resident's visibly wet with urine pants; -CNA B, with soiled gloves, put a clean shirt on the resident and repositioned the resident back on the bed; -CNA B, with soiled gloves on, left the resident's room, into the hall with the resident's dirty linen; -CNA removed the dirty gloves and sanitized his/her hands; -CNA B failed to wash all areas of the resident's skin where urine from the heavily soaked brief had touched, including the resident's genitals, buttocks, buttock cleft, lower back, front and back of upper thighs, and hips; -CNA B failed to doff his/her gloves, sanitize his/her hands and don new gloves when providing care from a dirty to clean area; -CNA B failed to sanitize his/her hands before donning gloves when first providing care to the resident and failed to doff his/her gloves and sanitize his/her hands before going out into the hall. During an interview on 6/13/25 at 1:13 P.M., CNA B said: -The last time the resident received incontinence care was during his/her shower that morning, perhaps around 10:00 A.M.; -He/She removed the resident's pants because they were wet with urine; -CNAs were expected to change their gloves and sanitize their hands during perineal care when going from a dirty to a clean task to prevent cross contamination and for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Impairment on one side of lower body; -Maximum assistance required from staff for toileting, lower body dressing, bed mobility and transfers; -Frequently incontinent of bladder; -Occasionally incontinent of bowel; -At risk for pressure ulcers; -Diagnoses included fractures, heart failure, kidney disease, diabetes mellitus and overactive bladder. Review of the resident's care plan, undated, showed: -Problem: Required staff assistance for ADLs and personal hygiene/personal care tasks to be met/completed due to impaired functional mobility, impaired bed mobility, activity intolerance, decreased body strength and overall generalized weakness. Interventions included: Required more staff assistance with ADLs and personal hygiene/personal care; -Problem: Incontinent of bladder. Interventions included: Assist with peri-care after each incontinent episode and ask the resident if he/she needed assistance to go to the restroom through out the day. Observation on 6/13/25 at 11:43 A.M., showed the resident sat in a wheelchair, on top of a Hoyer lift (mechanical device used to assist in transferring individuals with limited mobility from one place to another) pad (sling, specialized harness which residents sit in while it is connected to the Hoyer lift to safely support residents during transfer) at a dining room table, eating lunch. The resident was neatly groomed and had a slight odor of urine. During an interview on 6/13/25 at 12:46 A.M., the resident said: -He/She believed the last time staff provided him/her incontinence care was early in the morning; -Staff usually provided incontinence care after lunch. Observation on 6/13/25 at 1:20 P.M., showed: -CNA C donned gloves without sanitizing his/her hands; -CNA B sanitized his/her hands and donned gloves; -The resident was sitting in his/her wheelchair on top of a Hoyer pad; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B and CNA C transferred the resident from his/her wheelchair to his/her bed using a Hoyer Lift; -The resident said I'm all wet! I can feel it on the Hoyer pad! during the transfer to his/her bed; -CNA B removed the resident's gown, which was visibly wet with urine in the back; -CNA C removed the resident's heavily urine soaked brief and tucked it down in between the resident's legs. There was a strong smell of urine present; -The resident's inner thighs and genital area were bright pink; -CNA C, with dirty gloves, washed the resident's perineal area with a towel wet with water and no rinse peri-care solution; -Both CNAs, with dirty gloves, assisted the resident to roll to his/her right side, touching the resident's left hip, legs, upper shoulders and upper back; -CNA C, with dirty gloves, removed the resident's brief which was visibly soaked with urine up to the waist band and had a minimal amount of bowel movement present. There was a strong smell of urine and feces present; -CNA C, with dirty gloves, used perineal wipes to clean the resident's perineal area, using a new wipe with each new area to clean; -CNA B reminded CNA C to doff his/her gloves and don new gloves before giving additional care to the resident; -CNA C doffed his/her gloves, without sanitizing his/her hands first, then donned new gloves; -CNA C placed a new brief in place under the resident and applied Calazinc cream (barrier cream with calamine and zinc) to the resident's buttocks, buttock cleft and upper thighs; -Both CNAs, with dirty gloves, rolled the resident back and forth from his/her left to right side, completely removed the resident's urine wet gown, urine wet Hoyer pad, and dirty chuck pad from underneath the resident, putting the dirty linen in a trash bag; -CNA C, with dirty gloves, put Calazine cream on the resident's front inner thighs, then secured the clean brief to the resident and put a clean gown on the resident; -CNA C doffed his/her gloves, failed to sanitize his/her hands, donned new gloves and placed the resident's bed linen on him/her, put the resident's call light within reach, and lowered the resident's bed; -CNA C doffed his/her gloves, failed to sanitize his/her hands, then removed the linen cart from the resident's room into the hall; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B and CNA C failed to doff their gloves, sanitize their hands and don new gloves before giving care from a dirty area to a clean area. During an interview on 6/13/25 at 1:44 P.M., CNA C said: -CNAs were expected to change their gloves and sanitize their hands during perineal care when going from a dirty to a clean task; -CNAs were expected to sanitize their hands and put on new gloves before applying cream to a resident's skin; -The resident was at risk of cross contamination and infection when the CNA used dirty gloves to apply cream to the resident's perineal area; -The resident's gown and Hoyer pad were wet with urine; -He/She was assigned to care for the resident; -The last time he/she provided incontinence care to the resident was when he/she came on shift, around 7:00 A.M.; -He/She should have checked on the resident every two hours for any incontinence needs to prevent skin breakdown. 3. During an interview on 6/13/25 at 11:27 A.M., Licensed Practical Nurse (LPN) A said he/she expected nursing staff to round on residents who were dependent on staff for ADLs at least every two hours to check for incontinence, to address any resident needs and to reposition residents. During an interview on 6/13/25 at 2:45 P.M., the Administrator said: -She expected nursing staff to know of and to follow facility policies; -She expected CNAs to round on ADL dependent residents every two hours, or as needed, to check for incontinence and reposition residents to prevent skin breakdown; -She expected CNAs to sanitize their hands before and after care, before donning gloves, and after doffing gloves for infection control; -She expected CNAs to sanitize their hands, don new gloves when going from a dirty to clean task and/or area when providing perineal care to reduce the risk of cross contamination and infection control; -CNAs put residents at risk of infection and/or delayed wound healing when they applied cream to residents' skin with dirty gloves; -Residents who were in heavily urine soaked briefs were at risk of skin breakdown, urinary tract infections and delayed healing and/or infection of existing wounds/skin issues. It was also matter of resident dignity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00253402

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 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** Based on observation, interview and record review, the facility failed to provide treatment consistent with professional standards of practice to an existing pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for one resident (Resident #1) out of three sampled residents. The facility also failed to consistently complete and document assessments of the resident's skin and failed to assess and document the resident's pressure ulcer weekly. The census was 82. Review of the National Pressure Ulcer Advisory Panel (NPUAP), prevention and treatment of pressure ulcers: quick reference guide, Washington DC: National Pressure Ulcer Advisory Panel 2014, showed the following: -Assess the pressure ulcer initially and re-assess it at least weekly; -With each dressing change, observed the pressure ulcer for signs that indicate a change in treatments as required (e.g., Wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications); -Address the signs of deterioration immediately. Review of the Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Chapter 3, Section M, defines the different stages of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) as follows: -Stage I: an observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in skin temperature, tissue consistency, sensation, and/or a defined area of persistent redness; -Stage II: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue). May also present as an intact or open/ruptured blister. Review of the facility's Pressure Ulcers/Skin Breakdown - Clinical Protocol policy, dated November 2024, showed: -The nurse shall describe and document/report the following: -Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; -Photograph wound; -Pain assessment; -Resident's mobility status; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Current treatments, including support surfaces; -All active diagnoses; -The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration; -During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. Review of Resident #1's Physician Order Sheet, showed: -An order, dated 11/25/24, for weekly skin assessments every Tuesday during evening shift; -No order found for the outside wound care company to evaluate and treat the resident's wound; -No order found to complete weekly wound assessments. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/3/25, showed: -Severe cognitive deficiency; -Impairment on both sides of lower body; -Dependent on staff for toileting, lower body dressing, and transfers; -Maximal assistance required from staff for bed mobility; -Incontinent of bowel and bladder; -At risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction); -No unhealed pressure ulcers present; -Diagnoses included traumatic spinal cord dysfunction, heart failure, kidney disease, diabetes mellitus and dementia. Review of the resident's care plan, undated, showed: -Problem: At risk for impairment to skin integrity related to decreased mobility, incontinent of bowel and bladder, obesity, DM and skin changes associated with aging; -Interventions included: Provide wound care treatments with dressing changes as ordered by the attending physician; Weekly skin assessment by nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic medical health record (EMHR), showed no weekly wound reports from the outside wound care company in the uploaded files. Review of the resident's weekly skin assessments, showed, -On 4/22/25 at 2:49 P.M., no documentation of a pressure ulcer; -No weekly skin assessment for the week of 4/27/25. Review of the facility's weekly wound reports, showed on 4/24/25, the resident had a pressure ulcer located on right buttocks, medial line, acquired 1/14/25, measuring 2.0 centimeter (cm) by 1.0 cm; no drainage, skin pink, well approximated, tender to touch. Treatment: Cleanse wound and applied protective barrier cream. Review of the resident's weekly skin assessments, showed no weekly skin assessment for the week of 4/27/25. Review of the facility's weekly wound reports, showed: -On 4/28/24, the resident had a pressure ulcer located on right buttocks, medial line, acquired 1/14/25, measuring 2.0 cm by 1.0 cm; no drainage, skin pink, well approximated, tender to touch. Treatment: Cleanse wound and applied protective barrier cream; -On 5/5/25, the resident had a pressure ulcer located on right buttocks, medial line, acquired 1/14/25, measuring 2.0 cm by 1.0 cm; no drainage, skin pink, well approximated, tender to touch. Treatment: Cleanse wound and applied protective barrier cream. Review of the resident's weekly skin assessments, showed: -On 5/6/25 at 5:52 P.M., no documentation found of a pressure ulcer; -No other weekly skin assessments found for May. Review of the facility's weekly wound reports, showed: -On 5/12/25, no documentation showing the resident had a pressure ulcer; -On 5/19/25, no documentation showing the resident had a pressure ulcer; -No other facility weekly wound reports provided for the week of 5/25/25 or 6/1/25. Review of the resident's Treatment Administration Record (TAR), dated May 2025, showed, no orders to treat the resident's pressure ulcer (PU) located on his/her right buttock. Review of the resident's weekly skin assessment, dated 6/3/25 at 10:06 P.M., showed no documentation found of a pressure ulcer. Review of the resident's TAR, dated June 2025, 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
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 6/8/25, to apply Triad Hydrophilic wound dressing (paste used to treat pressure ulcers to help manage low to moderate exudate (drainage) and to assist in with natural debridement (remove dead, damage or infected tissue from wound to promote healing) to buttocks and sacral region (triangle bones located above coccyx (tailbone) daily until healed every evening shift for wound care; -Documentation showed the facility administered the treatment as ordered. Review of the facility weekly wound report, dated 6/9/25, showed no documentation found for the resident. Review of the resident's weekly skin assessment, dated 6/10/25 at 9:47 P.M., showed Stage II PU located at resident's coccyx, painful. There were no other details documented. Review of the resident's progress notes, showed no documentation showing the Primary Care Physician (PCP), Director of Nursing (DON), or the resident's responsible party (RRP) were notified of the Stage II PU at the resident's coccyx as documented in the weekly skin assessment dated [DATE]. During an interview on 6/13/25, at 11:27 A.M., Licensed Practical Nurse (LPN) A said: -He/She expected staff to report any changes in residents' skin to the nurse; -Nurses were expected to assess the residents' skin, document their findings in an incident report, notify the PCP, get orders to treat the skin issue, notify the RRP and the DON, then document the skin issue, what was done, who they notified, and any new orders in a progress note in the residents' electronic medical health record (EMHR); -Nurses were expected to complete weekly skin assessments on residents, documenting on a skin assessment form in the EMHR; -The DON was responsible for completing weekly wound assessments and documenting in the EMHR; -Nurses were responsible for wound treatments. Observation on 6/13/25 at 11:42 A.M., showed the resident sat in a wheelchair, at a dining room table, preparing to each lunch. The resident was neatly groomed and had a slight odor of urine. The resident was not able to answer questions. Observation on 6/13/25 at 1:02 P.M., showed,: -Certified Nurse Assistant (CNA) B and CNA C giving incontinence care to the resident in his/her room, while the resident lay in his/her bed; -CNA B donned gloves without sanitizing his/her hands; -CNA B rolled the resident to his/her right side, pulled the resident's pants down and pulled the resident's brief to one side. The brief, heavily soaked with urine, was visibly wet up to the waistband of the brief. There was a strong smell of urine present; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was a wound present at the resident's coccyx (tailbone) which was red and had scattered open areas within the wound borders. The wound was not covered with a dressing; -CNA B provided incontinence care; -CNA B, with soiled gloves, applied Calazinc cream (barrier cream containing calamine and zinc) on to the resident's wound located at his/her coccyx, before putting a new brief on the resident. During an interview on 6/13/25 at 1:13 P.M., CNA B said: -CNAs were expected to sanitize their hands and put on new gloves before applying cream to a resident's skin; -The resident was at risk of cross contamination and infection when the CNA used dirty gloves to apply cream to the resident's coccyx pressure ulcer; -He/She should not have applied the barrier cream to the resident's coccyx wound because there were open areas in the wound. He/She should have reported the open areas to the nurse and the nurse should provide wound treatments. During an interview on 6/13/25 at 2:45 P.M., the Administrator said: -She expected nursing staff to know of and to follow facility policies; -Nurses were responsible for completing weekly skin assessments; -Nurses were responsible for administering wound treatments per physician orders; -She expected nurses to assess residents' wounds when administering treatments, assess if there are any changes, notify the PCP, put in new orders if given, notify the RRP and DON, and document all in a progress note; -The DON was responsible for completing weekly wound assessments; -Residents were expected to have a physician order to see the outside wound care company; -The DON would round with the outside wound care company and assess the residents' wounds with them; -She expected the DON to use the wound report from the outside wound care company as residents' weekly wound assessments; -She expected the weekly wound reports from the outside wound company to get uploaded into residents' EMHR in a timely manner, usually within a week of the visit, so other nurses could view the report if there were any questions regarding the wounds; -The DON was not expected to complete a separate weekly wound assessment; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265627	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Care Center of Chesterfield	1025 Chesterfield Pointe Parkway Chesterfield, MO 63017

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected the DON to update wound orders after the outside wound care company completed their weekly wound assessments for residents; -CNAs should not apply any treatment to a pressure ulcer as it was outside of their scope, CNAs did not have the appropriate training to treat wounds; -She expected CNAs to alert nurses of any skin issues and nurses were expected to administer any physician prescribed wound treatment orders.