STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265680	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Skilled Nursing & Rehabilitation Center	37 North Clark Avenue Ferguson, MO 63135

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review, the facility failed to investigate an injury of unknown origin for one of three sampled residents (Resident #1). The census 67. Review of the facility's policy on Injuries of Unknown Origin, updated 4/30/20, showed the following: -Investigation should include Who, What, When, Why and How. Enable the investigator to record the information and establish a reasonable cause known source of the incident or injury within 24 hours of the incident or injury. If the investigator is unable to establish a reasonable cause or known source, further investigation is required. -Extended Investigation: Further investigation is required if there is Injury of Unknown Origin or Suspected Abuse within 24 hours and 1 hour for Abuse. The following will be needed: Statements from all involved witnesses and reporters. Expand the time frame surrounding the incident for collecting data and begin timeline. Follow-up on new information. Obtain related professional expertise. If the suspected perpetrator is staff, interview the other residents the staff person was assigned to. Gather assignment sheets and begin conducting interviews. Additional information obtained in the investigation should allow the investigator to answer the Who, What, When, Where, Why and How and lead the establishment of a reasonable cause. If the reasonable cause cannot be established in either investigative phase, the cause should be reported as unknown; -Corrective Action Required Following: After the investigative phase is completed, the nursing home is required to take action based upon the findings to correct the known and reasonable causes as well as the prevent further reoccurrence of the alleged incident. -Evidence of Investigation: The resident's record must include enough information about the incident to enable staff to identify, plan for and meet the resident's needs. Evidence of the investigation must be readily available to state licensing and certification staff and others according to their authority. Review of Resident #1's 5 Day Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/9/25, showed the following: -Diagnoses of Alzheimer's disease, high blood pressure and pneumonia; -Short/Long term memory loss; (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required maximum assistance of staff for bathing, dressing, grooming and toilet use; -Required moderate to maximum staff assistance for transfers; -No open areas or bruises. Review of the resident's progress note, dated 5/26/25 at 8:22 A.M., showed the following: -Sent to the hospital related to swelling and pain of the left hip; -Resident has shortness of breath and congestion; -Family and physician aware; -No documentation regarding the resident's skin. During an interview on 5/29/25 on 1:30 P.M., hospital staff said the resident has a second degree burn with blistering on the dorsal side (back side) of his/her right hand overlying first and second metacarpal (bones in your hand that connect your wrist to your thumb and finger bones) that is of superficial partial thickness. He/She also had a couple of little spots of blistered skin on his/her fingers on the inside of his/her hand, as well as burns on his/her left hand and thigh. The Director of Nursing (DON) told the hospital staff she had no idea how the resident could have gotten burned, because he/she does not have access to anything hot like a coffee pot or curling iron. His/Her spouse visited him/her at the facility on May 26, 2025 and said he/she did not have the burns then. Observation on 6/5/25 at 10:15 A.M., showed the resident lay in a low bed next to the wall with a fall mat on the right side. The resident's left hand showed a healing wound approximately 4 centimeters (cm) in size. During an interview on 6/5/25 at 10:10 A.M., Certified Nurse Aide (CNA) B said he/she has taken care of the resident on the day shift. He/She recently saw the wound on his/her left hand. The resident didn't have the wound prior to him/her going on vacation a week ago. CNA B doesn't know how he/she developed the wound. During an interview on 6/6/25 at 10:22 A.M., Registered Nurse (RN) A said he/she was the charge nurse on 5/26/25. Staff reported the resident complained of left leg pain. During the assessment, the resident's leg appeared swollen and he/she complained of pain. An order was received to send the resident to the hospital. CNA D reported a blister to the resident's left hand when the resident was on his/her way to the hospital. RN A did not assess the resident's skin and did not notice the blister to the left hand. He/She was more focused on the resident's leg. RN A failed to document the blister or report it to the DON. During an interview on 6/5/25 at 2:50 P.M., Licensed Practical Nurse (LPN) C said he/she was made aware of the blister to the resident's left hand when the resident was on his/her way to the hospital. The blister was fluid filled and intact at the time of transfer. LPN C failed to document the blister in the medical record. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 3:10 P.M., the DON said the hospital called about the wound to the resident's left hand and asked whether the resident sustained a burn. The resident had no access to hot liquids. She interviewed the charge nurses but failed to talk to nurse aides. The staff failed to report the change in the resident's skin. She expected staff to report it to the nurse who should assess, notify the physician and document in the medical record. During an interview on 6/6/25 at 11:17 A.M., the Administrator said staff failed to report the blister prior to the resident going to the hospital. If staff had reported the blister, an investigation would have been done to determine the cause of the blister. He expected staff to report any changes to the resident's skin to the charge nurse. The charge nurse should assess, call the physician for orders and document in the medical record. MO00254960 MO00255257