STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265834	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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. Based on observation, interview and record review, the facility failed to ensure services were provided to prevent pressure ulcers (skin and tissue damage caused by prolonged, unrelieved pressure on the skin) for one resident (Resident #3). Staff failed to provide ordered treatment to the resident's sacral wound after an incontinent episode, leaving the wound exposed to air and failed to complete ordered daily wound care to the resident's right ankle pressure ulcer for three days while documenting the treatment as completed on the Treatment Administration Record (TAR). The sample size was seven. The census was 122.Review of the facility's Wound Management Policy, revised 11/15/22, showed:Policy: To promote Wound healing of various types of Wounds, the Facility will provide Evidence-Based Treatments in accordance with current Standards of Practice and Physician Orders; Procedure: Wound Management: -Wound Treatment will be provided in accordance with Physician's Order; -Cleansing Method; -Type of Dressing; -Frequency of Dressing Change. Charge Nurse will Notify Physician in the absence of Treatment Orders. Dressing Changes may be provided outside of the frequency parameter in certain situations: -Urine, Feces, or other Bodily Fluids have saturated through the Dressing; -Dressing is Dislodged; -Dressing is Soiled. Wound Dressing's will be Applied in accordance with Manufacturer's Recommendations. Treatment Selection will be based on the Etiology of the Wound. Pressure Injuries will be differentiated from Non-Pressure Wounds. Wound Characteristics/Documentation: -Location of the Wound; -Pressure Injury & Stage; -Non-Pressure-Level of Tissue Destruction; -Size (Shape, Depth, Tunneling and/or Undermining); -Volume & Exudate Characteristics; -Pain Evaluation; -Presence of Infection/Bioburden; -Condition of the Wound Bed & Wound Edges; -Condition of the Peri-Wound;-Resident/Resident Representative Preferences/Goals. Guidelines for Dressing Selection: -Obtain Physician's Order; -Review Wound Care Formulary to assist in Treatment decision process; -Wound Care Formulary may not be appropriate for use in all circumstances; -Treatments will be documented on the Treatment Administration Record. The Effectiveness of Treatments will be Monitored through ongoing Evaluation of the Wound(s). Considerations Modification: -Lack of progression towards healing;-Changes in Wound Characteristics; -Changes in the Resident/Resident Representative's Preferences/Goals (e.g., comfort care associated with end of life in accordance with his/her rights). Review of Resident #3's care plan, revised 1/28/26, showed:-Focus: Resident has a wound to his/her sacrum, stage four (a severe full-thickness wound where skin and underlying tissues are destroyed) that he/she receives treatment to. Resident has a wound to right medial heel and right second toe;-Goal: To remain without complications over through the next review;-Interventions: Low air loss mattress, observe for signs of infection, provide treatment per current order. Refer to physician orders for details. Wound doctor to follow wounds. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/1/26, showed:-Cognitively intact;-Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device: Yes;-Is this resident at risk of developing pressure ulcers/injuries: Yes;-Current number of unhealed pressure injuries: One;-Number of Stage four pressure ulcers: One;-Other open lesion on the foot: Yes;-Diagnoses included: diabetes, muscle weakness, acquired absence of left leg below knee, acid reflux, neurogenic bladder (the bladder does not empty properly due to a neurological (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition), spina bifida occulta (is a mild form of spina bifida caused by a gap forming between the vertebrae in your spinal cord) and pressure ulcer of sacral region stage four. Review of the resident's electronic Physician Order Sheet (ePOS), dated May 2026, showed:-An order, dated 5/6/26, Right Medial Heel: Cleanse with wound cleanser. Apply Santyl (prescription ointment used to help clean wounds and promote healing) with calcium alginate (a gelatinous water-insoluble substance derived from brown seaweed), cover with a 4x4 wrap with kerlix (gauze) and secure with tape. Change daily and as needed if soiled. Every day shift for Wound Care;-An order, dated 5/15/26 to 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt (sodium chloride-impregnated sterile dressing used to manage heavily draining and infected wounds) cover with Sacral border gauze and change daily and as needed if soiled. Every day shift for Wound care;-An as needed (PRN) order, dated 5/15/26 to 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if soiled every eight hours as needed for wound;-An order, dated 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if soiled. Two times a day (7a-10 am and 4pm -7pm) for Wound care;-A PRN order, dated 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if soiled every eight hours as needed for wound. Review of the resident's TAR, dated May 2026, showed:-An order, dated 5/6/26, Right Medial Heel: Cleanse with wound cleanser. Apply santyl with calcium alginate, cover with 4x4 wrap with kerlix secure with tape. Change daily and as needed if soiled. Every day shift for Wound Care;-Shown as completed on 5/15, 5/16, 5/17, 5/18, and 5/19/26;-An order, dated 5/15/26 to 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt, cover with Sacral border gauze and change daily and as needed if soiled. Every day shift for Wound care;-Shown as completed on 5/15/, 5/16, 5/17, and 5/18/26;-An as needed (PRN) order, dated 5/14/26 to 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if soiled every eight hours as needed for wound;-TAR was blank on 5/14, 5/15, 5/16, 5/17, 5/18, and 5/19/26;-An order, dated 5/19/26, Sacrum: Cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if Soiled. Two times a day (7am-10 am and 4pm -7pm) for Wound care. Noted to start at 4pm on 5/19/26;-A PRN order, dated 5/19/26, Sacrum: cleanse with wound cleanser, pat dry, apply mesalt cover with Sacral border gauze and change daily and as needed if soiled every 8 hours as needed for wound-TAR was blank on 5/19/26. Observation and interview on 5/19/26 at 9:40 A.M., showed Resident #3 lay in bed. There was a foul odor in the room noted in the hallway. The resident said he/she did not have much feeling in his/her sacral area and was not always sure when he/she had a bowel movement but did get diarrhea frequently. The resident said he/she had an incontinence episode around 1:30 P.M. yesterday and the dressing to his/her sacrum had to be removed. The dressing to his/her sacrum was not replaced and there was still no dressing on the area. He/She said there was also a wound to his/her right ankle that has not been changed since 5/15/26. The resident said staff had not been in to check his/her brief that morning, only to check his/her blood sugar. Observation and interview on 5/19/26 at 10:22 A.M. showed Assistant Director of Nursing (ADON) A outside the resident's room at the treatment cart. ADON A asks where the odor was coming from and entered the resident's room to talk to the resident and inform he/she was going to complete the resident's wound care. ADON A went back to his/her cart and gathered supplies for the resident's wound care. ADON A said nurses were responsible for completing wound care when he/she was off during the week and on the weekends. He/She was off yesterday. If a resident was soiled and the dressing needed to be removed during incontinence care, the Certified Nursing Assistant (CNA) should have told the nurse so it could be replaced. Observation on 5/19/26 at 10:30 A.M., showed ADON A entered the resident's room. He/She wiped down the bedside table and placed a disposable pad and supplies on the table. ADON A performed hand hygiene and donned a gown and gloves. ADON A removed the resident's brief and had the resident roll to his/her right side. The resident had dried bowel movement covering the sacral (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area and on the resident's shorts. There was no dressing noted to the resident's sacral area. The resident reported to ADON A the dressing came off yesterday at 1:30 P.M. after an episode of diarrhea. The resident said he/she did not know he/she had another episode of diarrhea since that episode and could not always feel it. Staff had not checked on him/her yet this morning. The ADON started to clean the resident. He/She said he/she needed more wipes, removed the gown and gloves, performed hand hygiene, and left the room. When ADON A returned, CNA E was with the ADON. ADON A washed his/her hands, donned gown and gloves and finished cleaning the resident's bowel movement. CNA E washed his/her hands, donned gown and gloves and then assisted ADON A in placing a new pad under the resident and placed a new brief and shorts on the resident. CNA E also removed the resident's right shoe. He/She then removed the dirty items and placed them in the trash, removed his/her gown and gloves, performed hand hygiene and left the room. ADON A removed gloves, washed hands, and donned new gloves. ADON A completed the wound treatment for the sacral area and noted to the resident that he/she had new areas that he/she would report to the physician. ADON A removed the resident's right sock. ADON confirmed the date shown on the dressing was 5/15/26. There was dried brown drainage to the resident's heel. The dressing was stuck to the open area when removed. ADON A cleansed the area with wound cleanser and said the wound care was to be completed daily. The ADON removed his/her gloves, performed hand hygiene, donned new gloves and completed the wound treatment on the resident. ADON A cleaned up the trash, removed his/her gown and gloves, washed hands and left the room with the trash. During an interview on 5/19/26 at 2:40 P.M., Licensed Practical Nurse (LPN) F said nurses were responsible for the wound care and any dressing changes on the weekends and if the wound care nurse was off during the week. The documentation of the wound care should not be marked as completed until after it was done. Something could happen and staff may not have gotten to it. Wounds could deteriorate fast. During an interview on 5/19/26 at 3:05 P.M., the Director of Nursing (DON) said she would expect staff to follow physician orders and to document correctly. They should not have documented something as done if not done. If a resident refused, then she would expect staff to put a note in the medical record. The wound nurse did the majority of the wound care, and the nursing staff was responsible for the more minor care such as skin tears or creams. The nurses were responsible for all the wound care if the wound nurse was not at the facility and on the weekend. She would also expect the CNA to let the nurse know if the dressing came off during care so it could be replaced. During an interview on 5/19/26 at 3:15 P.M., the Administrator said he would expect staff to follow physician orders. Treatments should not be documented as completed if they were not done. Nurses were responsible for wound care if the wound nurse was off. There should have been a note in the medical record if the resident refused treatment. 3013273