STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265838	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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 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. 34477 Based on observation, interview and record review, the facility failed to ensure services were provided to meet professional standards of practice and per the resident's plan of care when staff failed to apply wraps to Resident #13's legs, per physician orders. The sample was size was five. The census was 77. Review of the facility's Wound Care policy revised October 2010, showed: -Purpose: To provide guidelines for the care of wounds to promote healing; -Preparation: -Verify there is a physician's order for this procedure; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and the reason(s) why; -The signature and title of the person recording the data; -Reporting: -Notify the supervisor if the resident refuses the wound care; -Report other information in accordance with facility policy and professional standards of practice. Review of Resident #13's admission Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 12/17/24, showed: -No cognitive impairment; -Rejection of care: No behaviors exhibited; -Required partial assistance with lying to sitting and sitting to standing; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required maximal assistance with putting on and taking off footwear and dressing his/her lower body; -Diagnoses included congestive heart failure (CHF, a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs. Symptoms include swelling in the legs), diabetes, high blood pressure and chronic obstructive pulmonary disease (COPD, a lung disease that damages the airways and makes it hard to breathe). Review of the resident's physician orders, showed an order, dated 12/17/24 to wrap leg daily with tubigrip or ace wrap in the morning for swelling. Review of the resident's care plan, in use during the survey, showed: -Staff did not address the resident's need for leg wraps; -Staff did not address any behaviors related to the resident's plan of care. Review of the resident's January 2025 medication administration record (MAR), showed staff initialed the resident's wraps had been applied as ordered on 1/2/25. Observations of the resident on 1/2/25 from 11:59 A.M. to 2:45 P.M., showed the resident in his/her room. The resident's legs were not wrapped. The resident's legs appeared to be swollen. The resident's socks appeared to be too tight around the resident's ankles due to the swelling. During an interview on 1/3/25 at 9:20 A.M., Certified Medication Technician (CMT) A said nurses or therapy applied wraps to residents' legs. During an interview on 1/3/25 at 12:51 P.M. the resident's Nurse Practitioner (NP) said the resident was not always compliant with wearing wraps. He/She would be compliant for days and then refuse. The NP did not know why the resident would sometimes refuse. She was not sure the resident was always alert and oriented, especially if the resident did not have on oxygen. Due to this, the NP was not sure the resident always understood the potential consequences of refusing to wear the leg wraps. It was very important for the resident to wear the wraps due to having CHF. The resident had been hospitalized a few times recently due to exacerbation of CHF. It could be very bad if the resident's legs became really swollen and began leaking fluid. It could be difficult to heal. During an interview on 1/3/25 at 2:00 P.M., the Director of Nursing (DON) said staff should not document a treatment was done if it had not been done. Staff should document if and when a resident refused their treatment. MO00247391 -

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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 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** 34477 TN: See edit below in red Based on observation, interview and record review, the facility failed to ensure two residents, who were incontinent of bladder, received the necessary services to maintain good personal hygiene when staff failed to check or clean one resident who was bed bound (Resident #25) and left one resident in his/her wheelchair surrounded by a large puddle of urine (Resident #64). In addition, staff failed to provide showers at least twice weekly for both residents. Review of the facility's Activities of Daily Living (ADL), Supporting policy, last revised in March 2018, showed: -Resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs; -Residents who are unable to carry ADLs 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: -Hygiene (bathing, dressing, grooming and oral care) -Elimination (toileting); -If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching in a different way or at a different time, or having another staff member speak with the resident may be appropriate. Review of the facility's Bath, Shower/Tub policy, revised 2/2018, included: -The purpose of this procedure are to promote cleanliness, provide comfort to the resident and observed the condition of the resident's skin; -Documentation: -The date and time the shower/tub bath was performed; -If the resident refused the shower/tub bath, the reason(s); -Reporting: Notify the supervisor if the resident refuses the shower/tub bath. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #25's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/20/24, showed: -Cognition not assessed; -Rejection of care: Behavior not exhibited; -Self-care not assessed; -Frequently incontinent of urine; -Occasionally incontinent of bowel; -Diagnoses included cancer and palliative care (a medical approach that focuses on improving the quality of life for people with serious illnesses); -Resident has a condition or chronic disease that may result in a life expectancy of less than six months: Yes. Review of the resident's physician order sheet, showed an order dated 8/20/24 to admit to hospice care. Review of the resident's care plan, last revised on 12/16/24, showed: -Focus: Resident often refuses medications, ADLs and other cares; -Goal: Resident will be without complications related to refusal of medications and cares; -Interventions included: Continue to offer cares and medications; -Staff did not address the resident's refusal to take showers or baths or any preferences related to bathing; -Staff did not address the resident's incontinence and amount of assistance needed or related interventions. Observation on 1/2/25 at 1:19 P.M., showed the Director of Nursing (DON) rolled the resident onto his/her left side for a skin assessment. The resident's brief was saturated with urine and the pad under the resident was saturated with urine and feces. The DON provided peri-care. During an interview on 1/2/25 at 1:19 P.M., the resident said the last time someone changed him/her was around 7:30 A.M. Staff changed him/her one time a day. The resident would get soaked and the pad underneath him/her would also get soaked. Observations and interviews on 1/3/25, showed: -At 6:30 A.M., the resident lay in bed. The resident said he/she was changed a couple of hours ago. The pad under the resident was dry; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 10:18 A.M. and 10:25 A.M., the resident lay in bed. The resident said he/she was not comfortable. He/She said he/she smelled and was having a bowel movement now. No one had cleaned the resident since early that morning. The pad under the resident was the same one observed at 6:30 A.M. The resident wanted to be changed and turned. Review of the 100 Hall's shower book, showed: -The resident was scheduled to receive showers on Wednesday and Saturday evenings; -One shower sheet for December 2024, dated 12/18/24, was completed by hospice; -No other documentation to show the resident was offered or refused any other showers for the month of December 2024 or January 2025; Review of the resident's hospice binder, showed: -Hospice/Long Term Care Coordinated task plan of care; -Health Aide visits: Wednesdays and Saturdays; -12/18/24, bath given; -No other documentation to show if the resident was offered or refused a shower or bath for December 2024; -1/2/25, refused bath from Aide. Review of the resident's progress notes, from October 2024 through January 2025, showed: -On 1/2/25 at 7:30 P.M., Hospice Aide was here today to give resident a shower and resident refused the shower. Hospice Nurse made aware; -No other documentation the resident refused showers. During an interview on 1/2/25 at 11:28 A.M. and 1:19 P.M., the resident said he/she wanted a shower, but only by female staff. The resident had not had a bath or shower for over a week. During interviews on 1/3/25, at 10:18 A.M. and 10:25 A.M., the resident said he/she had just called the hospice company to ask about getting a bath. He/She hadn't had one in two weeks. He/She smelled and the room smelled. It was disgusting. During an interview on 1/3/25 at 10:37 A.M., Certified Nurse Aide (CNA) H said the resident refused to take a shower yesterday. Staff had to do care in pairs because the resident had accused them of stealing and touching him/her inappropriately in the past. There are usually three CNAs assigned to the hall who do their own showers. Or, the shower aide, who worked Monday through Friday, did all of the resident showers. TN: delete red, please. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/25 at 11:17 A.M., the DON said the resident was a heavy wetter. The resident had been checked on prior to the DON completing the skin assessment on 1/2/25. While the she was trying to clean the resident, the resident was actively urinating. If a resident was wet, staff should provide care and clean them. Residents should receive showers at least twice weekly. If a resident refused showers, it should be documented on the resident's care plan. The DON said her guess was that facility staff were offering the resident showers on the same days hospice was supposed to provide showers. However, the showers provided by hospice should be in addition to the showers being provided by staff. Failure to provide incontinence care or showers could be a dignity issue. 2. Review of Resident # 64's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Rejection of care: Behavior not exhibited; -Required substantial/maximum assistance with toileting and showering; -Always incontinent of bowel and bladder; -Diagnoses included high blood pressure, diabetes and dementia. Review of the resident's care plan, in use during the survey, showed: -Focus: Resident has history of resisting care related to adjustment to nursing home (last revised 8/6/23); -Goal: Resident will cooperate with care and adjust to new environment; -Interventions included: Allow resident to make decisions about treatment regime, to provide sense of control, provide care based on resident preferences; -Focus: Resident is at risk for injury related to fall as he/she is on psychotropic medications (A class of drugs that treat mental illnesses by altering the chemical makeup of the brain and nervous system), history of falls prior to admission and poor safety awareness (last revised on 6/8/23); -Goal: Resident will not have any major injuries with falls; -Interventions included: Call light within reach and answered promptly, environmental evaluation to assess for safety, keep environment/room tidy and keep pathways clear, up ad lib without assistive device; -Focus: Resident is incontinent of bowel and bladder (date initiated 1/17/24); -Goal: Resident to remain free of skin breakdown related to incontinence; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included: Alert medical doctor of ongoing issues related to incontinence, encourage resident to use the restroom/call for help to use the restroom every four hours and as needed. Resident often refuses help to use the restroom and declines to be taken when he/she is visibly soiled. Continue to educate the resident on the importance of incontinence management; -The care plan did not address the resident's shower/bathing preferences. Review of the 100 Hall shower book, showed: -The resident was scheduled to for showers on Tuesday and Friday evenings; -For the month of December 2024, the resident had completed shower sheets for 12/6, 12/19 and 12/27/24; -No documentation to show the resident refused any showers/baths. During an interview on 1/3/25 at 10:37 A.M., CNA H said the resident did not refuse showers. Observation on 1/2/25, showed: -At 11:44 A.M. Physical Therapist (PT) L entered the resident's room. The resident sat in his/her wheelchair next to his/her bed. The resident had his/her legs propped up on the bed to the left of the wheelchair. The PT asked the resident if he/she had had an accident because the floor behind the resident looked wet. PT L told the resident he/she needed to be cleaned up and asked the resident to put on his/her call light. The resident said the call light did not work. PT L said he/she would tell staff and come back later. PT L then left the room; -At 2:09 P.M., the resident remained in his/her room in his/her wheelchair in the same location. A large wet puddle was observed behind the resident's wheelchair and underneath his/her wheelchair. The floor was sticky and there were visible dried yellow areas at the edges of the puddle. The resident said there was not much he/she could do due to being diabetic and in a wheelchair; -During an interview at 2:25 P.M., Registered Nurse (RN) M said the resident was able to voice his/her needs. The resident needed assistance to use the bathroom. Staff should check on the resident at least every two hours; -At 2:30 P.M., RN M went with the surveyor into the resident's room. RN M turned the light on and saw the puddle under and behind the resident. The resident confirmed the puddle was urine and said no one had been in to assist him/her with going to the bathroom. The resident said this happened all the time and he/she was not happy about it. RN M said he/she would have staff help clean up the resident and left the room. RN M returned moments later with two CNAs who said they would clean up the resident. RN M said he/she would have housekeeping clean the resident's floor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/2/25 at 2:38 P.M., PT L said he/she told someone in housekeeping or maintenance about the puddle under the resident. He/She could not remember exactly who was told. PT L said he/she went back to the resident's room later and the puddle was cleaned up. A coworker had spoken with the resident about the appropriate places to go to the bathroom. This type of incident had been happening more frequently. He/She was not sure if this was a behavior or if the resident had a cognitive decline. During an interview on 1/2/25 at 2:40 P.M., CNA H said he/she was assigned to the resident and just helped clean up the resident. CNA H said the resident's brief was dry. The resident had a tendency to pull down his/her pants and urinate. This had been happening for at least a year. Staff are supposed to check on residents at least every two hours. Review of the resident's medical record showed no documentation regarding the resident urinating on the floor. During an interview on 1/3/25 at 11:17 A.M., the DON said residents should receive showers at least twice a week. If they frequently refused, it should be documented and included on their care plan. She was not aware staff said the resident would urinate on the floor. This should have been documented in the resident's medical record. If staff were made aware a resident was wet or there was urine on the floor, she would expect them to address it immediately. -

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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 - 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** 25073 jw Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards by failing to obtain and administer a resident's medication for rheumatoid arthritis (RA, a chronic autoimmune disease that causes the body's immune system to attack its own tissue resulting in joint inflammation, pain and stiffness), who was on Medicare Part A (While a resident is on Medicare part A, the facility is required to cover the cost of room and board, nursing care, therapy, medical supplies and equipment, medications, transportation and social services at 100 % for the first 20 days, after that there is a co-pay) and failed to follow physician ordered wound treatments for a wound vac (A medical device that uses suction to help wounds heal), and failed to obtain orders for a wet to dry dressing (a type of wound dressing that involves applying a moist gauze to a wound and allowing it to dry) when staff were unable to obtain supplies for the wound vac for one resident (Resident #24). The facility also failed to follow physician's orders for daily wound care treatments for one resident's bilateral (both) lower extremities and left buttock (Resident #87). The sample was five. The census was 77. Review of the facility's Wound Care policy revised October 2010, showed: -Purpose: To provide guidelines for the care of wounds to promote healing; -Preparation: -Verify there is a physician's order for this procedure; -The following information should be recorded in the resident's medical record: -The type of wound care given; -The date and time the wound care was given; -The name and title of the individual performing the wound care; -Any change in the resident's condition; -All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and the reason(s) why; -The signature and title of the person recording the data; -Reporting: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Notify the supervisor if the resident refuses the wound care; -Report other information in accordance with facility policy and professional standards of practice. Review of the facility's Change in a Resident's Condition or Status, revised November 2015, showed: -Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. -Policy Interpretation and Implementation: -The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On -Call Physician when there has been: -A need to alter the resident's medical treatment significantly; -Refusal of treatment or medications (i.e., two (2) or more consecutive times); -Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments. Review of the facility's policy for Charting and Documentation, revised July 2017, showed: -All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record; -The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care; -Policy Interpretation and Implementation: -The following information is to be documented in the resident medical record: -Medications administered; -Treatments or services performed; -Changes in the resident's condition; -Documentation of procedures and treatments will include care-specific details, including: -The date and time the procedure/treatment was provided; -The name and title of the individual(s) who provided the care; -The assessment data and/or any unusual findings obtained during the procedure/treatment; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-How the resident tolerated the procedure/treatment; -Whether the resident refused the procedure/treatment; -Notification of family, physician or other staff, if indicated; and -The signature and title of the individual documenting. Review of the facility's Admissions Policies, revised December 2006, included: -The primary purpose of our admission policies is to establish uniform guidelines for personnel to follow in admitting residents to the facility; -Our admission policy applies to all residents admitted to the facility without regard to payment source; -The objective of our admission policies are to: -Admit residents who can be adequately care for by the facility; -Assure that appropriate medical and financial records are provided to the facility prior to or upon the resident's admission; -It shall be the responsibility of the Administrator, through the Admissions Department, to assure that the established admissions policies, as they may apply, are followed by the facility and the resident. 1. Review of Resident #24's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/25/24, showed: -Cognitively intact; -Independent with skills of decision making; -No rejection of care -Range of Motion (ROM) impairment on one side for upper and lower extremity; -Dependent on staff for toileting hygiene, transfers, baths and showers; -Pain present; -No pressure ulcers (injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure or friction); -No venous/arterial ulcers (ulcers caused by decreased blood circulation); -No foot problems; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-No other skin problems; -The resident's admission assessment showed wound measurements. So, the MDS is not accurate when it says no other skin problems. -11/24/24, discharge with return anticipated; -12/3/24. Re-entry; -12/9/24, discharge with return anticipated; -12/13/24, re-entry to the facility. Review of the resident's Physician Order Sheets (POS), dated December 13, 2024, showed: -An order dated 12/13/24, for a wound vac to the resident's left lower leg at 125 millimeter (mm) of mercury Hg (a unit of pressure used to measure the suction force applied by the wound vac device) to be changed every Monday, Wednesday and Friday; -No orders for a wet to dry dressing; -An order dated 12/16/24, for Xeljanz ER (used to treat moderate to severe forms of RA when other medications have not worked well. It helps reduce inflammation in the body); 11 milligrams (mg) once daily in the morning; -An order dated 12/17/24, to hold the Xeljanz ER 11 mg. Review of the resident's progress notes, showed: -On 12/13/24 at 3:09 (P.M.), the resident arrived back to the facility. Staff noted a wound to left lower extremity, waiting for wound vac to arrive. No new orders; -On 12/14/24 at 7:17 A.M., wound vac applied to left lower wound. Wound measures 18.5 centimeters (cm) by 9 cm by 0.3 cm; -On 12/17/24 at 3:24 P.M., the Nurse Practitioner, (NP) okayed a hold for Xeljanz; -Staff did not document the wound vac was not available from 12/22/24 through 12/29/24 or that staff applied a wet to dry dressing; -Staff did not document why the resident's Xeljanz was on hold; -Staff did not document any additional wound measurements. Review of the resident's care plan, dated 12/13/24, showed: -The care plan did not address the wound on the resident's left lower leg; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265838	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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 - Actual harm Residents Affected - Few	-The care plan did not address the use of the wound vac; -The care plan did not address the use of a wet to dry dressing; -The care plan did not address the resident's pain related to RA. Review of the resident's Treatment Administration Record (TAR), for December 2024, showed staff documented the resident's wound vac treatment completed as ordered on 12/16/24, 12/18/24, 12/20/24, 12/23/24, 12/25/24, 12/27/24 and 12/30/24. There was no documentation of a wet to dry dressing. Review of the resident's TAR for January 2025, showed staff documented they provided the wound vac treatment as completed on 1/1/25. During an interview on 1/3/25, at 7:18 A.M., the resident said: -He/She was admitted to the facility on [DATE], for skilled therapy services including wound care; -It took three days before staff applied the wound vac; -The floor nurses did not know how to apply the wound vac and/or where to get the wound vac supplies; -The wound vac was not changed on 12/18/24 12/20/24 or 12/23/24; -On 12/24/24, the alarm on the wound vac pump kept alarming because the collection canister was full; -Staff did not have access to additional collection canisters; -The Nurse working on 12/24/24, took the wound vac dressing off and silenced the alarm; -The Nurse applied a wet to dry dressing to the wound; -The resident's family member came to the facility and did a wet to dry dressing on 12/25-31/24; -On 1/3/25, the Wound Nurse applied a new wound vac. There are no measurements documented so it is unknown if the wound condition deteriorated due to the treatment not being provided as ordered; -Prior to coming to the facility, he/she was taking RA medication, Xeljanz XR, 11 mg once a day; -The facility had the Nurse Practitioner put the medication on hold because it was too expensive; -He/She was having increased pain in his/her hands and knees; -On a scale of 1 to 10, his/her pain level was an 11; -The longer he/she did not get his/her RA medications, the worse the symptoms were becoming and soon the damage would be irreversible; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265838	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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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 - Actual harm Residents Affected - Few	-As far as he/she knew the facility did not substitute any other medication for his/her Xeljanz XR. During a telephone interview on 1/3/25 at 9:33 A.M., the NP said the resident's Xeljanz XR was put on hold due to the cost of the medication. He/She put the resident on Prednisone (short term anti-inflammatory drug) yesterday for increased inflammation and pain. During a telephone interview on 1/3/25 at 10:20 A.M., the resident's Primary Care Physician said the resident's RA medication was on hold due to the cost. It would cost approximately $6,000.00 per month and the facility would be financially responsible for the cost. A resident should not be taken off a long term medication just because they were in a Medicare Part A bed. He would expect the facility to follow physician's orders. Medications and treatments should not be documented as provided if they had not been provided. During an interview on 1/3/25 at 11:43 A.M., Central Supply (CS) I, said he/she ordered general medical supplies. Wound care products were ordered by the Wound Care Nurse and/or the Director of Nursing (DON). He/she did not know anything about who ordered wound vac supplies and/or if enough wound care products were ordered. During a telephone interview on 1/3/25, at 12:17 P.M., Licensed Practical Nurse (LPN) B said on or around 12/23/24, during the day shift, the resident's family member reported the wound vac was alarming. The collection canister was full of bloody drainage. LPN B turned off the wound vac. He/She was unable to find the equipment to replace the collection canister. He/She removed the wound vac dressing and applied a wet to dry dressing. He/She did not contact the resident's physician because he/she thought the resident already had an order for the dressing. He/She thought he/she documented the dressing on the resident's TAR. If the TAR showed he/she documented the wound vac dressing was changed, that documentation was in error. He/She administered a wet to dry dressing. During a telephone interview on 1/3/25 at 1:50 P.M., a representative from the wound vac company said wound vac supplies should be ordered two weeks in advance. The company sent the wound vac supplies out for the resident on 12/12/24. The shipment contained a pump and two dressing change kits. No collection canisters were ordered. On 12/23/24, two dressing kits were ordered, but no collection canisters. On 12/26/24, the facility ordered six dressing kits and three canisters. (continued on next page)

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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 - Actual harm Residents Affected - Few	During a telephone interview on 1/6/25 a 2:02 P.M., the resident's Responsible Party (RP) said the resident was not admitted with the wound vac. He/She had a wound vac on while he/she was in the hospital. When the resident was discharged from the hospital the hospital staff removed the wound vac because the wound vac pump belonged to the hospital. The resident was admitted to the facility with orders for a wound vac. The facility assured the hospital staff they would able to provide a wound vac for the resident when he/she arrived at the facility. The resident was in the facility for three days prior to getting the wound vac applied to his/her wound. On or around 12/23/24, the wound vac stopped working. Staff did not have the skills or equipment to replace the wound vac. The resident went more than a full week without the wound vac. LPN B applied a wet to dry dressing to the resident's lower leg on 12/24/24. When the RP came to visit the resident on 12/25/24, the resident's wound was draining so much bloody fluid, he/she changed the dressing. He/She brought the supplies for a wet to dry dressing and did the dressing change. The RP applied the resident's wet to dry dressing changes until 1/3/25, when staff put another wound vac on the resident. The resident was supposed to be seen at the wound clinic on 12/30/24, but the appointment was canceled. The facility said the resident canceled the appointment, but the resident said he/she did not cancel the appointment. The facility also had the house Physician discontinue the resident's RA medications because it cost too much. The resident kept telling the RP that he/she was in pain and was having decreased function of his/her hands due to not getting the medication. During an interview on 1/3/25 at 2:00 P.M., the administrator and DON did not deny the resident's RA medication was on hold because it was very expensive. The DON said she was not aware, the resident did not have his/her wound vac applied because the wound vac supplies had not been ordered. She was not told the resident was getting a wet to dry dressing applied to his/her would by his/her family member. 2. Review of Resident #87's medical record showed: -Original admitted [DATE]; -A readmitted [DATE]; -Diagnoses included chronic venous hypertension (improper functioning of the vein valves of the leg causing swelling and skin changes), with ulcer and inflammation (swelling) of both lower extremities, non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity. Review of the resident's admission MDS, dated [DATE], showed: -No cognitive impairment; -No Rejection of care; -Required partial assistance with sit to stand, toileting hygiene, showers, lower body dressing; -No diagnosis of peripheral/arterial vascular disease (narrow blood vessels reduce blood flow to the limbs); -No pressure ulcers. (continued on next page)

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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 - Actual harm Residents Affected - Few	Review of the resident's physician orders dated 12/16/24, showed: -An order, for left lateral foot: Apply betadine (an antiseptic product to treat infections) daily; -An order for posterior (back of) thigh (does not specify which thigh): clean, apply collagen (protein used to treat wounds) and calcium alginate (dressing that promotes wound healing) and cover with a boarder dressing (self-adherent a sterile, foam dressing), once a day and as needed (PRN); -An order for right posterior leg: Foam cleanser, triad cream (a zinc-based wound dressing paste that aids with healing); -An order for left posterior leg: Foam cleaner, Ca-alginate, wrap with rolled gauze (stretchy gauze like material that clings to itself use to wrap around a wound or injury) and Ace wraps (brand of elastic bandage that is used to provide support and compression) once daily and PRN; -An order for left medial (facing towards the body) leg: Foam cleanser, triad cream, collagen, gauze wrap and Ace wraps once daily and PRN. Review of the resident's care plan, revised on 12/17/24, showed: -Focus: Resident has impaired skin, present on admission as evidenced by bilateral lower extremity lymphedema (condition that causes swelling in both legs); -Goal: Integrity will be managed daily until resolution without evidence of severe complications; -Interventions: Check skin daily, educate on avoiding skin injuries, handle gently during activities of daily living (ADLs), keep skin dry to the extent possible, resident is only allowing Wound Care Nurse to complete treatments and is taking off Coban dressing (A self-adhering bandage or wrap that sticks to itself but does not adhere well to other surfaces) at his/her own will; -Focus: Resident has bilateral lower extremity lymphedema wounds that are being followed by the Wound Physician; -Goal: Resident will be without complications related to wounds; -Interventions: If complications arise, report to physician for new orders if applicable. Review of the resident's TAR dated 12/31/24 and 1/1/25, showed staff documented the resident's treatments completed as ordered. Observation and interview on 1/2/25, at 11:46 A.M., showed the resident sat on the edge of his/her bed. A dressing on his/her left outer foot was dated 12/30/24. The resident said staff had not changed any of his/her wound dressings since 12/30/24. The Wound Physician quit and no longer worked for the facility. The Wound Nurse had been off sick. Staff had not changed the dressing as of 1/2/24 at 11:46 A.M., because the facility did not have the needed wound supplies. Review of the resident's TAR on 1/3/24, at 12:00 P.M., showed staff documented the resident refused his/her treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 1/3/24 at 1:30 P.M., showed the resident sat on the edge of his/her bed. The resident said he/she refused to have his/her dressings changed this morning. The dressing on his/her left lower leg was dated 1/3/24. During an interview on 1/3/25 at 2:00 P.M., the Administrator and DON said it was not acceptable to document a treatment was provided when it had not. All wound treatments should have orders. They would expect the Nurse on duty to notify the Physician if a treatment or medication was not available. MO00247046 MO00247270 MO00247391 34477

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to ensure resident records were complete and accurately documented when staff documented treatments were provided when they were not (Residents #24, #87 and #13). The sample was 5. The census was 77. Review of the facility's Wound Care policy revised October 2010, showed: -Purpose: To provide guidelines for the care of wounds to promote healing; -Preparation: -Verify there is a physician's order for this procedure; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and the reason(s) why; -The signature and title of the person recording the data; -Reporting: -Notify the supervisor if the resident refuses the wound care; -Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #24's, quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/25/24, showed: -Cognitively intact; -Independent with skills of decision making; -No rejection of care. Review of the resident's Physician Order Sheets (POS), dated December 13, 2024, showed: -An order dated, 12/13/24 for a wound vac (A medical device that uses suction to help wounds heal) to the resident's left lower leg at 125 millimeter (mm) of mercury Hg (a unit of pressure used to measure the suction force applied by the wound vac device) to be changed every Monday, Wednesday and Friday; -No orders for a wet to dry dressing. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, showed: -On 12/13/24 at 3:09 P.M., the resident arrived back to the facility. Staff noted a wound to left lower extremity, waiting for wound vac to arrive. No new orders; -On 12/14/24 at 7:17 A.M., wound vac applied to left lower wound. Wound measures 18.5 centimeters (cm) by 9 cm by 0.3 cm.; -No documentation the wound vac was not available on 12/20/24, 12/23/24, 12/25/24, 12/27/24, 12/30/24 or 1/1/25; -Staff did not document the application of a wet to dry dressing (a type of wound dressing that involves applying a moist gauze to a wound and allowing it to dry). Review of the resident's Treatment Administration Record (TAR), for December 2024, showed staff documented the resident's wound vac treatment completed as ordered on 12/20/24, 12/23/24, 12/25/24, 12/27/24 and 12/30/24. There was no documentation of a wet to dry dressing. Review of the resident's TAR for January 2025, showed staff documented they provided the wound vac treatment on 1/1/25. During an interview on 1/3/25, at 7:18 A.M., the resident said: -He/She was admitted to the facility on [DATE], for skilled therapy services including wound care; -The wound vac was applied to the wound by the treatment Nurse on 12/16/24. It took three days before staff applied the wound vac; -The floor Nurses did not know how to apply the wound vac and/or where to get the wound vac supplies; -The wound vac was not changed on 12/20/24 or 12/23/24; -On 12/24/24, the alarm on the wound vac pump kept alarming because the collection canister was full; -Staff did not have access to additional collection canisters; -The Nurse working on 12/24/24, took the wound vac dressing off and silenced the alarm; -The Nurse applied a wet to dry dressing to the wound; -The resident's family member came to the facility and did a wet to dry dressing on 12/25-31/24; -On 1/3/25, the wound Nurse applied a new wound vac; (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/3/25 at 10:20 A.M., the resident's Primary Care Physician said he would expect the facility to follow physician's orders. Medications and treatments should not be documented as provided if they had not been provided. During an interview on 1/3/25 at 11:43 A.M., Central Supply (CS) I, said he/she orders general medical supplies. Wound care products are ordered by the wound care Nurse and/or the Director of Nursing (DON). During a telephone interview on 1/3/25, at 12:17 P.M., Licensed Practical Nurse (LPN) B said, on or around 12/23/24, during the day shift, the resident's family member reported the wound vac was alarming. The collection canister was full of bloody drainage. LPN B turned off the wound vac. He/She was unable to find the equipment to replace the collection canister. He/She removed the wound vac dressing and applied a wet to dry dressing. He/She did not contact the resident's physician because he/she thought the resident already had and order for a wet to dry dressing. He/She thought she documented the wet to dry dressing in on the resident's TAR. If the TAR showed he/she documented the wound vac dressing was changed, that documentation was in error. He/she administered a wet to dry dressing. During a telephone interview on 1/3/25 at 1:50 P.M., a representative from the wound vac company said, wound vac supplies should be ordered two weeks in advance. Wound vac supplies were sent out for Resident #24 on 12/12/24. The shipment contained a pump and two dressing change kits. No collection canisters were ordered. On 12/23/24, two dressing kits were ordered, but no collection canisters. On 12/26/24, the facility ordered six dressing kits and three canisters. During a telephone interview on 1/6/25, the resident's Responsible Party (RP) said, the resident was not admitted with the wound vac. He/She had the wound vac on while he/she was in the hospital. When the resident was discharged from the hospital, hospital staff removed the wound vac because the wound vac pump belonged to the hospital. The resident was admitted to the facility with orders for a wound vac. The facility had assured the hospital staff they would be able to provide a wound vac for the resident when she/she arrived at the facility. The resident was in the facility for three days prior to getting the wound vac applied to his/her wound. On or around 12/23/24, the wound vac stopped working. Staff did not have the skills or equipment to replace the wound vac. The resident had gone more than a full week without the wound vac. LPN B, did apply a wet to dry dressing on 12/24/24, to the resident's lower leg. When the RP came to visit the resident on 12/25/24, the resident's wound was draining so much bloody fluid, he/she changed the dressing. He/she brought the supplies for a wet to dry dressing and did the dressing change. The RP did the resident's wet to dry dressing change until 1/3/25, when staff put another wound vac on the resident. 2. Review of Resident #87's medical record showed: -Original admitted [DATE]; -A readmitted [DATE]; -Diagnoses included chronic venous hypertension (improper functioning of the vein valves of the leg causing swelling and skin changes), with ulcer and inflammation (swelling) of both lower extremities, non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity. (continued on next page)

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	265838	A. Building B. Wing	01/03/2025

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Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's admission MDS, dated [DATE], showed: -No cognitive impairment; -No Rejection of care: No behaviors exhibited. Review of the resident's POS, showed on 12/16/24: -A order, for left lateral foot: Apply betadine (An antiseptic product to treat infections) daily; -A order for, posterior (back of) thigh (does not specify which thigh): clean, apply collagen (protein used to treat wounds) and calcium alginate (dressing that promotes wound healing) and cover with a boarder dressing (self-adherent a sterile, foam dressing), once a day and as needed (PRN); -An order for right posterior leg: Foam cleanser, triad cream (a zinc-based wound dressing paste) to aid with healing; -An order for, left posterior leg. Foam cleaner, Ca-alginate, wrap with rolled gauze (stretchy gauze like material that clings to itself use to wrap around a wound or injury) and Ace wraps (brand of elastic bandage that is used to provide support and compression) once daily and PRN; -An order for left medial (facing towards the body) leg. Foam cleanser, triad cream, collagen, gauze wrap and ace wraps once daily and PRN. Review of the resident's TAR dated 12/31/24 and 1/1/25, showed staff documented the resident's treatments completed as ordered. During observation and interview on 1/2/24, at 11:46 A.M., the resident sat on the edge of his/her bed. A dressing on his/her left outer foot, dated 12/30/24. The resident said staff had not changed any of his/her wound dressings since 12/30/24. The Wound Physician had quit and no longer worked for the facility. The wound Nurse had been off sick. Staff had not changed the dressing as of 1/2/24 at 11:46 A.M., because the facility did not have the needed wound supplies. Review of the resident's TAR on 1/3/24, at 12:00 P.M., showed staff documented the resident refused his/her treatment. Observation on 1/3/24 at 1:30 P.M., showed the resident sat on the edge of his/her bed. The dressing on his/her left lower leg was dated 1/3/24. 3. Review of Resident #13's admission MDS, dated [DATE], showed: -No cognitive impairment; -No rejection of care: No behaviors exhibited. Review of the resident's physician orders, showed an order, dated 12/17/24 to wrap leg daily with tubigrip (A tubular bandage that provides and compression) or ace wrap in the morning for swelling. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's 1/25 TAR showed staff initialed the resident's wraps had been applied as ordered on 1/2/25. Observations of the resident on 1/2/25 from 11:59 A.M. to 2:45 P.M., showed the resident in his/her room. The resident's legs were not wrapped. The resident's legs appeared to be swollen. The resident's socks appeared to be too tight around the resident's ankles due to the swelling. During an interview on 1/3/25 at 9:20 A.M., Certified Medication Technician (CMT) A said Nurses or therapy applied wraps to residents' legs. During an interview on 1/3/25 at 12:51 P.M. the resident's Nurse Practitioner (NP) said the resident was not always compliant with wearing wraps. He/She would be compliant for days and then refuse. The NP did not know why the resident would sometimes refuse. She was not sure the resident was always alert and oriented, especially if the resident did not have on oxygen. Due to this, the NP was not sure the resident always understood the potential consequences of refusing to wear the leg wraps. It was very important for the resident to wear the wraps due to having CHF. The resident had been hospitalized a few times recently due to exacerbation of CHF. It could be very bad if the resident's legs became really swollen and began leaking fluid. It could be difficult to heal. During an interview on 1/3/25 at 2:00 P.M., the Administrator and DON said it is not acceptable to document a treatment as provided when it was not provided. All wound treatments should have orders. They would expect the Nurse on duty to notify the physician if a treatment or medication was not available. 34477

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25073 Based on observation, interview and record review, the facility failed to maintain an effective pest control program to ensure resident rooms (Resident #87, #25 and #64) were free from gnats (small, two winged fly that resembles a mosquito). This failure had the potential to affect all residents. The sample was five. The census was 77. Review of the facility's pest control policy dated May 2008, showed: Policy Statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: -The facility maintains an on-going pest control program to ensure the building is kept free of insects and rodents; -Pest control services are provided by the facility's vendor; -Windows are screened at all times; -Maintenance services assist when appropriate and necessary in providing pest control services. 1. Review of Resident #87's, admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/25/24, showed: -Cognitively intact; -Independent with skills of decision making; -No rejection of care. Observations and interview on 1/2/25, at 11:15 A.M., and 1:40 P.M., showed the resident sat on the bed in his/her room. The resident had food and drinks on his/her over the bed table. His/Her trash can was full of trash, old food and cups of juice. The room was swarming with gnats. 20-30 gnats were noted in the resident's trash can and flying throughout the room. Gnats were landing on the resident's over the bed table landing on the resident's meal tray and in the resident's glass of juice. The resident had removed his/her wound dressings from his/her lower legs and gnats were landing on the resident's open wounds. The resident said the gnats have been an ongoing problem for some time. He/she has to cover everything to prevent gnat from landing and dying on his/her food. During an interview on 1/2/25 at 1:40 P.M., the Director of Nursing said she was unaware of the gnats in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265838	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations and interview on 1/3/25 at 6:38 A.M., 7:13 A.M., 12:48 P.M., and 2:20 P.M., showed the resident's room still had a swarm of gnats flying around her table, trash can and his/her face and body. The resident said, staff had put a cup of vinegar in her room this morning, but nursing staff threw it away. 2. Review of Resident #25's quarterly MDS, dated [DATE], showed: -Cognition not assessed; -Self-care not assessed; -Diagnoses included cancer and palliative care (a medical approach that focuses on improving the quality of life for people with serious illnesses). Observation and interview on 1/2/25 at 11:28 A.M. and 1:19 P.M., and 1/3/25 at 8:15 A.M., showed the resident lay in bed with gnats flying all over his/her room. The resident said the gnats have been in his/her room for a long time. The resident said he/she has to cover all his/her food and drinks because of the gnats. No one had been in the resident's room to treat for gnats. 3. Review of Resident # 64's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Required substantial/maximum assistance with toileting and showering; -Diagnoses included high blood pressure, diabetes and dementia. Observation of the resident's room on 1/3/25 at 8:09 A.M., showed several gnats flying near the door to the bathroom. The floor was sticky. 4. During an interview on 1/3/25 at 6:44 A.M., the Maintenance Director said he was aware some rooms had gnats. The residents in those rooms had food and juice in their rooms. If a problem was reported to him, he would contact the pest control company and have them come address the issue. He had treated the drains for gnats, but they were still around. 5. During an interview on 1/3/25 at 9:56 A.M., a representative with the pest control vendor said they were last in the facility on 12/11/24. At that time, the kitchen was treated for gnats. The drains needed to be cleaned in order to alleviate the issue. They were contacted today to come out to the facility to treat for gnats in specific resident rooms. 6. During an interview on 1/3/25 at 2:00 P.M., the Administrator said he was not aware of the gnats in the residents' rooms. The Director of Nursing said she only became aware of the gnats when she was assisting with skin assessments and wound care yesterday. 34477 -