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 03/26/2026
NAME OF PROVIDER OR SUPPLIER Lakeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - 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 interview and record review, the facility failed to ensure ongoing skin monitoring, physician notification, and timely treatment for one resident (Resident #1) who developed skin shearing (mechanical injury caused by the combination of friction and gravity, where the skin sticks to a surface, like bedding, causing deep tissue damage and blood vessel damage) and an unstageable (full-thickness skin and tissue loss in which the extent of tissue damage could not be determined due to slough (dead tissue) or eschar (necrotic tissue)) pressure ulcer (localized damage to the skin that usually occur over a bony prominence as a result of pressure). In addition, facility staff failed to complete a skin assessment and provide wound care for one resident (Resident #2) who was admitted to the facility with a pressure ulcer. Four residents were sampled for wounds, and problems were identified with two. The census was 103.Review of the facility's Wound Care policy, revised October 2010, showed:-Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing;-Preparation:-Verify that there is a physician's order for this procedure;-Review the resident's care plan to assess for any special needs of the resident;-Documentation: 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 position in which the resident was placed;--The name and title of the individual performing wound care;--Any changes in the resident's condition;--All assessment data obtained when inspecting the wound;--How the resident tolerated the procedure;--Any problems or complaints made by the resident related to the procedure;--If the resident refused the treatment and 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 the facility's Medication and Treatment Orders policy, dated July 2016, showed:-Policy statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing;-Drug and biological orders must be recorded on the physician's order sheet in the resident's chart;-The signing of orders shall be by signature or a personal computer key;-Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order. Review of the facility's Charting and Documentation policy, dated July 2017, showed:-Documentation in the medical record may be electronic, manual or a combination;-The following information is to be documented in the resident medical record;--Treatments or services performed;-To ensure consistency in charting and documentation of the resident's clinical record, 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;--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. 1. Review of Resident #1's Comprehensive Skin Evaluation/Assessment, dated 2/3/26, showed:-admission date 2/2/26;-Skin: Dry, intact, and warm;-No presence of wounds. Review of the (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 0686 Level of Harm - Actual harm Residents Affected - Few	resident's Braden Scale (tool used to assess a resident's risk of developing pressure ulcers) assessment, dated 2/3/26, showed a score of 15 (a score of 15 to 18 means at risk for pressure ulcers). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/7/26, showed:-Resident high risk for developing a pressure ulcer and/or pressure injury;-Resident admitted with no pressure ulcers and/or pressure injuries. Review of the resident's weekly skin assessments showed:-On 2/10/26, skin dry, intact, warm and no presence of skin breakdown;-On 2/17/26, no skin assessment documented. Review of the resident's progress notes, dated 2/18/26, showed:-At 6:57 P.M., staff documented the resident presented with a skin shear to left buttock measuring 2.0 centimeters (cm) by (x) 2.0 cm. Nurse applied foam dressing and sent message to Nurse Practitioner (NP) for treatment order;-No additional nursing documentation showing the NP returned the call and/or any new treatment orders;-No documentation the resident's responsible party was notified of the resident's change in condition. Review of the resident's physician order sheet (POS), dated 2/18/26, showed no new treatment orders for the wound identified on 2/18/26. Review of the resident's progress notes, dated 2/19/26, showed:-Staff documented the resident remained on antibiotic therapy related to an upper respiratory infection and incident follow up related to a new wound. No changes noted;-No documentation of wound size, notification of family and/or physician, or any new physician orders obtained for wound care. Review of the resident's progress notes, dated 2/20/26 through 2/24/26, showed no documentation of the resident's wound identified on 2/18/26. Review of the resident's Comprehensive Skin Evaluation/Assessment, dated 2/23/26, showed:-Staff documented the resident's skin was dry, warm, and had the presence of wounds. Staff identified a new wound on the resident's sacrum (area at base of the spine);-No wound description including size or stage (way of defining tissue damage severity) of the wound noted. In the space designated for notifications, staff documented no notifications were required. Review of the resident's POS, showed:-An order, dated 2/23/26 at 3:10 P.M., for the resident to be followed by wound care;-No wound care orders noted. Review of the resident's Wound Care Management note, dated 2/24/26, showed:-Resident was seen for wound evaluation and treatment;-Resident's wound on the sacral region measured 3.0 cm x 5.0 cm x unable to determine (UTD) cm. 60% necrotic and 40% granulation (healing tissue);-Treatment plan: Cleanse area with normal saline (NS) pat dry, apply Santyl (medication which removes dead skin tissue from wounds), dress with calcium alginate (highly absorbent gel forming dressing), cover with a foam bordered dressing, change daily and as needed (PRN). Review of the resident's POS, dated 2/24/26, showed no treatment orders for wound care related to the wound identified on 2/23/26. Review of the resident's POS and treatment administration record (TAR), showed:-An order, dated 2/25/26, at 9:24 P.M., for wound care to sacrum. Cleanse with wound cleanser, pat dry, apply Santyl to wound bed followed by calcium alginate, cover with dry protective dressing. Change daily and PRN if soiled or dislodged, every day shift for wound care. Low air loss mattress (mattress with alternating pressure with a steady flow of air to prevent and treat pressure ulcers);--The TAR showed staff documented the first treatment applied on 2/26/26. Review of the resident's Wound Care Management note, dated 3/3/26, showed:-Resident re-evaluated for pressure wound;-Wound measured 5.0 cm x 3.0 cm x UTD cm. Wound bed: 15% slough, 80% necrotic, and 5% granulation;-Treatment plan: Cleanse with NS, pat dry, apply Santyl, and cover with bordered gauze dressing daily and PRN. Review of the resident's POS and TAR, showed:-An order, dated 3/3/26, at 9:28 A.M., for wound care to unstageable sacrum, cleanse with wound cleanser, pat dry, apply Santyl to wound bed followed by calcium alginate, cover with dry protective dressing. Change daily every 12 hours and PRN;--The TAR showed the treatment not documented as administered on 3/3/26. Review of the resident's care plan, in use during the time of the investigation, initiated and revised 3/9/26, showed:-Focus: The resident has an unstageable pressure ulcer to sacrum and is at risk for further breakdown;-Goal: Will have intact skin, free of redness, blisters or discoloration by/through next review;-Interventions: Administer medication as ordered. Administer treatment as ordered, monitor (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	dressing every shift to ensure it is intact and adhering, report lose dressing to treatment nurse, monitor nutritional status, monitor/document/report to physician PRN changes in skin status. Review of the resident's Wound Care Management note, dated 3/10/26, showed:-Resident re-evaluated for chronic pressure wound;-Wound measured 4.5 cm x 4.5 cm x UTD cm. 60% slough, 20% necrotic and 20% granulation;-Treatment plan: Cleanse with NS, pat dry, apply Santyl to wound bed, cover with bordered gauze dressing, change daily and PRN. Further review of the resident's TAR, showed staff failed to document the treatment as completed for wound care to the unstageable sacrum on 3/12/26 and 3/16/26. Review of the resident's progress note, dated 3/17/26 at 7:00 A.M., showed the resident sent to the hospital for respiratory distress. During an interview on 3/2/26 at 9:49 A.M., Family Member (FM) F said he/she provided the resident a bath on 2/23/26 and noticed the resident had an open area on his/her buttocks, at the crack between his/her buttocks. The area was about the size of a dime. FM F told Assistant Director of Nursing (ADON) B about the resident's skin breakdown. The nurse checked the resident's medical record and said the resident's medical record did not show any documentation the resident had any skin breakdown. On 2/27/26, the resident had a dressing over the area that was dated 2/25/26. FM F removed the dressing and the resident's wound was brown and black and was emanating a horrible odor. During an interview on 3/26/26 at 1:10 P.M., ADON B said FM F did approach him/her and reported the resident had a new wound on his/her buttocks. ADON B referred FM F to the Wound Nurse. He/She looked in the resident's record and found no documentation of a wound. He/She did not go assess the resident and/or document the family member's observation and/or concerns in the resident's medical record. He/She is the ADON for the 200, 300 and 400 halls. He/She did not know which residents had pressure ulcers and/or wounds on his/her units because the wound reports go to the Director of Nursing (DON). He/She was not the charge nurse on the day FM F approached him/her. He/She was just doing rounds on that day. Both nurses that documented the initial observations of the resident's skin breakdown work for a staffing agency. He/She didn't know why the resident's physician was not notified of the wound noted on 2/18/26, when the resident's skin breakdown was first identified. He/She is not responsible for updating resident care plans. He/She did not document FM F's concerns or observations because he/she referred FM F to the Wound Nurse. The Wound Nurse is responsible for documenting anything dealing with wounds. During an interview on 3/26/26 at 1:55 P.M., Wound Nurse C said he/she is the only Wound Nurse at the facility. He/She remembered FM F telling him/her about the resident's skin breakdown. He/She did assess the resident or fill out a Comprehensive Skin Evaluation/Assessment. He/She did not measure or stage the area. He/She wrote an order for the resident to be seen by the specialized wound care management team. He/She did not call the resident's physician or obtain treatment orders. He/She was responsible for weekly wound assessments and daily wound care, Monday through Friday. Weekend nurses were responsible for doing daily treatments and should be assessing all new residents and re-admitted residents. He/She did not do a weekly skin assessment on the resident on 2/17/26. He/She could not remember why the skin assessment was not done. The facility used to have two wound care nurses. It was overwhelming to be the only nurse responsible for wound care and wound documentation. The resident did go from 3/10/26 to 3/24/26 without having a formal skin assessment preformed and documented. The resident did develop the wounds at the facility. Wound Nurse C didn't know why it took two days to initiate the resident's treatment after the order was written. 2. Review of Resident #2's admission MDS, dated [DATE], showed:-Diagnoses included quadriplegia (paralysis affecting all four limbs);-Always incontinent of bowel;-At risk for pressure ulcers;-No pressure ulcers at the time of assessment. Review of the resident's care plan, in use during the time of the investigation, showed:-Focus: Resident is at risk for skin breakdown related to being bedbound and Braden Risk score;-Goal: Will maintain adequate nutrition/hydration to prevent skin breakdown. Will prevent or delay skin breakdown to the extent possible given risk factors;-Interventions: Administer treatment as ordered, apply barrier cream as indicated, check skin during daily care provisions. Review of the resident's hospital Discharge summary, dated [DATE], (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	showed a Registered Dietician assessment, dated 3/9/26, referenced skin/wound, pressure injury to sacrum. Review of the resident's Braden Scale Observation/Assessment, dated 3/10/26, showed a score of 8 (a score of 9 or below means very high risk for pressure ulcers). Review of the resident's medical record, showed no skin assessments documented as completed from 3/9/26 through 3/14/26. Review of the resident's progress note, dated 3/14/26, showed he/she was discharged to the hospital for respiratory distress. No skin evaluation/assessment noted. During an interview on 3/15/26 at 8:45 A.M., Hospital Nurse G said the resident returned to the same hospital from where he/she had been discharged to the facility 3/9/26. He/She returned to the hospital from the facility with a deep tissue injury (a serious form of pressure injury where intense, prolonged pressure damages soft tissue under the skin) to his/her coccyx. Upon admission to the hospital on 3/14/26, the resident was noted to still be wearing the same protective skin dressing the hospital staff had applied prior to the resident's discharge to the facility on 3/9/26. 3. During an interview on 3/26/26 at 3:33 P.M., the Director of Nursing (DON) and Administrator-in-Training said, both Wound Nurse C and ADON B were terminated effective 3/25/26 for poor work performance related to wound care and wound care management. 4. During an interview on 3/26/26 at 2:28 P.M., the facility's Medical Director and primary care physician for both residents said he was not informed of Resident #1's wounds when they were first identified by nursing staff. He was not informed Resident #2 had a dressing on his/her coccyx when he/she was re-admitted to the facility on [DATE]. Nursing staff should absolutely assess every resident from head to toe on admission and/or re-admission. Skin assessments should be completed on a weekly basis, at minimum. The facility has had problems with communication regarding pressure ulcers and wound care. 27912022804303