STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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 - Minimal harm or potential for 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** Based on interview and record review, the facility failed to provide documentation of ongoing assessments of a surgical wound as directed in facility policy for one resident (Resident #1), in a review of eight sampled residents, when the resident's wound deteriorated. The facility failed to notify the surgeon when the wound had an increase in bleeding for four days which caused a delay in the resident being sent to the emergency department following a miscommunication and a missed appointment with the surgeon. The facility census was 32.Review of the facility's policy, Wound Treatment Management, last revised 04/2025, showed the following:-It is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;-Treatment decisions will be based on etiology of the wound, characteristics of the wound and location of the wound;-The facility will follow specific physician orders for providing wound care and are able to provide standard of care provisions for all residents;-Consideration for needed modification included lack of progression towards healing, changes in the characteristics of the wound, changes in the resident's goals and preferences;-The effectiveness of treatments will be monitored through ongoing assessment of the wound. Review of the facility's policy, Notification of Changes, last revised 04/2025, showed the following:-The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification;-The facility must inform the resident, consult with the resident's physician and/ or notify the resident's family member or legal representative when there is a change requiring such notification;-Circumstance requiring notification includes significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status including clinical complications, circumstances that require a need to alter treatment. 1. Review of Resident #1's undated face sheet showed the following:-admission date 04/18/26;-Diagnoses included pathological fracture left femur (broken bone in an area weakened by a pre-existing medical condition), encounter for orthopedic aftercare, acute posthemorrhagic anemia (critical condition caused by a sudden rapid loss of a large volume of blood). Review of the resident's care plan, last revised 04/19/26, showed the following:-At risk for complications secondary to anti-coagulant use;-Will have no unaddressed bleeding or adverse drug event;-At risk for alteration to skin integrity secondary to left hip surgical incision;-Will have no unaddressed alteration to skin integrity;-Weekly skin check per facility schedule, notify the physician of alterations for prompt/proper intervention;-The resident has an actual skin impairment/wound, left hip incision;-Will have no unaddressed complications to skin/wound or prescribed treatments;-At risk for infection secondary to recent hospitalization, left hip incision, diabetes and multiple myeloma (a blood cancer);-Will have no untreated signs or symptoms of infection. Review of the resident's April 2026 physician order sheet showed the following:-Apixaban (blood thinner) 5 milligrams (mg) twice daily;-Clean surgical site to left hip with normal saline, apply 4x4 gauze pad and abdominal (ABD, a highly absorbent multi-layered medical dressing) pad to site, creating a pressure dressing, cover with tape daily, ordered 04/23/26. Review of the resident's progress note/weekly skin check, dated 04/26/26 at 3:01 P.M., showed the following:-Surgical wound. Wound was present on admission. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status of the resident's wound and the resident had another appointment scheduled for the 5/11/26 with the surgeon. Review of the resident's medical record showed no documentation staff completed any assessments of the wound from 05/06/26 until 05/11/26 at 7:58 A.M. Review of the resident's progress note, dated 05/11/26 at 7:58 A.M., showed the resident's incision on the left leg was found dehisced. Staples had detached and red/brownish flesh was bulging out of the resident's incision. Staff attempted to contact the surgeon who did not answer, then notified the on-call physician. The on-call physician ordered to send the resident to the hospital. Review of the resident's hospital records, dated 05/11/26 at 5:40 P.M., showed the following:-The resident presented to the Emergency Department (ED) with bleeding from left hip surgical incision site;-The resident stated he/she had drainage since surgery, with increased pain and discomfort in the surgical site. During an interview on 05/19/26 at 1:40 P.M., the resident's family member said the following:-He/She was upset the facility did not react sooner to the wound bleeding and draining;-The facility should have taken the resident to the appointment on 05/07/26 or to the emergency department sooner. During interviews on 05/19/26 at 3:30 P.M. and 05/20/26 at 3:40 P.M., Registered Nurse (RN) I from the surgeon's office said the following:-The resident told him/her they were having a heck of a time with his/her incision and staff would not let him/her out of bed due to the wound bleeding;-The resident came to the surgeon's office on 05/07/26 at 2:30 P.M. for an appointment, however, the surgeon was out of the office so he/she did not see the resident. The office did not get a call back from the facility that morning to let them know if they were coming at 9:15 A.M. or if they were coming at 2:30 P.M.;-The resident said he/she could not get staff to listen to him/her about his/her wound;-The facility finally called 911 and sent the resident to the emergency room on [DATE];-The resident was admitted to the hospital on [DATE];-He/She tried to call the Assistant Director of Nursing two times on 05/11/26 to confirm the dosage of the resident's blood thinner and still had not received a call back;-He/She felt the facility let the wound deteriorate for too long and should have involved the surgeon, not just the facility physician. During an interview on 05/19/26 at 2:40 P.M., Certified Nurse Assistant (CNA) B said the following:-The resident's wound was always draining. As it got worse, he/she told the charge nurse, but was unable to remember exactly when that was;-Each time the resident went to the bathroom or therapy, the wound bled more and he/she told the charge nurse. During an interview on 05/19/26 at 3:05 P.M., RN H from the surgeon's office said the following:-He/She reviewed the resident's chart at their office and determined the first call from the facility was on 04/22/26 stating the resident's incision had an increase in serosanguinous drainage, staples were intact, no redness or fevers;-The nurse was instructed to use pressure dressing and to call back in the next few days if bleeding had not resolved;-He/She did not receive another call until 05/06/26 at 3:11 P.M. when LPN A called and said the surgical incision had a lot of drainage and staff had to change the dressing twice in 12 hours;-He/She returned a call to LPN A who said at the end of the previous week, the drainage increased, the blood thinner was decreased on 05/04/26, and there was no odor or purulent drainage to the wound;-The surgeon asked the facility to bring the resident to the office the following morning at 9:15 A.M. instead of in the afternoon;-LPN A could not confirm if they would have transportation available that morning;-He/She told LPN A to call him/her on his/her personal cell phone in the morning to confirm if they would be at the morning appointment or if they needed to keep the afternoon appointment;-He/She did not receive any further communication from the facility until the resident's family member called the office on 05/11/26 to see if the surgeon was going to continue the resident's care in the hospital. During an interview on 05/19/26 at 5:00 P.M., the Assistant Director of Nurses (ADON) said the following:-The resident's surgical wound had a lot of drainage and edema upon admission;-He/She helped LPN A with the dressing change on 05/06/26. All the staples were intact with drainage from the distal end, no odor, no redness and pain was controlled. There was more drainage than he/she would expect so he/she told LPN A to call the surgeon. During an interview on 05/20/26 at 10:15 A.M., the Administrator said the following:-She expected staff to follow physicians' orders;-She expected staff to contact the physician and seek treatment for a (continued on next page)

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