STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to the Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information no less frequently than quarterly, for three quarters preceding the annual survey. The census was 38. Review of the fiscal years Payroll Based Journal (PBJ) staffing report, showed the facility triggered for failing to submit data for:-Fiscal year quarter 1, 2025 (October 1 to December 31);-Fiscal year quarter 2, 2025 (January 1 to March 31);-Fiscal year quarter 3, 2025 (April 1 through June 30). During an interview on 9/25/25 at 10:18 A.M., the Administrator said she has not been able to log in to the account to submit the PBJ. The account kept saying it was the incorrect password. The help desk would send a new password, but she still was not able to get in. The PBJs are supposed to be submitted quarterly. The Administrator no longer has an account to submit PBJs.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure their facility assessment was reviewed and updated as necessary and at least annually. The census was 38.Review of the facility's Facility Assessment policy, revised 9/18/17, showed:-Requirement: Nursing facilities will conduct, document and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents;-Purpose: The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. This assessment is used to make decisions about direct care staff needs, as well as the facility's capabilities to provide services to the residents in the facility;-Guidelines for Conducting the Assessment includes:-The facility will review and update this assessment annually or whenever there is/the facility plans for any change that would require a modification to any part of this assessment. Review of the facility's Facility Assessment Tool, dated 1/4/24, showed:-Persons involved in completion of assessment included: -Registered Nurse (RN) G listed as Director of Nurses (DON); -Licensed Practical Nurse (LPN) H listed as Assistant Director of Nurses (ADON); -Physician J listed as Medical Director; -LPN I listed as Infection Preventionist;-Date(s) of assessment or update: 1/4/24;-Date(s) assessment reviewed with quality assessment and assurance (QAA)/quality assurance performance improvement (QAPI) committee: Blank;-Resident Profile: -Indicate the number of residents you are licensed to provide care for: Our community is licensed for 60 beds. During an interview on 9/29/25 at 1:01 P.M., the Administrator said Physician J has not been the facility's Medical Director in over a year. LPN H has not been the ADON for over a year and LPN I has not been the Infection Preventionist in about a year. RN G has not been the DON for months. On 9/1/25, the facility changed their bed count from 60 to 47 beds. The facility assessment should be updated once a year and as needed. She has not met with the involved parties to review and revise the facility assessment this year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure quality assessment and assurance (QAA) meetings consisted of the required committee members when the Medical Director failed to attend the facility's QAA meetings. The census was 38.Review of the facility's Quality Assurance Performance Improvement (QAPI) Program policy, dated 1/7/25, showed:-Guiding Values or Principles: The written QAPI plan for the facility will identify and address areas that need improvement in order to ensure the best quality of life for the people in our community;-QAA Committee and oversight of QAPI in our Community:-The Administrator, all department managers, Medical Director, consulting pharmacist, residents, family members or responsible parties, and at least three general staff members (one from each department);-Reporting on QAPI Activities:-The Administrator will discuss our QAPI activities at the quarterly QAA meeting that consists of all the department managers, Medical Director, pharmacy consultant, resident, general staff, etc. During an interview on 9/25/25 at 10:34 A.M., the Assistant Director of Nurses (ADON) and Administrator said QAA meetings are held quarterly. The Medical Director does not attend the QAA meetings. In the QAA meetings, the department heads identify system-wide issues and ways to address them. After the meetings take place, the ADON discusses the QAA meetings with the Medical Director. The Medical Director should be attending the QAA meetings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) and use good infection control practices while providing wound treatments on two residents (Resident #15 and Resident #5). The sample was 12. The census was 38. Review of the facility's Clean Dressing Change policy, dated 1/16/25, showed:-Intent: It is the policy of the facility to change dressing in accordance with state and federal regulations. -Procedure: -Verify and review physician's orders for procedure; -Perform hand hygiene and assemble equipment and supplies for dressing change; -Put on gloves and clean the bedside stand or table with germicidal disposable cloth; Establish a clean field; -Remove gloves and perform hand hygiene; -Set up supplies on barrier; -Position the resident for comfort; -Put on clean gloves; -Remove dressing; -Remove gloves and perform hand hygiene; -Put on clean gloves; -Cleanse wound with gauze and prescribed cleaning solution; -Use a dry gauze to pat the wound dry; -Remove gloves and perform hand hygiene. Review of the CDC recommendations for EBP, show:-Every staff member must clean their hands before entering and leaving the room;-Providers and staff must also wear gloves and gown for the following high contact resident care activities: -Dressing; -Bathing or showering; -Changing linens; -Providing hygiene; -Changing briefs or assisting with toilet care; -Wound care: Any skin opening requiring a dressing. 1. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/15/25, showed:-Resident rarely understood or able to understand;-Dependent on staffing for personal hygiene, toilet hygiene and mobility in bed. -Diagnoses included non-Alzheimer's dementia, malnutrition, depression and anxiety; -The resident is at risk for developing pressure ulcer. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident has a pressure wound to his/her buttocks measuring 3 centimeters (cm) by 4 cm;-Approach: Cleanse and dry affected area to right buttock; apply Medihoney (an ointment used to remove dead tissue) to the wound bed and cover with dry dressing daily and as needed (PRN);-The care plan did not address EBP. Review of the resident's Physician Order Sheets (POS), dated 9/25/25, showed an order, dated 8/20/25, cleanse and dry affected area to right buttock; apply Medihoney to the wound bed and cover with dry dressing daily and PRN. During observation and interview on 9/26/25 at approximately 9:00 A.M., Licensed Practical Nurse (LPN) F prepared the treatment at the medication cart. LPN F said he/she couldn't log into the computer to look at the treatment order but thought the treatment was cleanse the right buttock with saline and apply a calcium alginate (a specialized dressing) dressing and cover with a dry dressing. LPN F opened a package of small gauze dressings and removed the gauze with ungloved hands and placed it back into the package. LPN F then removed a pair of bandage scissors out of his/her uniform pocket and cut the calcium alginate dressing and placed the scissors back into his/her uniform pocket. The outside of the resident's room showed no EBP sign. LPN F entered the room with treatment supplies and laid the opened dressings directly on the resident's nightstand with no barrier. The resident lay in bed and LPN F positioned the resident to his/her right side. There was no dressing present to the resident's right buttock. The resident's buttock had a dime sized superficial open area with a pink and moist wound bed with no drainage or odor. LPN F said the resident's right buttock wound was a Stage II pressure wound. LPN F performed hand hygiene and applied clean gloves. LPN F placed the calcium alginate on the resident's wound and said the piece of calcium alginate that he/she cut was too big. LPN F then removed his/her bandage scissors out of his/her uniform shirt pocket and cut the piece of calcium alginate to a smaller size and applied the calcium alginate to the resident's right buttock (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure wound. LPN F then covered the resident's right buttock pressure wound with a border gauze (a specialized dressing). LPN F did not clean the bandage scissors prior to cutting the calcium alginate. LPN F did not use a clean barrier to place clean supplies on. LPN F did not use EBP while providing direct care. LPN F did not provide the correctly ordered treatment. 2.Review of Resident #5's quarterly MDS, dated [DATE], showed:-Cognitively intact.-Diagnoses included cancer and diabetes;-One Stage III pressure ulcer (full thickness skin loss in which subcutaneous (under the skin) fat is exposed and may contain non-viable tissue). Review of the resident's care plan, in use at the time of survey, showed:-Problem: Pressure ulcer: The resident is at risk for infection related to chronic (long term) process, impaired mobility, and impaired skin integrity as evidenced by chronic wounds and repeated infections.-The care plan did not address EBP. Review of the resident's POS, dated 9/25/25, showed an order, dated 6/16/25, wound to coccyx (tailbone), cleans with normal saline, apply Santyl (an ointment that removes dead tissue) and Gentamycin (antibiotic) ointment to wound bed, cut calcium alginate to fit wound bed and cover with dry dressing) daily and PRN. Observation on 9/29/25 at 9:02 A.M., showed LPN B gathered the treatment supplies off of the medicine cart and entered the resident's room. The resident's room did not have an EBP sign on the door. The resident lay in bed. Certified Nursing Assistants (CNA) C and D entered the resident's room. CNA C and D assisted the resident in bed by turning the resident side to side and removed the resident's brief. The resident was positioned to his/her left side by CNA D. LPN B placed the treatment supplies and a pair of office paper scissors directly on the resident's bed, without a barrier. LPN B removed the dressing, dated 9/28/25, from the resident's coccyx. A very small, approximately one half of an inch, wound was present to the resident's coccyx. The resident's coccyx wound appeared macerated (wrinkled and softened skin from prolonged moisture) and had a pin hole opening. LPN B performed hand hygiene and changed his/her gloves. LPN B opened a package of small gauze and placed the gauze on top of a peanut butter jar located on the resident's nightstand. LPN B then removed the gauze from the top of peanut butter jar and soaked the gauze with normal saline and cleansed the resident's coccyx wound. LPN B removed another piece of small gauze off the top of the peanut butter jar and dried the resident's coccyx wound. LPN B performed hand hygiene and changed his/her gloves. LPN applied the Santyl and Gentamycin to the resident's coccyx wound. LPN B cut the calcium alginate with the same scissors that were laying directly on the resident's bed. LPN B placed the cut calcium alginate dressing on the resident's wound and covered the wound with a border gauze. LPN B did not utilize a clean barrier to lay the treatment supplies on. LPN B did not clean the scissors prior to cutting the calcium alginate dressing. LPN B, CNA C, and CNA D did not wear isolation gowns while providing direct care to the resident. During an interview on 9/30/25 at 8:20 A.M., Certified Medication Technician (CMT) A said he/she did not know what EBPs were or when they are utilized during resident care. During an interview on 9/30/25 at 8:29 A.M., CNA C said he/she did not know what EBPs were or when they are utilized during resident care. During an interview on 9/30/25 at 8:45 A.M., LPN B said she didn't think there were any type of clean barriers available to use for treatments. LPN B said he/she would normally not clean the treatment scissors prior to use because the nurse who used them before LPN B should have cleaned them. LPN B did not know what EBPs were and when they needed to be used. 3. During an interview on 9/30/25 at 8:00 A.M., the Assistant Director of Nursing (ADON) said she is also the facility Infection Preventionist (IP) and said she was aware of the EBP and when they need to be used. The facility has not implemented EBP with resident care. There is no policy for the EBP. She expected staff to use a disposable barrier pad or a clean towel to lay any treatment supplies on. She expected staff to use bandage scissors and clean them with disinfectant wipes before use. She expected staff to use good infection control practices when providing the residents their treatments. 4. During an interview on 9/30/25 at 10:51 A.M., the Administrator said she was familiar with EBP and expected the facility to implement them during resident care and use good infection control practices when providing the residents their treatments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNA) received a minimum of 12 hours of ongoing education annually for three out of three sampled CNAs (CNA D, CNA C and Certified Medication Technician (CMT) E). The census was 38.Review of the facility's Required In-service Training for Nurse Aides, dated, 1/16/25, showed-Intent: It is the policy of the facility to provide a staff education plan in accordance with state and federal regulations;-Procedure: Required in-service training for nurse aides will: -Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; -Include dementia management training and resident abused prevention training; -Address areas of weakness as determined in nurse aides' performance review and facility assessment and may address the special needs of residents as determined by the facility staff; -For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.Review of the list of CNA's and CMT's that have worked more than one year at the facility showed only three employees. 1. Review of CNA D's, employee file, showed:-Hire date: 11/23/23;-CNA hours of training completed: six. 2. Review of CNA C's employee file, showed:-Hire date: 1/3/24;-CNA hours of training completed: seven. 3. Review of CMT E's employee file, showed:-Hire Date: 6/12/24;-CNA hours of training completed: two. 4. During an interview on 9/26/25 at approximately 11:00 A.M., the Director of Nursing (DON) said she was not aware the CNAs required 12 hours of training. It is her responsibility, along with the Assistant Director of Nursing (ADON), to provide the education to the CNAs. 5. During an interview on 9/30/25 at 10:51 A.M., the Administrator said she expected the CNA staff to complete the 12 hours of annual training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure residents were assessed to self-administer medications and physician orders were maintained for self-administration of medication for one resident observed with medications left at bedside (Resident #41). The sample was 12. The census was 38.Review of Resident #41's medical record, showed diagnoses included asthma-chronic obstructive pulmonary disease (COPD, lung disease) overlap syndrome (symptoms of both asthma and COPD) and heart failure. Review of the resident's physician order summary (POS), showed:-An order, dated 8/16/25, for albuterol sulfate hydrofluoroalkane (HFA) aerosol inhaler (medication used to treat asthma); 90 microgram (mcg)/actuation (release of a single dose); inhale two puffs by mouth three times a day;-An order, dated 8/16/25, for Incruse Ellipta (umeclidinium, medication used to treat COPD) blister with device; 62.5 mcg/actuation; one puff inhalation; inhale one puff once daily;-An order, dated 9/18/25, for Breo Ellipta (fluticasone furoate-vilanterol, medication used to treat asthma or COPD) blister with device; 100-25 mcg/dose; one puff inhalation; once a day;-An order, dated 9/18/25, for Spiriva with HandiHaler (tiotropium bromide, medication used to treat COPD) capsule with inhalation device; 18 mcg; one cap inhalation; once a day;-An order, dated 8/16/25, discontinued on 9/18/25, for Symbicort (budesonide-formoterol, medication used to treat COPD) HFA aerosol inhaler; 80-4.5 mcg/actuation; two puff inhalation; inhale two puffs by mouth two times a day;-No physician orders for the resident to self-administer the inhaler medications or to keep the medications at bedside. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's use of inhalers, ability to self-administer medications, or ability to keep medications at bedside. Observation on 9/25/25 at 12:54 P.M., showed three inhalers on the resident's bedside table, including Incruse Ellipta, albuterol sulfate HFA, and Symbicort. During an interview, the resident said he/she is able to keep his/her inhalers in his/her room and administer them him/herself. He/She does not need staff assistance or monitoring for inhaler use. Observation on 9/29/25 at 2:24 P.M., showed the resident not in his/her room. An Incruse Ellipta inhaler and albuterol sulfate HFA inhaler on his/her bedside table, in plain view. Observation on 9/30/25 at 9:01 A.M., showed the resident's Incruse Ellipta inhaler and albuterol sulfate HFA inhaler on his/her bedside table. During an interview on 9/30/25 at 9:03 A.M., Certified Medication Technician (CMT) A said the resident keeps his/her inhalers in his/her room. He/She went to the hospital recently and came back with the inhalers and said he/she was going to keep them at bedside. The resident wants to keep the inhalers in his/her room for a sense of independence. He/She can administer his/her inhalers without supervision. Physician orders must be obtained for residents to be able to self-administer their medications and keep them at bedside. Nurses are responsible for obtaining physician orders. During the interview, CMT A reviewed the resident's physician orders for inhalers and said none of the inhalers have orders for the resident to self-administer or keep at bedside. During an interview on 9/30/25 at 9:19 A.M., Licensed Practical Nurse (LPN) B said the resident can administer his/her inhalers and keep them at bedside. He/She has to have physician orders for this. Nurses do not assess residents for their ability to safely and appropriately use their inhalers. The physician is the only person responsible for monitoring self-administration of medication. During an interview on 9/30/25 at 8:50 A.M., the Director of Nurses (DON) said physician orders must be obtained for a resident to be able to self-administer their own medications and keep them at bedside. If a resident has physician orders to self-administer their inhalers, the DON would want to see a demonstration to know they can follow physician orders to administer at the correct times and to use the inhaler properly, including swishing their mouth after using certain inhalers. During an interview on 9/30/25 at 9:25 A.M., the Assistant Director of Nurses (ADON), Director of Nurses (DON) and Administrator said the resident is alert and oriented. He/She has physician orders to self-administer some of his/her other medications, such as creams. During the interview, the DON reviewed the resident's medical record and confirmed there were no physician orders for the resident to self-administer his/her inhalers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure reports with respect to surveys, certifications and complaint investigations conducted during the preceding three years were available for review by residents, family members and legal representatives of residents. The census was 38.Review of the facility's list of resident rights, undated, showed the right to be fully informed of state survey reports. Observations on four out of four days of survey, showed no reports with respect to surveys, certifications and complaints available for review. There was no notice posted regarding availability of survey results. During a group interview on 9/29/25 at 1:30 P.M., four out of four residents, whom the facility identified as alert and oriented, said they did not know they had the right to review survey results. They would like to be able to review survey results. During an interview on 9/29/25 at 1:16 P.M., the Social Services Director (SSD) said she did not know if survey results were available anywhere for people to review. During an interview on 9/29/25 at 2:51 P.M., the Administrator said she has a binder in her office that used to contain survey results and was out in a common area for people to review, but people used to take things out of it. Survey results should be available for residents and family members to review. Going forward, she will be responsible for ensuring this is done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents are free from chemical restraints imposed for purposes of discipline or convenience by not limiting one resident's as needed (PRN) psychotropic (a medication used to treat mental and emotional disorders) to 14 days (Resident #40). The sample was 12. The census was 38. Review of the facility's Pharmacy Services- Drug Regimen Free from Unnecessary Drugs policy, dated 1/16/25, showed:-Intent: The intent of this policy is each resident's entire drug medication regimen is managed and to promote or maintain the residents highest practicable mental, physical, and psychosocial well-being; The facility implements PRN orders for psychotropic medications are used when the medication is necessary and PRN use is limited;-Procedure: PRN orders for psychotropic drugs are limited to 14 days. Review of the facility's Psychotropic Management policy, dated 1/16/25, showed:-Policy statement: The facility will monitor use of psychotropic medications by residents to reduce its effects and achieve their highest practicable level of functioning;-Interpretation and Implementation: -A psychotropic drug is any drug that affects brain activities, associated processes and behavior; These drugs include but are not limited to: Anti-psychotics (medication used to treat mood disorders); Antidepressants; Anti-anxiety; and Hypnotics (medications used to promote sleep); -Staff will monitor for any new behaviors, or ongoing behaviors; -Non-pharmacological interventions will be attempted to reduce behaviors; -If PRN psychotropic medications is prescribed the order will be limited to 14 day or less; To write a new order after 14 days the physician must evaluate the resident to determine if that PRN order is necessary. Review of Resident #40's care plan, in use at the time of survey, showed;-Focus: The resident is on hospice;-Interventions: Administer drugs for palliation (managing symptoms and providing relief to serious medical conditions). Review of the resident's medical record, showed diagnosis that include generalized anxiety. Review of the resident's Physician Order Sheet (POS) dated September 2025, showed;-An order, dated 4/21/25, Haloperidol (medication used to treat restlessness, agitation, and anxiety) 2 milligrams (mg) per one milliliter (ml); Administered 0.5 mls every 2 hours PRN for generalized anxiety. -No stop date for the resident's PRN Haloperidol. Review of the resident's Medication Administration Record (MAR), dated 8/1 through 8/31/25 showed:-An order, dated 4/21/25, Haloperidol 2 mg per one ml; Administered 0.5 mls every 2 hours PRN for generalized anxiety;-On 8/4/25 at 6:56 P.M., Haloperidol was documented as administered. Review of the resident's MAR, dated 9/1 through 9/29/25 showed:-An order, dated 4/21/25, Haloperidol 2 mg per one ml; Administered 0.5 mls every 2 hours PRN for generalized anxiety;-On 9/29/25 at 6:48 A.M., Haloperidol was documented as administered. During an interview on 9/26/25 at 2:50 P.M., Licensed Practical Nurse (LPN) F said the resident has episodes of anxiety and hallucinations at times. The staff will try to check on him/her more frequently and ensure his/her needs are met. The resident does not take the PRN Haloperidol. The resident usually refuses the PRN Haloperidol and it should be discontinued. During an interview on 9/30/25 at 8:00 A.M., the Director of Nurses (DON) and the Assistant Director of Nursing (ADON) said the resident is on hospice and the hospice nurse wrote the orders. They have not been tracking use of psychotropic medications on the residents. The ADON said she was aware that PRN psychotropic medications are expected to have a 14 day stop date and a reassessment needs to be completed to determine if the resident needs the medication. The ADON and DON said they do not expect floor nursing staff to monitor stop dates on psychotropic medications. They expected the pharmacist to make a recommendation related to PRN psychotropic medications. During an interview on 9/30/25 at 10:51 A.M., the Administrator said she expected a stop date on PRN psychotropic medications. A reassessment is expected to be completed to determine if the resident requires an extension of the medication. Wright, [NAME] (42795) - RESIDENT NOTE No Notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document a discharge summary that included a recapitulation of stay, final summary of resident's status at the time of discharge, and reconciliation of medications for one resident sampled for discharges (Resident #38). The sample was 12. The census was 38.Review of the facility's Discharge Summary policy, undated, showed:-Intent: It is the policy of the facility to assure that a discharge summary is completed in accordance to State and Federal requirements;-Procedure:--When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:-a. A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment;--When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: -a. A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; -b. A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; -c. Reconciliation of all pre-discharge medications with the resident's post-discharge medications. Review of the resident's medical record, showed:-admission date 7/7/25;-Diagnoses included dementia with agitation, depression, fracture of unspecified part of neck of left femur (thigh bone), hypertension (high blood pressure), heart failure, mixed hyperlipidemia (high cholesterol), hypoxemia (low levels of oxygen in the blood), sciatica (nerve pain), and unspecified abdominal pain. Review of the resident's progress notes, dated 8/18/25, showed:-On 7/7/25, staff documented the resident admitted to the facility. Resident alert and oriented times two. Resident speaks Bosnian and understands no English. Resident representative in attendance when admitted ;-On 7/18/25, the Social Services Director (SSD) documented assessment review completed. Resident is to remain long term in this facility. Resident and/or representative does not need to be asked about discharging to the community, or only ask on compressive assessments;-On 8/18/25 at 11:23 A.M., the SSD documented the resident discharged home with family today;-On 8/18/25 at 11:44 A.M., Licensed Practical Nurse (LPN) A documented resident discharged home with family today. Belongings were taken by family. All medication was sent with responsible party. Review of the resident's Discharge/Release form, signed 8/18/25, showed:-Date of discharge: [DATE];-Location of discharge and physician documented;-Brief explanation to support this action: Discharge home with spouse and caregiver;-Signed by resident representative and Social Services Director. Review of the resident's medical record, showed:-No recapitulation of the resident's stay;-No final summary of the resident's status at the time of discharge, including nursing assessments;-No reconciliation of the resident's pre-discharge medications with his/her post-discharge medications. During an interview on 9/29/25 at 2:33 P.M., the SSD said the resident was admitted to the facility for long-term care. His/Her spouse kept getting depressed and felt bad about the resident being in a nursing home. The resident's responsible party came to the facility on a Friday and said the resident's spouse was having a hard time and wanted the resident to come home. The family wanted to take the weekend to think about it. The next week, the resident's representative and spouse came to the facility and said they were bringing the resident home. The SSD offered home health and the family declined and left with the resident. The SSD does not think a physician order is required to discharge a resident. When a resident is discharged , the nurse writes a note in the resident's medical record, assesses the resident and gives the resident their medications. During an interview on 9/30/25 at 8:28 A.M., the Assistant Director of Nurses (ADON) said the resident was supposed to be there long-term. She was not aware of any discussion about the resident's discharge. The resident's family showed up one day (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and said they were taking the resident home. When a resident is discharged , the nurse should obtain a physician order for discharge and to discharge with or without medications. The nurse should obtain a set of vital signs upon discharge and provide the resident with their medications, physician orders, contact information, and ancillaries. The nurse should document a discharge summary in the resident's medical record. During an interview on 9/30/25 at 10:20 A.M., the Administrator said she expects staff to document a resident's discharge plans in their medical record. Staff should document an assessment of the resident upon discharge and a summary of the resident's stay. Documentation should include what the resident left with, their medications and physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to complete a Level I Preadmission Screening and Resident Review (PASARR, a federally required screening for all applicants to a Medicaid-certified nursing facility to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care) for one of two residents sampled for PASARR review (Resident #4). The sample was 12. The census was 38.Review of the facility's Coordination and PASARR Program policy, dated 1/16/25, showed:-Intent: It is the policy of the facility to assure that all residents admitted to the facility receive a PASARR in accordance with State and Federal regulations;-Procedure included:-Preadmission screening for individuals with a mental disorder and individuals with intellectual disability. The facility will not admit, on or after January 1, 1989, any new residents with mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission. Review of Resident #4's medical record, showed:-admission date 11/16/21;-Diagnoses included bipolar disorder and anxiety disorder;-No Level I PASARR screening documented. During an interview on 9/26/25 at 9:24 A.M., the Social Services Director (SSD) said a Level I PASARR screening was not completed for the resident because the resident's stay at the facility is private pay. All beds in the facility are Medicaid-certified. The SSD did not know a Level I PASARR screening must be completed on all residents in Medicaid-certified beds, regardless of the resident's payor source. During an interview on 9/26/25 at 9:29 A.M., the Administrator said a Level I PASARR screening is required for all residents admitted to the facility because all beds in the facility are Medicaid-certified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure residents' care plans were updated routinely and accurately reflected residents' code status orders. Do Not Resuscitate (DNR) orders were not accurately reflected in four of 22 sampled residents' care plans (Residents #20, #25, #7 and #37). The census was 38.Review of the facility's Comprehensive Resident Centered Care Plans Policy, revised 1/26/25, showed:-The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth by state and federal regulation, including measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment;-The resident will have the right to participate in the development and implementation of his or her person-centered care plan, including by not limited to: participation in the planning process, the right to participate in establishing goals and outcomes of care, and the right to receive or deny services included in the plan of care;-Care plans are modified between care plan conferences when appropriate to meet the resident's current needs, problems, and goals;-The care plan will be updated or revised for the following reasons: significant change in condition, a change in planned interventions, new diagnoses, new medications, or abnormal labs. 1. Review of Resident #20's medical record, showed:-Diagnoses included history of cerebral infarction (stroke, an occlusion of one or more blood vessels in the brain), dysphagia (difficulty swallowing), history of seizures, functional incontinence, and metabolic encephalopathy (a condition where the brain does not receive enough oxygen or nutrients, leading to changes in brain function);-A copy of the resident's active DNR order, signed by the resident and physician on 8/27/25. Review of the resident's physician orders at the time of survey, showed an order for Do Not Resuscitate status placed by the physician on 8/27/25. Review of the resident's care plan, in use at the time of survey, showed a focus regarding the resident's active code status, which is listed as full code, and interventions including reviewing the resident's code status quarterly for accuracy. 2. Review of Resident #25's medical record, showed:-Diagnoses included acute cystitis (an inflammation in the bowel, typically caused by bacterial infection, metabolic encephalopathy, acute respiratory failure with hypoxia (a condition where the body's lungs cannot adequately provide oxygen to the tissues, leading to low levels of oxygen in the blood), and unspecified hallucinations (sensory experiences that occur in the absence of external stimuli).-A copy of the resident's active DNR order, signed by the resident on 6/30/25 and by the physician on 7/2/25. Review of the resident's physician orders at the time of survey showed an order for Do Not Resuscitate status placed by the physician on 6/30/25. Review of the resident's care plan, in use at the time of survey, showed no focus regarding the resident's DNR status or section of the care plan addressed the resident's code status. 3. Review of Resident #7's medical record, showed:-Diagnoses included Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out everyday tasks), acute pressure ulcer of the left foot (a skin wound resulting from prolonged, unrelieved pressure on the skin, causing tissue damage and loss due to impaired blood flow), and xerotis cutis (a condition characterized by abnormally dry and itchy skin).-A copy of the resident's active DNR order, signed by the resident on 4/9/24. Review of the resident's physician orders at the time of survey, showed an order for Do Not Resuscitate status placed by the physician on 8/18/25. Review of the resident's care plan, in use at the time of survey, showed a focus regarding the resident's active code status, which was listed as full code, and interventions including reviewing the resident's code status quarterly for accuracy. 4. Review of Resident #37's medical record, showed:-Diagnoses included vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), history of falls, generalized muscle weakness, and metabolic encephalopathy.-A copy of the resident's active DNR order, signed by the resident on 7/7/25 and by the physician on 7/9/25. Review of the resident's physician orders at the time of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey, showed an order for Do Not Resuscitate status placed by the physician on 7/7/25. Review of the resident's care plan, in use at the time of survey, showed no focus regarding the resident's DNR status or section of the care plan addressed the resident's code status. 5. During an interview on 9/30/25 at 8:45 A.M., Certified Medication Technician (CMT) A said the facility Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) Coordinator is responsible for creating, revising, and updating resident care plans at the facility. Care plans should include information specific to the resident including care needs, transferring status, wounds, and code status information. Care plans should be updated quarterly and are important because they help drive resident-centered care and inform staff of the resident's care needs. 6. During an interview on 9/30/25 at 8:49 A.M., Certified Nursing Aide (CNA) C said the facility MDS Coordinator and Social Services Coordinator are responsible for developing and updating care plans for residents at the facility. Care plans should include resident-specific care needs such as transferring status, toileting status, dietary needs, and the resident's code status information. Updating care plans routinely is important as care needs including transferring status and code status information can often change over the duration of a resident's admission. 7. During interview on 9/30/25 at 8:52 A.M., Licensed Practical Nurse (LPN) B said the MDS Coordinator and Social Services Coordinator are responsible for developing and updating care plans for residents at the facility. Care plans should include care needs, transfer status, and code status. It is important for code statuses to be accurately reflected in the resident's care plan as all code status information in the resident's record should match in each part of the record. LPN B was aware of the active DNR orders for Residents #20, #25, #7 and #37, and in the event of an emergency staff are instructed to check the facility's dedicated binder containing physical copies of each resident's code status order. 8. During an interview on 9/30/25 at 10:29 A.M., the Director of Nursing (DON) and Administrator said the MDS Coordinator is responsible for developing and updating care plans for the residents. Each resident's care plan should be updated quarterly and should include care needs, transfer status, dietary preferences, frequent behaviors, and the resident's code status. In the event that a code status change occurs, the resident's care plan should be updated to reflect the change given the order is signed and valid. The Administrator said Residents #20, #25, and #7 recently had changes made to their code statuses within the last couple of months. The Administrator expected their care plans to be updated as soon as the validity of the DNR order was confirmed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 one resident with a pressure wound (skin or soft tissue injury that develops with prolonged periods of pressure over specific areas of the body) received necessary treatments and services to promote healing (Resident #15). The sample size was 12. The census was 38. Review of the facility's Treatment and Services to Prevent and Heal Pressure Ulcers policy, undated, showed:Intent: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preference, goals for care and professional standards of practice that will meet each resident's physician, mental, and psychosocial needs; -Procedure: The facility will ensure that based on the comprehensive assessment of a resident with pressure ulcers receives necessary treatment and services, consistent, with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing; The pressure sore will be evaluated weekly and the nurse will document the size, location, odor (if any), drainage (if any), and current treatment ordered. Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/15/25, showed:-The resident is rarely understood or able to understand;-Dependent on staffing for personal hygiene, toilet hygiene and mobility in bed;-Diagnoses included non-Alzheimer's dementia; malnutrition (inadequate nutrition), depression and anxiety; -The resident is at risk for developing pressure ulcer. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident has a pressure wound to his/her buttocks measuring 3 centimeters (cm) by 4 cm;-Approach: Cleanse and dry affected area to right buttock; Apply Medihoney (an ointment used to remove dead tissue) to the wound bed and cover with dry dressing daily and as needed (PRN). Review of the resident's Physician Order Sheet (POS), dated 9/25/25, showed;-An order, dated 8/20/25, Cleanse and dry affected area to right buttock; Apply Medihoney to the wound bed and cover with dry dressing daily and PRN;-The order did not reflect what product is to be used to clean the wound. Review of the resident's progress notes, dated 9/23/25 at 2:56 A.M., showed the right buttock wound measured 2 cm by 2.5 cm, treatment done as ordered. During observation and interview on 9/26/25 at approximately 9:00 A.M., Licensed Practical Nurse (LPN) F prepared the treatment at the medication cart. LPN F said he/she couldn't log into the computer to look at the treatment order but thought the treatment was cleanse the right buttock with normal saline (sterile salt water) and apply a calcium alginate (a specialized dressing) dressing and cover with a dry dressing. With ungloved hands, LPN F opened a package of small gauze dressings and removed the gauze and placed it back into the package. LPN F then removed a pair of bandage scissors out of his/her pocket and cut the calcium alginate dressing into a small square piece. LPN F entered the room with treatment supplies and laid the opened dressings directly on the resident's nightstand with no barrier. The resident lay in bed and LPN F positioned the resident to his/her right side. There was no dressing present to the resident's right buttock. The resident's buttock had a dime sized superficial open area with a pink and moist wound bed. The wound had no drainage or odor. LPN F said the resident's right buttock wound was a Stage II (a wound with partial thickness loss, presents as a shallow open ulcer) pressure wound. With gloved hands, LPN F soaked the gauze with normal saline and cleaned the wound, dried the wound, and placed the calcium alginate on the resident's wound. LPN F removed the calcium alginate and said the piece of calcium alginate that he/she cut was too big. LPN F then removed his/her bandage scissors out of his/her uniform shirt pocket and cut the piece of calcium alginate to a smaller size and re-applied the same calcium alginate to the resident's right buttock pressure wound. LPN F placed his/her bandage scissors back into his/her uniform shirt pocket. LPN F did not clean the bandage scissors prior to cutting the calcium alginate. LPN F then covered the resident's right buttock pressure wound with a border gauze (a specialized dressing). LPN F said the wound looked a lot better. Review of the resident's Treatment Administration Record (TAR), dated 9/1 through 9/29/25, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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	showed:-An order, dated 8/20/25, cleanse and dry affected area to right buttock; Apply Medihoney to the wound bed and cover with dry dressing daily and PRN; 6:00 A.M. to 2:00 P.M. shift.-On 9/26/25 6:00 A.M. to 2:00 P.M. shift; the resident's treatment was documented as completed. Review of the resident's progress notes, dated 9/27/25 at 2:25 A.M., showed the right buttock with Stage I pressure wound (intact skin with localized redness), 1.5 cm by 2.5 cm. There is much improvement from last week. MediHoney and dressing applied. Review of the resident's skin observation detailed report, dated 9/27/25 at 3:21 A.M., showed the resident had a pressure ulcer Stage II on buttocks. During an interview on 9/30/25 at 8:45 A.M., LPN B said treatment orders should be checked prior to administering, just like with medicine. The current treatment for the resident's right buttock pressure wound is to apply Medihoney and dry dressing. Calcium alginate is an old order the resident had previously. Normal saline is the only product used to clean wounds. During an interview on 9/30/25 at 8:00 A.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said the resident is on hospice. The hospice nurse normally writes the orders for wounds and monitors the wounds. The resident is not seen by an outside wound company. The resident's right buttock pressure wound is a Stage II. The ADON does wound rounds and lost her wound tracking documentation due to a recent virus on her computer. The current order for the resident's right buttock pressure wound is to cleanse the wound, dry the wound, apply Medihoney, and cover with a dry dressing. Normal saline is what most wounds are cleaned with unless the order specifies something different. Calcium alginate is not the resident's current order. The ADON and the DON expected staff to follow the orders, provide the correct treatment, and use good infection control practices. During an interview on 9/30/25 at 10:31 A.M., the Administrator said she expected the physician treatment orders to be followed and correctly administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications kept in facility medication rooms were within the date of expiration and failed to remove one of 22 sampled resident's expired hospital discharge medications (Resident #22). Concerns were noted in one of one medication rooms during the survey period. The census was 38.Review of the facility's Storage of Medications policy, revised 1/16/25, showed:-Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing;-The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the pharmacy or destroyed;-The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 1. Observation of the facility's only medication room on 9/26/25 at 11:46 A.M., showed:-One bottle of GeriCare Stool Softener Docusate Sodium (a type of laxative used to treat occasional constipation) 100 milligram (mg) oral tablets expired as of 3/25;-Two boxes of Bisacodyl Laxative Supplement (a medication used to treat constipation) 5 mg tablets expired as of 4/25;-Two bottles of cetirizine (an antihistamine used to relieve allergy symptoms) 10 mg tablets expired as of 3/25 prescribed for Resident #22;-One bottle of furosemide (a diuretic used to treat edema and high blood pressure) 20 mg tablets expired as of 4/25 prescribed for Resident #22;-One bottle of aspirin 81 mg tablets expired as of 3/25 prescribed for Resident #22. 2. During an interview on 9/30/25 at 8:45 A.M., Certified Medication Technician (CMT) A said since starting at the facility two months ago, she has taken on some of the responsibility of auditing the medication room for expired medications and biologicals. CMT A reviews the medication room weekly for expired medications, and the facility's pharmacy partner conducts a review of the medication room for expired meds once per month. Expired medications should be removed from the medication room shelves and placed into a bin designated for the facility's pharmacy partner to dispose. 3. During an interview on 9/30/25 at 8:49 A.M. Licensed Practical Nurse (LPN) B said the Assistant Director of Nursing (ADON), Director of Nursing (DON), nursing staff, and facility CMTs are responsible for auditing the medication rooms for expired medications and biologicals. All expired medications should be placed into the designated disposal bin for the facility's pharmacy partner to pick up once per week. 4. During an interview on 9/20/25 at 10:29 A.M., the Administrator and DON said they expected all medications and biologicals in the medication room to be within the date of expiration and removed if they are expired. The facility's pharmacy partner conducts a monthly audit of the medication room and they expected the pharmacy partner to remove expired medications during those audits. The Administrator said Resident #22's expired medications were left over from a stay at the Veteran's Affairs (VA) Hospital earlier in the year and she expected staff to have removed them once expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post the nurse staffing information daily in a prominent place readily accessible to residents and visitors. The census was 38.Observations on 9/25/25 at 10:00 A.M., and 12:02 P.M., showed no staffing information posted in a prominent place.Observations on 9/26/25 at 9:00 A.M., and 11:00 A.M., showed no staffing information posted in a prominent place.During an interview on 9/26/25 at 11:15 A.M., the Assistant Director of Nursing (ADON) said the staffing has not been posted for about a month. It usually was posted in the lobby of the facility. The Activities Director was responsible for posting it but that person no longer works at the facility. The ADON did not know who currently was responsible for posting the staffing hours.During an interview on 9/30/25 at 10:51 A.M., the Administrator said she expected staffing information to be posted daily in a prominent place.