STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop individualized service plans (ISP) to meet the needs of the residents. Staff failed to develop goals and interventions for one resident at risk for, and with a history of, pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction) to prevent the development of pressure ulcers. The resident developed a pressure ulcer and the ISP was not updated with goals and interventions for the care for the resident with a pressure ulcer (Resident #1). The facility also failed to develop needs, preferences, and services to be provided related to the provision of hospice care for Resident #1. In addition, staff failed to develop the ISP for one resident who was incontinent of bowel and bladder and required assistance from staff to be routinely cleaned (Resident #2). The sample was four. The census was 35. 1. Review of Resident #1's ISP, dated 11/8/24, showed: -Diagnosis: Alzheimer's disease;	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 1 -Primary care needs: Total assist with activities of daily living (ADLs), including bathing, dressing, grooming, toileting, and eating, & currently on hospice care; -Abilities: Not able to follow simple directions. Oriented to self only. Non-ambulatory. Incontinent of bowel and bladder. Require assist of one with transfers. Currently on hospice for dementia; -Challenges: Not able to make needs known verbally, look for nonverbal cues; -No need, goal, or care interventions for the risk of pressure ulcers; -No need, goal or care interventions added for the presence of a pressure ulcer. -No goals, approaches for care, or clinical interventions related to hospice care. Review of the resident's Physician Orders, dated 11/30/24, showed: -Diagnoses of constipation and recurrent seizures; -A treatment order dated 11/7/24, with lines drawn across the order and "D/C'd" handwritten on the order, to cleanse wound on left hip and change Duoderm (hydrocolloid dressing, used on low to moderately draining wounds that are not infected) every 3 days until healed; The handwritten note did not include initials or a date to show who and when the order was discontinued. -No further treatment orders obtained in the month of December 2024; -No order for weekly wound or skin assessments. Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed: -Treatment order date 11/7/24, cleanse wound on left hip and change Duoderm every 3 days until	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 2	A4754		

healed. Discontinued on 12/4/24;
-No order for or documentation of skin or wound assessments.

Review of the resident's Medication Administration Record (MAR), dated December 2024, showed no documentation of skin or wound assessments.

During an interview on 1/27/25 at 9:46 A.M., the Resident Care Coordinator (RCC) said there should be a weekly skin note in the MAR. He/She checked the resident's medical record and there was no weekly skin note in the MAR for the resident. On 12/4/24, the treatment was discontinued, and the order for a skin note dropped off. If a resident is at risk for pressure ulcers, staff should get orders for a weekly skin note even if there is no active wound.

Review of the resident's hospice nursing visit note, dated 12/12/24, showed:
-Skin: Pressure ulcer stage III (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed);
-A mark on a body diagram indicated the pressure ulcer located in the left hip/ischial (the part of the buttocks that touches the chair when sitting) area;
-Measurements: length 1.2 by width 1, no depth indicated;
-Drainage: Scant (small amount);
-Drainage type: purulent (containing puss) and serous (clear);
-Wound bed appearance: loose, stringy, yellow/tan slough (dead tissue), pink/red granulation (new tissue growth);
-Treatment orders: Order dated 12/12/24, wound to left buttocks. Cleanse with wound cleanser,

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	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 3	A4754		

pat dry, apply hydrocolloid dressing. Change every 3 days and as needed when soiled. Facility staff to provide all care in the absence of hospice;
-Observation of a picture of the wound included in the note, showed: The wound located on the left hip/buttocks area. The wound bed dark brown/black in color. The wound edges raised and reddened. The wound presented as an unstageable wound in the picture;
-Discussed assessment with facility staff Licensed Practical Nurse (LPN) I. Discussed patient's wound to left buttocks opening back up. LPN I reports order is to cleanse with wound cleanser, pat dry, apply hydrocolloid dressing. Change very three days and as needed when soiled.

During an interview on 1/27/25 at 9:25 A.M., LPN I said the resident had a wound on his/her hip. It started out as a red area; and it opened really small. The doctor ordered a Duoderm every 3 days. This was around December 14th.

During an interview on 1/28/25 at 1:44 P.M., LPN J said he/she was on call the weekend the family asked for the wound to be assessed, the weekend of December 28 and 29, 2024. A care partner asked him/her to come in and look at the wound around noon. He/She assessed the wound, cleaned it, and put a treatment in place. The family contacted the nurse practitioner who then reached out to the house nurse, LPN I. The wound was black and had a foul odor. It was about a half dollar size. It smelled so bad that it could be smelled from outside the room. Staff need to look at wounds every day. The resident cannot communicate his/her needs and is dependent on staff to care for him/her. He/She cleansed the wound and put a dressing on it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 4 Review of the resident's nurse's note, dated 12/29/24 at 4:15 P.M., showed: -This writer was called requesting assistance with sending resident to the ER for evaluation and treatment for a wound on his/her bottom. Upon arrival, family had left the building. Emergency medical services (EMS) called for transfer to the hospital; -No documentation of the wound assessment, appearance, odors, or resident condition completed by LPN J. Review of Resident #1's physician orders, showed an order dated 12/29/24, send to ER for evaluation and treatment. During an interview on 1/27/25 at 9:46 A.M., the RCC said he/she did the investigation on the pressure ulcer concern for the resident. The RCC said he/she never saw the wound. The resident went to the ER with a serious wound. Prior to that, he/she had a wound that healed, so the treatment orders were discontinued. No more treatment was ordered after that. When interviewing everyone, he/she was told there was a new order for a Duoderm dressing and that they were doing it every 3 days. He/She found an order initiated on December 12th to start the Duoderm again from hospice, it was not carried over into the resident's chart. He/She did not see any documentation about it, however. Normally, the bathing process identifies skin concerns. The resident is at risk for pressure ulcers with low weight and poor nutrition, so he/she should have had a weekly skin note. During an interview on 1/27/25 at 2:21 P.M., Nurse Practitioner (NP) Q said he/she saw the	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 5	A4754		

resident around December 5, 2024, after being on leave. He/She was made aware that the resident had a small open area to the left hip that had since healed and the order for a Duoderm had been discontinued. The resident was at risk for pressure ulcers. The facility did, at some point, ask for a foam type dressing for preventative measures. The next time they were made aware that there was a skin concern was on December 29, 2024, the day the resident was sent to the emergency room. No one reported the wound had reopened prior to December 29, 2024.

During an interview on 1/27/25 at 2:09 P.M., the administrator said on November 4, 2024, the order for Duoderm was discontinued because the area to the left hip had healed. When the wound reopened on December 12, 2024, the treatment should have been added to the physician order sheet and there should be weekly wound assessments. Documentation of the wound condition and appearance should have been documented when it first reopened as well. The ISP should address risk for pressure ulcer and be updated if a pressure ulcer develops.

2. Review of Resident #2's ISP, dated 10/24/24, showed:
-Diagnoses included dementia and arthritis;
-Primary care needs: Needs assistance with all ADLs such as dressing, bathing, grooming, and wound care. Unable to ambulate independently and needs the assistance of a Hoyer lift (full body mechanical lift). Needs toileting assistance due to incontinence;
-No goals or interventions related to the resident's incontinence or need for perineal care (peri-care, the cleaning and maintenance of the

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	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 6 genital and anal areas). Observation on 1/27/25 at 6:35 A.M., 6:49 A.M., and 7:02 A.M., showed the resident sat in a Broda chair (wheeled reclining chair) in the TV area. During an interview on 1/27/25 at 6:48 A.M., Care Partner B said he/she works the night shift, 7:00 P.M. through 7:00 A.M. His/Her job includes cleaning, laundry, and changing residents. Observation on 1/27/25 at 7:57 A.M., showed the resident sat in a Broda chair in the dining room and ate breakfast. Observation on 1/27/25 at 8:35 A.M., showed staff propelled the resident in his/her Broda chair from the dining room to the TV room. At 11:55 A.M., the resident sat in the TV area. At 12:05 P.M., staff propelled the resident from the TV area to the dining room. At 12:48 P.M., the resident remained in the dining room as staff assisted him/her with lunch. At 1:02 P.M., Care Partner E propelled the resident from the dining area to the TV area. The resident was in his/her Broda chair from at least 7:57 A.M. till 1:02 P.M. without incontinence care being provided. Observation on 1/27/25 at 1:07 P.M., showed Care Partner E propelled the resident to his/her room. He/She had gloves on, and placed a barrier on the bed. Care Partner E and Care Partner G went to the bed. The Care Partners assisted the resident to remove his/her pants and unsecured his/her brief. The resident had whitish/yellow clumps of debris on his/her genitals that appeared to be from the wet brief. The resident had stool in the brief and the brief	A4754		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4754	Continued From page 7 was wet with urine. The Care Partners cleaned the bowel movement from the resident's buttocks. The care partners finished providing care. During an interview on 1/27/25 at 2:09 P.M., the administrator said the resident is incontinent. Care providers should check and clean residents in the morning, after each meal, and before bed. Night shift rounds every two hours. MO00247574	A4754		
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class I* Based on observation, interview and record review, the facility failed to ensure proper care was provided to two residents, to meet their needs. Resident #1's healed pressure ulcer (injury to the skin and/or underlying tissue, as a result of pressure or friction) to the left hip/buttocks area, reopened sometime between the dates of 12/5/24 and 12/12/24. The resident's personal physician and representative were not notified of the pressure ulcer reopening, or worsening. There was no documentation in the facility's resident medical record of the wound being present on the resident, notification of the physician, assessment of the wound, orders for wound care, or application of a treatment by facility nursing staff until 12/29/24. On 12/29/24, Resident #1's family asked for the wound to be	A4777		

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	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

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A4777	Continued From page 8 assessed by a nurse. The wound was black and had a foul odor. The resident's nurse practitioner was contacted and the resident was transported to the hospital. The hospital record showed a left large ischial (part of the pelvic area, located at the bottom of the buttocks) decubitus ulceration that required surgical debridement (removal of dead tissue). In addition, staff failed to follow one resident's ISP regarding toileting for one resident who required total assistance and remained up in a chair on 1/27/25 from 6:35 A.M. through 1:35 P.M., without being toileted or cleaned of incontinence (Resident #3). The sample was four. The census was 35. 1. Review of the facility's Prevention of Pressure Wounds policy, last revised 1/1/18, showed: -Complete an assessment of risk for the resident upon admission, readmission, and change in condition; -Put interventions into place using one or more of the items below: -Pressure relief mattress/chair cushion, turn schedule, heel protectors, exercise program; -Staff education and training; -Physical therapy, oxygen therapy; -Monitor skin condition daily for problems; -Regular bathing; -Supplements; -Include goal on the ISP to prevent development of pressure areas; -Treatment: -Report the wound to the physician and obtain appropriate treatment orders. Notify physician of progress or lack of progress weekly. Chart contact with the physician; -Notify the family, Administrator, and Resident Care Coordinator (RCC); -Chart initial description of wound. Include	A4777		

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	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

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A4777	Continued From page 9	A4777		

measurements, odor, drainage, color of tissue, status of wound bed and edges (do not stage the wound). Then chart weekly with any change or new treatment order.

Review of Resident #1's ISP, dated 11/8/24, showed:
-Diagnosis: Alzheimer's disease;
-Primary care needs: Total assist with activities of daily living (ADLs), including bathing, dressing, grooming, toileting, and eating;
-Abilities: Not able to follow simple directions. Oriented to self only. Non-ambulatory. Incontinent of bowel and bladder. Require assist of one with transfers. Currently on hospice for dementia;
-Challenges: Not able to make needs known verbally, look for nonverbal cues;
-Goal: The nurse manager will keep in close contact with family related to condition, doctors orders, and lab results:
-Approaches for care, support, assistance: The nurse contacts the doctor and family with any changes in condition.
-No need, goal, or care interventions for the risk of pressure ulcers;
-No need, goal or care interventions added for the presence of a pressure ulcer.
-No goals, approaches for care, or clinical interventions related to hospice care.

Review of the resident's Physician Orders, dated 11/30/24, showed:
-Diagnoses of constipation and recurrent seizures;
-A treatment order dated 11/7/24, with lines drawn across the order and "D/C'd" (no initials or date of the change) handwritten on the order, to cleanse wound on left hip and change Duoderm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 10	A4777		

(hydrocolloid dressing, used on low to moderately draining wounds that are not infected) every 3 days until healed;
-No further treatment orders obtained in the month of December 2024;
-No order for weekly wound or skin assessments.

Review of the resident's Treatment Administration Record (TAR), dated December 2024, showed:
-Treatment order date 11/7/24, cleanse wound on left hip and change Duoderm every 3 days until healed. Discontinued on 12/4/24;
-No order for or documentation of skin or wound assessments.

Review of the resident's Medication Administration Record (MAR), dated December 2024, showed no documentation of skin or wound assessments.

During an interview on 1/27/25 at 9:08 A.M., the administrator said documentation of skin condition is documented in the MARs/TARs. The facility does not use wound reports to track wounds. Staff check the skin when they are providing care. If it looks different prior to the last time it was seen, they should make a note. Measurements, appearance, and odors are not routinely documented.

During an interview on 1/27/25 at 9:46 A.M., the RCC said there should be a weekly skin note in the MAR. He/She checked the resident's medical record and there was no weekly skin note in the MAR for the resident. On December 4th the treatment was discontinued, and the skin note order dropped off. If a resident is at risk for pressure ulcers, staff should get orders for a weekly skin note even if there is no active wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 11 The house nurse would be responsible for the skin assessments. Review of the resident's Nurse's Notes, showed: -On 12/5/24, seen by Physician P today. No new orders; -On 12/19/24 at 11:00 A.M., new order received per Nurse Practitioner (NP) Q for Tramadol (used to treat pain). Family made aware; -On 12/23/24 at 9:00 A.M., per staff, resident refused to eat meals over the weekend despite all attempts to be fed. Family attempted to feed the resident and the resident still refused; -No further nurses notes through 12/28/24. Review of the resident's Monthly Summary, dated 12/6/24, showed: -Position: Every 2 hours; -Skin turgor: Fair; -Bladder: Incontinent; -Bowel: Incontinent; -No decubitus or other skin conditions noted. Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:23 A.M., showed: -The resident in bed on his/her back. Care Partner M and Care Partner S were in the room at his/her side and provided personal care; -The Care Partners looked closely at the left hip/buttocks area and talked amongst each other. Care Partner S exited the room while Care Partner M waited at the bedside; -The video was continued on another clip. Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:29 A.M., continuation from a previous clip, showed: -Care Partner M stood and waited by the	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 12	A4777		

resident's side;
-Care Partner S entered the room and said they were going to have to wait a minute because he/she did not know what they want him/her to do;
-Care Partner S walked over to the table in the room and said, the patch thing is right here, but he/she did not want to put it on him/her if it is not supposed to be on and he/she is not supposed to. Care Partner S picked up a dressing labeled Hydrochloride dressing (Duoderm);
-Care Partner S walked back over to the resident and looked closely at his/her left hip/buttocks area and said he/she was going to ask. He/She then exited the room while the Care Partner M waited in the room;
-The video was continued on another clip.

Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:41 A.M., continuation from a previous clip, showed:
-Care Partner S entered the room and said he/she was told they could go ahead and put it on;
-Level one Medication Aide (L1MA) F entered the room and told the Care Partners to just put some cream and put a band aid on it. L1MA F picked out an outfit for the resident and the Care Partners got the resident dressed;
-No Nurse assessed the left hip or applied a treatment.

Review of the resident's handwritten hospice communication note, written by hospice and provided to the facility, dated 12/12/24 at 10:37 A.M., showed:
-Wounds: (blank);
-New orders: (blank);
-Up in Broda (medical reclining chair) upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 13	A4777		

Registered Nurse Care Manager (RNCM) arrival. Patient appears lethargic (a state of extreme tiredness). Opening eyes intermittently. Patient has nonsensical speech. Skin warm to touch and intact. Patient has clear lung sounds. Bowel sounds hyperactive. Continues to have good appetite.

Observation of a video recording in the resident's room, recorded on 12/12/24 at 11:43 A.M., showed:
-A hospice staff person entered the room with the resident, who sat in a Broda chair;
-He/She removed the blanket from the resident. The resident wore no clothing. The hospice staff person picked up the resident and placed him/her in the bed. During the transfer, no dressing was visible on the left hip/buttocks and a darkened area with reddened skin surrounding the darkened area was visible to the camera and appeared to be approximately the size of a quarter;
-The hospice staff person looked closely at the resident's left hip/buttocks area, pulled his/her phone out of his/her pocket, and took a picture of the resident's left hip;
-The hospice staff placed a clean brief on the resident and assisted to dress the resident. No staff applied a treatment to the left hip.

Review of the resident's facility medical records, showed no documentation the physician was notified of the wound.

Review of the resident's hospice nursing visit note (which was not a part of the resident's facility medical record), dated 12/12/24, showed:
-Time in 10:37 A.M.;
-Time out 11:30 A.M.;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 14 -Skin: Pressure ulcer stage III (full thickness tissue loss, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed); -A mark on a body diagram indicated the pressure ulcer located in the left hip/ischial (the part of the buttocks that touches the chair when sitting) area; -Measurements: length 1.2 by width 1, no depth indicated; -Drainage: Scant (small amount); -Drainage type: purulent (containing puss) and serous (clear); -Wound bed appearance: loose, stringy, yellow/tan slough (dead tissue), pink/red granulation (new tissue growth); -Treatment orders: Order dated 12/12/24, wound to left buttocks. Cleanse with wound cleanser, pat dry, apply hydrocolloid dressing. Change very 3 days and as needed when soiled. Facility staff to provide all care in the absence of hospice; -Observation of a picture of the wound included in the note, showed: The wound located on the left hip/buttocks area. The wound bed dark brown/black in color. The wound edges raised and reddened. The wound presented as an unstageable wound in the picture; -Discussed assessment with facility staff Licensed Practical Nurse (LPN) I. Discussed patients wound to left buttocks opening back up. LPN I reports order is to cleanse with wound cleanser, pat dry, apply hydrocolloid dressing. Change very three days and as needed when soiled. During an interview on 1/27/25 at 9:25 A.M., LPN I said the resident had a wound on his/her hip. It started out as a red area; it opened really small. The doctor ordered a Duoderm every 3 days. This was around Dec 14th. LPN I said she forgot	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 15	A4777		

to add the order to the resident's physician order sheet and the treatment record.

Review of the resident's facility medical records, showed no documentation the resident's physician was notified of the wound with drainage and slough or of an order for Duoderm every 3 days.

During an interview on 1/31/25 at 11:18 A.M., the Operations Manager said he noticed the discrepancy between the handwritten hospice notes and the typed hospice notes. He feels the handwritten notes are accurate because they were written that day. The Operations Manager stated the typed hospice visit notes were not provided to the facility by the hospice agency. He acknowledged the facility nurse did not have any documentation of the wound to help clarify discrepancies.

Review of the resident's handwritten hospice communication note, written by hospice and provided to the facility, dated 12/19/24 at 10:45 A.M., showed:
-Wounds: Left buttocks/hip;
-Patient pleasant/accepting. This Registered Nurse (RN) and Hospice Health Aide (HHA) got patient up to whirlpool. Pain noted by groans/grimacing. Bandage to wound changed.

Observation of a video recording in the resident's room, recorded on 12/19/24 at 2:42 A.M., showed:
-A hospice staff person entered the room with the resident, who sat in a Broda chair;
-He/She removed the blanket from the resident. The resident wore no clothing. The hospice staff person picked up the resident and placed him/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 16	A4777		

in the bed;
-Hospice Nurse N entered the room and said he/she wanted to bandage the wound and then wanted to talk to (unintelligible) about it;
-Hospice Nurse N walked over to the resident with dressing supplies and a treatment was applied;
-The hospice staff assisted the resident to get dressed.

Review of the resident's typed hospice nursing visit note (which was not a part of the resident's facility medical record), dated 12/12/24, showed:
, dated 12/19/24, showed:
-Time in: 10:45 A.M.;
-Time out: 11:40 A.M.;
-Skin: Pressure ulcer stage III left buttocks;
-Measurements: 1 by 1, no depth indicated;
-Scant drainage: Purulent;
-Wound bed appearance: soft, brown/black eschar (dead tissue), pink/red granulation;
-Observation of a picture of the wound included in the note, showed: The wound bed dark brown/black in color. The wound edges raised and reddened. The skin surrounding the wound edges reddened and appear inflamed. The wound presented as an unstageable wound in the picture;
-Discussed assessment with facility nurse, LPN I. This RN discussed with LPN I that patient appeared to be in pain during visit when getting into the whirlpool. LPN I contacted NP Q. New order obtained for tramadol.

Review of the resident's facility medical records, showed no documentation the physician was notified of the resident's wound and the increased redness around the wound edges.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 17 Observation of a video recording in the resident's room, recorded on 12/24/24 at 6:59 A.M., showed: -The resident lay in bed on his/her right side as Care Partner T provided care. Care Partner L entered the room and stood at the foot of the bed and partially blocked the camera view. Care Partner T said "that's bad, that's a real bad bedsore". Care Partner T repositioned the resident and said "I was trying not to hurt your bedsore"; -Care Partner T positioned the resident so his/her left hip was visible to the camera. The wound, black in color, visible on the left hip/buttocks area, was approximately the size of a half dollar. The skin surrounding the wound appeared reddened. Review of the resident's handwritten hospice communication note, written by hospice and provided to the facility, dated 12/26/24 at 10:50 A.M., showed: -Wounds: Left buttocks/hip; -Pleasant and accepting. No pain noted. Wound covered. Barrier cream applied. Observation of a video recording in the resident's room, recorded on 12/26/24 at 11:29 A.M., showed: -The resident in bed. Hospice Nurse N stood at the bed and put lotion on the resident's back; -A second hospice staff entered the room and looked at the resident's left hip wound and whispered "it's worse". Hospice Nurse N whispered "yes, it is, they never did assess" him/her yet; -The hospice staff said "this is outrageous"; -Hospice Nurse N walked to the resident's bedside and said "it's bad, we need to bandage it	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 18	A4777		

up and take a picture of that wound". The hospice nurse provided personal care and applied a Duoderm dressing over the wound.

Review of the resident's typed hospice nursing visit note (which was not a part of the resident's facility medical record), dated 12/26/24, showed:
-Time in: 11:15 A.M.;
-Time out: 11:45 A.M.,
-Skin: left buttocks stage III pressure ulcer;
-Measurements: Length 1.4, width 1.4, no depth;
-Drainage: None;
-Wound bed appearance: Soft, brown/black eschar;
-Observation of a picture of the wound included in the note, showed: The wound bed dark brown/black in color. The wound edges reddened and the skin peeled off in places. The skin surrounding the wound edges reddened and appear inflamed. The wound presented as an unstageable wound in the picture;
-Discussed assessment with staff (LPN I), discussed wound care needing to be done daily, educated that care was done during visit.

During an interview on 1/27/25 at 10:29 A.M., Hospice Nurse N said he/she did recall the visits with the resident. The last visit was on December 26th. There was no drainage in the wound at that time. He/She cleansed the wound after hospice staff got him/her out of the shower. The wound was darkened in color, soft brown eschar, surrounding tissue was pink. Estimated 1.5 centimeters (cm) by 1.5 cm in size, constant through all visits. It started to darken overtime. He/She talks with the facility nurse after each visit.

Review of the resident's facility medical records,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 19	A4777		

showed no documentation the physician was notified of the resident's wound, redness, inflammation, peeling back, and need for daily wound care.

Observation of a video recording in the resident's room, recorded on 12/28/24 at 10:50 A.M., showed:
-Care Partner S stood at the resident's side and provided care;
-Care Partner F sprayed an unidentifiable spray into the air throughout the room;
-Care Partner S looked closely at the resident's wound and made a facial grimacing. The two staff whispered between each other;
-Care Partner F said "it smells better already";
-Care Partner S said, "oh" "is this what" and Care Partner F shushed him/her and nodded to the camera. Care Partner S said, "no they need to hear this" and Care Partner F said "no they don't, not from me" "that is how we get in trouble";
-Care Partner S said it was hurting the resident. The resident yelled out several times as staff changed the dressing. Both staff continued to whisper as they applied the treatment.

Review of the resident's facility medical records, showed no documentation the house nurse or physician was notified of the wound odor.

During an interview on 1/29/25 at 4:36 P.M., Care Partner S said when providing care on 12/28/24 Care Partner F was shushing him/her because there was a wound that needed treatment and they were not supposed to do it, but he/she said we should do it anyway. Wound treatments require a nurse. The wound was circular in shape. It appeared dry. The wound bed was dark purple with redness around it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 20 There were odors. It was getting worse than it was on December 10th. If care partner sees a new wound, they are to report it to the nurse. If a wound is not getting better, they should report it to the nurse. He/She was in there one time with LPN I to assess the wound. He/She wiped it and put a patch on it. Observation of a video recording in the resident's room, recorded on 12/29/24 at 12:49 P.M., showed: -Care Partner S in the room with the resident in his/her Broda chair. He/She wrapped his/her arms around the resident's waste, picked him/her up, and placed him/her into bed; -Care Partner H entered the room. Care Partner S told the second staff that the resident stinks and he/she said something to (intelligible) and he/she was told "don't say nothing, we can get in trouble for talking about it"; -The staff assisted the resident into bed and were whispering. Care Partner H said you can smell it, that's how it smelled last night; -Staff provided personal care. During an interview on 1/27/25 at 7:21 A.M., Care Partner H said during the day, there is one nurse per house. He/She remembered the resident. He/She was not too familiar with the circumstances, but what he/she knows is, the family came in and the wound smelled bad. He/She was the one who first noticed the smell, the night before the family visited. He/She cannot say how long it was smelling before he/she noticed it. When he/she noticed the smell, it was a Saturday evening, the day before the resident went to the hospital. He/She noticed a bad smell when he/she assisted the resident to bed and the dressing was saturated and appeared black.	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 21 He/she had never cared for the resident before that night. LPN J, a nurse for a different house, is the nurse he/she reported it to the next day, on Sunday. Care partners are to report immediately if we notice worsening of a wound. Care partners do not document in the medical record. At 10:10 A.M., Care Partner H said he/she never laid eyes on the wound, but instead noticed the smell and the dressing was a black color. The next day, he/she informed LPN J what he/she noticed the prior evening. The family was there during lunch, about 11:30 A.M. and he/she let LPN J know about the odor and dressing about the same time the family arrived. Observation of a video recording in the in the resident's room, recorded on 12/29/24 at 1:30 P.M., showed: -A visitor sat at the resident's side. LPN J and Care Partner S entered the room. LPN J said he/she did not know what the treatment is, he/she was waiting to hear from LPN I; -LPN J assisted the resident to his/her right side. The brief was unsecured and no dressing was visible on the left hip/buttocks wound. The wound was large and black in color. The skin surrounding the wound was reddened. The reddened skin covered the entire left buttocks area; -LPN J exited the room to get supplies; -The video continued on another clip. Observation of a video recording in the in the resident's room, recorded on 12/29/24 at 1:35 P.M., continuation from a previous clip, showed: -Care Partner S at the resident's bedside. A visitor was in the room; -LPN J returned to the room with supplies and said he/she was trying the find what the doctor	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 22	A4777		

order was, but he/she did not see an order written, he/she was going to clean it real good, this wound needs to be changed every day. He/She cleansed the wound and said he/she needed to get some puss out, he/she could become septic (systemic infection) with all that infection there;
-Care Partner S grabbed a Duoderm dressing and LPN J said that was too small, he/she grabbed a bigger one. LPN J held an extra-large Duoderm dressing and said there is an infection;
-The video was continued on another clip.

Observation of a video recording in the in the resident's room, recorded on 12/29/24 at 1:41 P.M., continuation from a previous clip, showed:
-LPN J and Care Partner S were at the bedside and continued to provide care;
-The resident began to express pain with the cleansing of the wound. LPN J said he/she would stop for now. The extra-large Duoderm dressing was placed on the resident's left hip/buttocks.

During an interview on 1/28/25 at 1:44 P.M., LPN J said he/she was on call the weekend the family asked for the wound to be assessed, a care partner had him/her come in and look at the wound around noon. He/She assessed the wound, cleaned it, and put a treatment in place. The family contacted the nurse practitioner who then reached out to the house nurse, LPN I. The wound was black and had a foul odor. He/She asked staff about the wound and staff said the wound was not there on Thursday, but it didn't look like something that started that quickly. It was about a half dollar size. It smelled so bad that it could be smelled from outside the room. Staff need to look at wounds every day. The resident cannot communicate his/her needs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 23	A4777		

is dependent on staff to care for him/her. He/She cleaned the wound and put a dressing on it.

Review of the resident's nurse's note, dated 12/29/25 at 4:15 P.M., showed:
-This writer was called requesting assistance with sending resident to the ER for evaluation and treatment for a wound on his/her bottom. Upon arrival, family had left the building. Emergency medical services (EMS) called for transfer to the hospital;
-No documentation of the wound assessment, appearance, odors, or resident condition completed by LPN J.

Review of Resident #1's physician orders, dated 11/30/24, showed an order dated 12/29/24, to send the resident to the ER for evaluation and treatment.

During an interview on 1/27/25 at 9:08 A.M., the Administrator said when she came back from leave, it was brought to her attention that the resident's wound had become more excoriated (reddened), the hospice nurse and the house nurse had done his/her treatment, and it was not in that condition prior to the day the family voiced concerns. The resident was sent out to the hospital.

During an interview on 1/27/25 at 8:48 A.M., with Resident #1's representative, he/she staff informed him/her there was a wound, sometime in the fall 2024. Staff did not let him/her know the condition of the wound. Staff would update him/her when they were ordering various supplies, dressings, etc. for the hip wound, but did not say the wound was getting worse. The Visitor said he/she noticed the odor in short

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 24	A4777		

whiffs, he/she was not sure where it was coming from and primarily noticed it when the resident was up in the dining room. He/She did not know anything about the wound, so he/she did not think of that as a possibility of where the odor was coming from. On the day the resident went to the hospital, he/she was visiting. He/She got the whiff of the smell when the resident was at the table. He/She asked Care Partner H if the resident needed to be changed and Care Partner H said he/she does not need to be changed that the smell was his/her wound. He/She asked what Care Partner H was talking about. They went to the bedroom and there was a large wound. The smell was horrible. The other aide said, "oh yah, I smelled that last night". The nurse in the house was LPN I, but he/she was not working that day, so they summoned the on-duty nurse who responded very quickly. Staff in the house seemed to know about it. There have been a lot of concerns about care in this house and nursing care. Concerns were raised and brushed off.

During an interview on 1/27/25 at 9:46 A.M., the RCC said he/she did the investigation on the pressure ulcer concern for the resident. He/she never saw the wound. The resident went to the ER with a serious wound. Prior to that, he/she had a wound that healed, so the treatment orders were discontinued. No more treatment was ordered after that. When interviewing everyone, he/she was told there was a new order for a Duoderm dressing and that they were doing it every three days. The hospice nurse had put a new treatment on, the Thursday before the incident. He/She found an order initiated on December 12th to start the Duoderm again from hospice, but it was not carried over into the resident's chart. The house nurse is responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 25	A4777		

to get orders from the doctor and add them to the physician order sheet. Staff did not notice any odor or anything different about the wound on Saturday. On Sunday, there was an odor and the drainage had soaked through. Staff changed the dressing on Sunday. Staff noticed that it started draining and appeared worse than seen previously. It was sudden. He/She did not see any documentation about it, however. Normally, the bathing process identifies skin concerns. The resident is at risk for pressure ulcers with low weight and poor nutrition, so he/she should have had a weekly skin note. The RCC stated he/she expects facility staff to identify and report concerns. He/she expects hospice to report any concerns.

During an interview on 1/27/25 at 9:25 A.M., LPN I said he/she assessed the resident's wound every three days or if the dressing got dirty. The last time he/she assessed it was that Thursday before the resident went to the hospital. At that time, it was still just a little open area but not bad. No odors, no drainage. He/She could not recall the appearance of the wound bed. It was smaller than a penny. No staff ever reported concerns regarding the wound getting worse. Hospice was with him/her when he/she changed the treatment on that Thursday (12/26). He/she does not remember the hospice nurse's name.

Review of video footage on 12/26/24 showed a hospice nurse changing the resident's dressing. LPN I was not in the room at the time performing an assessment the wound or providing treatment.

During an interview on 1/27/25 at 2:09 P.M., the administrator said on December 4, 2024 the resident's order for Duoderm was discontinued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 26	A4777		

because the area to the left hip had healed. When the wound reopened on December 12, 2024, the treatment should have been added to the physician order sheet and there should have been weekly wound assessments. Documentation of the wound condition and appearance should have been documented when it first reopened as well. The nurse should document anytime the physician is called and when new orders are obtained. Any communication with the physician should be documented. If a wound had eschar, a Duoderm treatment every three days would not be appropriate. The wound would need a treatment order to be changed to daily and the wound would need to be observed by the nurse daily. If a care partner noticed a wound getting worse, they should report it to the nurse, no matter how minor it is. The care partner should notify the nurse immediately. If it is on the evening or night, when there is no nurse, the care partner should call the on-call nurse. The timeframe for the nurse assessing the area depends on the severity. It may only require a facetime conversation, or it might be able to wait until the nurse comes in the next day. For the resident, when the wound began to drain and had an odor, the on-call nurse should have been notified and come in immediately. The facility policy should be followed.

During an interview on 1/27/25 at 2:21 P.M., NP Q said he/she was calling on behalf of the resident's physician. He/She saw the resident around December 5, 2024, after being on leave. He/She was made aware that the resident had a small open area to the left hip that had since healed and the order for a Duoderm had been discontinued. The resident was at risk for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 27	A4777		

pressure ulcers. The facility did, at some point, ask for a foam type dressing for preventative measures. The next time they were made aware that there was a skin concern was on December 29, 2024, the day the resident was sent to the emergency room. No one reported the wound had reopened prior to December 29, 2024. When they called on December 29th, they reported that the resident developed a wound with eschar and that the surrounding skin was reddened. Once a wound develops eschar, it needs to have debridement (surgical removal of dead tissue) so it can heal. The resident was so frail, he/she needed a hospital setting to treat it. The resident was on hospice but after talking with the family, they said they wanted the wound to be treated aggressively, so they took him/her off hospice. Stage III and IV wounds can develop eschar and become unstageable. If a care partner noticed a large amount of drainage and odors from the wound, he/she would expect the nurse to be notified right away. Then the nurse needs to reach out to him/her or the physician. He/She should have been informed when the wound first reopened and immediately when it got worse. In the resident's condition, a wound could easily progress from a small open area to a large area quickly, in a few days. If the wound had eschar prior to her being notified, it would require a new treatment, a Duoderm would not be appropriate. During an interview on 1/29/25 at 2:55 P.M., NP Q said Care Partners and L1MAs are not qualified to complete wound care or assess wounds. The hospice documentation showing slough and drainage as early as December 12, 2024, is consistent with an unstageable pressure ulcer. If there is slough, a Duoderm is not an appropriate treatment for wound healing. He/She should have been informed so he/she could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 28 order an appropriate treatment to aide in wound healing. Review of the resident's hospital records, admission date 12/29/24, showed: -Encounter start date and time: 12/29/24 at 5:59 P.M.; -Admission diagnosis: Necrotizing fasciitis (a severe infection caused by bacteria. Early signs include red/warm/swollen skin that spreads quickly, fever and pain. Later symptoms include changes in skin color fatigue, puss oozing from the infected area, ulcers, blisters, or black spots on the skin); -History and physical: Resident with advanced dementia previously on hospice, presents to the ER from a memory care facility for evaluation of necrotic wound to the left hip. A visitor states he/she noticed a foul-smelling odor from the wound; -ER provider notes: Skin: Large decubitus ulcer noted to the left hip with area of dry gangrene (dead tissue caused by infection) and erythema (swelling). Foul-smelling odor; -Differential diagnoses: Osteomyelitis (inflammation of the bone caused by infection), infected decubitus ulcer, necrotizing fasciitis; -ER triage note: Patient to ER by EMS from nursing home for wound check to left buttocks. The family is concerned with the care that the patient is receiving at the facility. His/Her temperature is 100.8 (a temperature above 100.4 is consider a fever) on arrival to the ER; -Wound pressure ulcer left buttocks: Date first assessed 12/29/24 at 8:00 P.M. Present on admission. Pressure injury left buttocks orientation left, stage IV, 30% slough; -On 12/30/24 underwent incision and drainage (surgical procedure used to drain infection to	A4777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 29	A4777		

treat a collection of pus (abscess));
-On 12/30/24 computed tomography (CT, medical imaging using x-rays) exam: Large soft tissue wound of the left buttocks and hip region. Findings: Inferior left buttocks decubitus ulcer identified. Low density non-enhancing (tissue that does not respond to the imaging test) tissue or fluid extending form the decubitus ulcer to the level of the left ischium (lower and back portion of the hip bone). This may reflect fluid and/or necrotic soft tissue. There is gas identified in the superficial soft tissues in this region. This area measures 6.4 by 3.6 by 5.5 cm;
-12/30/24 at 12:02 A.M., wound left buttocks: circular in shape. Undermining (wound extends beyond the visible edges, creating a pocket or cavity under the skin). Peri-wound (skin surrounding the wound) erythematous (swollen), fragile, and painful. Measurements: 7 cm length by 6 cm width by 3 cm depth. Defined edges, unattached edges. Undermining depth: 1.5 cm. Vacuum dressing (used on highly draining wounds to pull excess moisture from the skin);
-12/30/24 at 10:55 A.M., operative report: excisional debridement of left ischial ulcer. Pre-op wound measurements: 4x6 cm. Post-op measurements 8x6x3 cm. A scalpel was used to excise the necrotic tissue circumferentially.

2. Review of Resident #3's ISP, dated 11/13/24, showed:
-Diagnoses included dementia, anxiety disorder, and depressive disorder;
-Primary care needs: Need help with grooming, bathing, toileting, and eating/drinking;
-Goal: Appearance and hygiene will remain intact and my need for dignity and privacy will be respected:
-Related challenges and preferences: Need

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 30	A4777		

assistance cleaning up after meals and snacks. Need assistance with bathing, grooming, and toileting;
-Approaches for care, support, and assistance: I will be assisted to bed for perineal care (peri-care, the cleaning and maintenance of the genital and anal areas) by staff after each meal.

Observation on 1/27/25 at 6:35 A.M., 6:49 A.M., and 7:02 A.M., showed the resident sat in a Broda chair (reclining wheeled chair) in the TV area.

During an interview on 1/27/25 at 6:48 A.M., Care Partner B said he/she works night shift, 7:00 P.M. through 7:00 A.M. His/Her job includes cleaning, laundry, and changing residents.

Observation on 1/27/25 at 7:57 A.M., showed the resident sat in his/her Broda chair in the dining room and ate breakfast. A staff person entered the dining area and assisted the resident to eat. At 8:35 A.M., staff propelled residents from the dining room to the TV room. Care Partner E said he/she will get the surveyor when he/she assists the resident to bed for care. At 11:55 A.M., the resident sat in the TV area. At 12:05 P.M., staff propelled the resident from the TV area to the dining room. At 12:48 P.M., the resident sat in the dining room as staff assisted with lunch.

Observation on 1/27/25 at 1:35 P.M., showed Care Partner E and Care Partner G propelled the resident to his/her room and transferred the resident into bed with the use of the Hoyer lift (full body mechanical lift). A strong smell of urine permeated the room. Staff unsecured the resident's brief. The resident had a large bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 31	A4777		

movement. The resident's brief was saturated with urine. The resident's buttocks, down to the mid thighs, and groin area were reddened. Staff cleansed the resident and the resident grimaced as staff wiped the reddened areas of the resident's skin. Staff applied skin protectant ointment and assisted the resident with a clean brief. Care Partner E said staff use a communication book, located in the kitchen, to know how to care for the residents. It will say who receives a shower, what the residents' care needs are, how they transfer and when they had their last bowel movement. When asked if he/she uses the ISP to know care needs, Care Partner E said he/she did not know what an ISP was, but he/she could provide the binder he/she uses.

Review of the communication binder, showed it included transfer needs, how much assistance is required for eating, but no documentation of incontinence care needs or risk for skin breakdown for the resident.

During an interview on 1/27/25 at 2:09 P.M., the administrator said the resident eats well, but is at high risk for skin tears and is incontinent. Care providers should check and clean residents in the morning, after each meal, and before bed. Night shift rounds every two hours.

*The higher classification merited due to the violation's effect on the resident(s).

NOTE: At the time of the inspection, the violation was determined to be at the class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the class I violation at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4777	Continued From page 32 the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level. MO00247574	A4777		
A4841	19 CSR 30-86.047(61)(A) Staffing Ration, Resident Care & Fire Safety Staffing Requirements. (A) The facility shall have an adequate number and type of personnel for the proper care of residents, the residents ' social well being, protective oversight of residents and upkeep of the facility. At a minimum, the staffing pattern for fire safety and care of residents shall be one (1) staff person for every fifteen (15) residents or major fraction of fifteen (15) during the day shift, one (1) person for every twenty (20) residents or major fraction of twenty (20) during the evening shift and one (1) person for every twenty-five (25) residents or major fraction of twenty-five (25) during the night shift. I/II Time Personnel Residents 7 a.m. to 3 p.m. (Day)* 1 3-15 3 p.m. to 9 p.m. (Evening)* 1 3-20 9 p.m. to 7 a.m. (Night)* 1 3-25 *If the shift hours vary from those indicated, the hours of the shifts shall show on the work schedules of the facility and shall not be less than six (6) hours. III	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 33 This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure an adequate number and type of personnel for the proper care of one resident (Resident #1) when staff, not qualified to provide wound care or wound assessments, provided care to the resident's wound. The sample was four. The census was 35. Review of the Position Description for job title Care Partner, showed: -Under supervision of house manager, provides primary care and assistance to residents with dementia. Interacts and engages residents though out the day to provide a person-centered care environment which is safe, clean, and meaningful for each resident. Assist residents with all facets of activities of daily living (ADLs) as well as leads residents in meaningful and fun activities. Provides assistance to residents as needed throughout the day; -Every care partner is a universal worker. A universal worker will do everything needed including cooking, cleaning, laundry, group and individual activities, passing medications, bathing, toileting, grooming, etc. It is also vital to do rounds regularly to ensure the safety of each resident; -Personal Care: Perform basic nursing/personal care services to residents including but not limited to bathing, shampooing, grooming, toileting, giving hygiene and comfort measures as well as feeding and hydrating residents as necessary. Keep management informed of changed in resident condition, family concerns,	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 34 and/or changes in status; -General: Is familiar with residents ISP and life story; -Qualifications: Med level 1, certified medication aide, or certified nursing assistant. First aide certified; -The job description did not include wound care or wound assessment. Review of Resident #1's ISP, dated 11/8/24, showed: -Diagnosis: Alzheimer's disease; -Primary care needs: Total assist with activities of daily living (ADLs), including bathing, dressing, grooming, toileting, and eating; -Abilities: Not able to follow simple directions. Oriented to self only. Non-ambulatory. Incontinent of bowel and bladder. Require assist of one with transfers. Currently on hospice for dementia; -Challenges: Not able to make needs known verbally, look for nonverbal cues; -No goal or care interventions for the risk of pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction); -No goal or care interventions added for the presence of a pressure ulcer. Review of the resident's Physician Orders, dated 11/30/24, showed: -Diagnoses of constipation and recurrent seizures; -A treatment order dated 11/7/24, with lines drawn across the order and "D/C'd" handwritten on the order (no initials or date on the entry), to cleanse wound on left hip and change Duoderm (hydrocolloid dressing, used on low to moderately draining wounds that are not	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 35	A4841		

infected) every 3 days until healed;
-No further treatment orders obtained in the month of December 2024;
-No order for weekly wound or skin assessments.

Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:23 A.M., showed:
-The resident in bed on his/her back. Care Partner M and Care Partner S in the room at his/her side and provided personal care;
-The Care Partners looked closely at the left hip/buttocks area and talked amongst each other. Care Partner S exited the room while Care Partner M waited at the bedside;
-The video was continued on another clip.

Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:29 A.M., continuation from a previous clip, showed:
-Care Partner M stood and waited by the resident's side;
-Care Partner S walked over to the table in the room and said, "the patch thing is right here", but he/she did not want to put it on him/her if it is not supposed to be on and he/she is not supposed to. Care Partner S picked up a dressing labeled Hydrochloride dressing (Duoderm);
-Care Partner S walked back over to the resident and looked closely at his/her left hip/buttocks area and said he/she was going to ask. He/She then exited the room while the Care Partner M waited in the room;
-The video was continued on another clip.

Observation of a video recording in the resident's room, recorded on 12/10/24 at 11:41 A.M., continuation from a previous clip, showed:
-Care Partner S entered the room and said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 36	A4841		

he/she was told they could go ahead and put it on;
-Level one Medication Aide (L1MA) F entered the room, left briefly to answer the doorbell, and then returned;
-L1MA F told the Care Partners to just put some cream and put a band aid on it. L1MA F picked out an outfit for the resident and the Care Partners got the resident dressed;
-No Nurse assessed the left hip or applied a treatment.

During an interview on 1/27/25 at 9:25 A.M., LPN I said the resident had a wound on his/her hip. It started out as a red area; it opened really small. The doctor ordered a Duoderm every three days. This was around Dec 14th.

Review of the resident's medical record showed no treatment or assessment orders for the resident's wound after the previous order was discontinued on 12/4/24.

Review of the resident's medical record showed no documentation of facility staff assessing or treating the wound after the previous order was discontinued on 12/4/24.

Observation of a video recording in the resident's room, recorded on 12/28/24 at 10:50 A.M., showed:
-Care Partner S stood at the resident's side and provided care;
-Care Partner F sprayed an unidentifiable spray into the air throughout the room;
-Care Partner S looked closely at the resident's wound and made a facial grimacing. The two staff whispered between each other;
-Care Partner F said "it smells better already";

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 37 -Care Partner S said, "oh" "is this what" and Care Partner F shushed him/her and nodded to the camera. Care Partner S said, "no they need to hear this" and Care Partner F said "no they don't, not from me" "that is how we get in trouble"; -Care Partner S said it was hurting the resident. The resident yelled out several times as staff changed the dressing to the left hip/buttocks area. Both staff continued to whisper as they applied the treatment. During an interview on 1/29/25 at 4:36 P.M., Care Partner S said when providing care on 12/28/24, Care Partner F was shushing him/her because there was a wound that needed treatment and they were not supposed to do it, but he/she said we should do it anyway. Wound treatments require a nurse. The wound was circular in shape. It appeared dry. The wound bed was dark purple with redness around it. There were odors. It was getting worse than it was on December 10th. If a care partner sees a new wound, they are to report it to the nurse. If a wound is not getting better, they should report it to the nurse. During an interview on 1/28/25 at 1:44 P.M., LPN J said he/she was on call the weekend the family asked for the wound to be assessed, the weekend of December 28 and 29, 2024, a care partner had him/her come in and look at the wound around noon. He/She assessed the wound, cleaned it, and put a treatment in place. The family contacted the nurse practitioner who then reached out to the house nurse, LPN I. The wound was black and had a foul odor. It was about a half dollar size. It smelled so bad that it could be smelled from outside the room. Staff need to look at wounds every day. The resident	A4841		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27755	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOLAN MEMORY CARE AT CALAIS	1225 TENNANT ROAD SAINT LOUIS, MO 63146

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4841	Continued From page 38 cannot communicate his/her needs and is dependent on staff to care for him/her. He/She cleaned the wound and put a dressing on it. During an interview on 1/29/25 at 2:55 P.M., the Nurse Practitioner (NP) said Care Partners and L1MAs are not qualified to complete wound care or assess wounds. The hospice documentation showing slough and drainage as early as December 12, 2024, is consistent with an unstageable pressure ulcer. If there is slough, a Duoderm is not an appropriate treatment for wound healing. She should have been informed so she could order an appropriate treatment to aide in wound healing. During an interview on 1/29/25 at 4:30 P.M., the Administrator said care partners and L1MAs are not qualified to assess wounds or complete treatments. They can only provide first aide. Once she became aware of the concerns with the resident's wounds, she started in-servicing staff. She is educating the nurses on their responsibility for skin assessments and to ensure the Care Partners are providing care as required. Staff should be reporting concerns with wounds to the nurses. They should not feel like they will get in trouble.	A4841		

PLAN OF CORRECTION

Provider/Supplier Name:	Dolan Memory Care Calais
Street Address, City, Zip:	1225 Tennant Rd. St. Louis MO 63146
Date of Survey:	1/27/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may have discussed this plan of correction. In addition, preparation and submission of this plan of correction does not constitute agreement of any kind by the facility as to the truth of any facts alleged or correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to resolution of this matter solely because the requirements under state law mandate submission of a plan of correction. The submission of the plan of correction should in no way be construed as agreement with the allegations of non-compliance or admissions by the facility.	
A4754	Individual Service Plan - Develop	
	The corrective action to be taken will be to update Residents #2 ISP will be updated with a goal and intervention for incontinent care or need for perineal care.	2/17/25
	Other Residents charts will be reviewed and updated if necessary.	3/17/25
	Upon developing ISP, the nurse manger will make sure the "Goals and Interventions" section for incontinent care or need for perineal care is appropriate to the resident's needs prior to meeting with the family.	Ongoing
	Resident care coordinator will review all ISPs on a quarterly basis.	Ongoing
	Resident # 1 no longer resides at the facility.	
A4777	Proper Care Per Individual Service Plan	
	Resident # 1 no longer resides at the facility.	

	The corrective action to be take will be to be in-serviced Staff on when residents should be provided incontinent care or perineal care; upon rising, after breakfast, lunch, dinner and PRN.	2/18/25
	In-service Nurse Manager on prevention of Pressure wound • Assessment upon admission an readmission, change in condition • Documentation of wound ex. Measurement, odor, color of tissue • Chart weekly with any change or treatment order	
	Staff will be updated by Nurse manager of any changes/updates to the ISP as needed.	Ongoing
	Ensure Nurse are reporting to physician and family o any changes in orders or wound change. Then report to Administrator and Resident Care Coordinator (RCC)	
	Administrator is responsible for training the Nurse manager and they in turn will train the care partners with administrator to follow up.	
	Administrator to check each home for wounds and start a charting system for follow-up weekly. Administrator & RCC to start sweep	
	New staff will be orientate to wound management upon orientation in home	
A4841	Staffing Ration, Resident Care & Fire Safety	
	The corrective action to be taken will be to in-service staff on wound care vs. First Aid Care of residents. What Care Partners are able to do (first aid) and what the Nurse Manager role is with wounds treatments.	2/18/25
	Train Care Partners of when and what to report to nurse manager when bathing and providing perineal care of Skin assessing.	Ongoing
	In-service Nurse Manager on prevention of Pressure wound • Assessment upon admission an readmission, change in condition • Documentation of wound ex. Measurement, odor, color of tissue • Chart weekly with any change or treatment order	
	Staff will be updated by Nurse manager of any changes/updates to the ISP as needed.	
	Ensure Nurse are reporting to physician and family o any changes in orders or wound change. Then report to Administrator and Resident Care Coordinator (RCC)	

	Administrator to check each home for wounds and start a charting system for follow-up weekly. Administrator & RCC to start sweep	
	New staff will be orientate to wound management upon orientation in home	
	Resident #1 no longer resides at the facility.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.