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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow acceptable nursing practice when staff left medication in one resident's room who did not have a physician order for self-administration or for medications to be left at the bedside (Resident #15). The sample was 15. The census was 58. Review of the facility's Self-Administration of Medications policy, revised, December, 2016, showed: -The residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; -As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident; -In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including the resident's: -Ability to read and understand medication label; -Comprehension of the purpose and proper dosage and administration time for his or her medications; -Ability to remove medications form a container and to ingest and swallow the	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Knittel, LNHA | TITLE: Administrator | (X6) DATE: 4/27/25

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.

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medication;
-Ability to recognize risks and major adverse consequences of his or her medications;
-If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications;
-The staff and practitioner will ask residents who are identified as being able to self-administer medications whether they wish to do so;
-The staff and practitioner will document their findings and the choices of resident's who are able to self-administer medications;
-The self-administering resident and the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken;
-If the resident is able and willing to take responsibility for documenting their self-administration of medications, the resident will be instructed on how to complete a record indicating the administration of the medication;
-Self-administration medications must be stored in a safe and secure place and is not accessible to other residents;
-Staff shall identify and give the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party;
-Nursing staff will review the self-administration medication record (MAR) on each nursing shift, and they will transfer pertinent information to the MAR kept at the nurse's station, appropriately noting that the doses were self-administered;
-The staff and practitioner will periodically re-evaluate a resident's ability to continue to self-administer medications.

Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated

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assessment instrument completed by facility staff, dated 12/9/24, showed:
-Cognitively intact;
-Diagnoses included heart failure, heart disease, diabetes, and respiratory failure;

Review of the resident's care plan did not address if the resident was identified as being able to self-administer medications or medications could be left at the resident's bedside.

Review of the resident's medical record showed, no self-administration of medication assessment completed.

Review of the resident's physician order sheets (POS), dated 4/9/25, showed;
-No order the resident could self-administer medications;
-No order for any medication to be left at the bedside;
-No order for Afrin (nasal decongestant) nasal spray;
-No order for Voltaren ointment (ointment for pain relief);
-No order for Thera-Worx muscle pain relief;
-An order dated, 3/14/25, for saline (salt water)nasal solution, use one a day as needed for nasal congestion;
-An order dated, 3/14/25, for Flonase nasal allergy spray, 50 micrograms (mcg), one spray each nostril, daily.

Observation and interview on 4/7/25 at approximately 10:30 A.M. and on 4/8/25 at 12:45 P.M., in the resident's room, showed on the bedside table next to the resident's bed, were three bottles of Afrin nasal spray, one half tube of Voltaren ointment, three large bottles of

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Thera-Worx muscle pain relief, one bottle of saline nasal spray, and one bottle of Flonase nasal spray. The resident said he/she watched TV and saw the commercial for the pain relief medication. He/She would then call his/her physician about the medication and express his/her desire to use the medication. The resident would instruct his/her private caregiver to purchase the medications. The resident was pretty sure his/her physician had no idea what medications the resident had at the bedside. The resident said he/she used the Afrin nose spray at least once a day to help with his/her anxiety. The resident was aware that was not what Afrin was used for. He/She thought the medication was okay to leave at the bedside because it could be purchased at a store without a physician order.

During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse B said she was not aware of any type of resident self-administering assessment. If resident medications were at the bedside, there should be a physician order stating the resident could have medications left at bedside. If there was no physician order for the medication that was at the bedside, it should be removed from the resident's room.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing said there were no residents in the building who could self-medicate. It was expected for staff to remove the medication from the room if there was not a physician order for the medication or for medications to be left at the bedside. She expected staff to complete the self-administration assessment if the resident requested to self-administer medications. The medication would have to be in a secure box so other residents didn't come into the room and

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F 554	Continued From page 4 remove it. They had instructed the resident in the past that he/she could not have medications at the bedside without approval of the physician.	F 554		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect,	F 574		

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exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;
(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
(v) Contact information for the Medicaid Fraud Control Unit; and
(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to provide accessible information on the location of the State Long-Term Care Ombudsman program or the State Survey Agency hotline number that was readily available

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to residents in the facility without assistance. The census was 58.

Observation throughout the survey on 4/7/25 through 4/9/25, showed the information regarding the State Agency hotline number and Ombudsman program was not visible throughout the facility.

During a group interview on 4/8/25 at 11:00 A.M., five residents, who the facility identified as alert and oriented, attended the group meeting. All residents said they did not know where the State Agency hotline number or the Ombudsman information was posted.

During an interview on 4/9/25 at 8:18 A.M., the Director of Nursing (DON) said she was not sure where the information was posted, but it should be accessible to residents and families. They were likely posted in the break room or social worker's office. At 8:25 A.M., the DON pointed out the sign where the Ombudsman's information was posted. The sign was in the lobby to the left of the front entrance, behind a wall. The DON said the information was not accessible to residents and families.

During an interview on 4/9/25 at 8:45 A.M., the Activity Director brought a poster board with the activity schedule. At the bottom of the board was the State Agency Hotline number and Ombudsman's information. She said the number on the board for the hotline was the wrong number, and she corrected it today. The boards were placed outside of each activity room daily. Residents who attended activities in the activity room had access to the information.

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F 574	Continued From page 7 During an interview on 4/9/25 at 11:40 A.M., the Administrator and DON said the State Agency Hotline number and Ombudsman's information was not accessible to all residents and families. The Administrator would expect the information to be accessible.	F 574		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure activities of daily living (ADL) were provided to three of 15 sampled residents. The facility failed to ensure one resident was toileted in a timely manner (Resident #10), failed to ensure two residents received nail care (Resident #15 and Resident #42), and failed to ensure one resident received routine showers (Resident #42). The census was 58. Review of the facility's ADL policy, dated 3/2018, showed: -Policy statement: residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene; -Policy implementation: residents will be provided with care, treatment and services to ensure that ADLs do not diminish unless the circumstances	F 677		

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of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable;
-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene, mobility, toileting, dining, and communication.

1. Review of Resident #10's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/21/25, showed:
-Cognitively intact;
-Dependent on staff for toileting hygiene;
-Required maximum assist for toilet transfers;
-Diagnoses included hip fracture, renal disease and depression.

Review of resident's care plan, in use at the time of survey, showed:
-Focus: The resident has bowel incontinence related to decreased mobility and muscle weakness;
-Interventions: Check the resident every two hours and assist with toileting as needed;
-Provide a bedpan or a bedside commode. Take the resident to the toilet the same time everyday the resident has a bowel movement.

Observation and interview on 4/7/25 at 9:07 A.M., showed the door to the resident's room was open and he/she could be heard yelling loudly, "Please! Someone help me! I need to go to the bathroom! Hello!" The resident sat in his/her wheelchair in his/ her room with a Hoyer (a specialized machine to used to transfer residents) pad underneath. The resident said staff got him/her up in the wheelchair about a half hour ago and

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said they would be right back because the resident needed to use the bathroom. The resident said he/she could not get to the bathroom by himself/herself. The resident said he/she would turn his/her call light on and call the front desk. When that didn't work and staff didn't come in, he/she would yell loudly. The resident said staff would frequently turn his/her light off without addressing his/her needs. The resident had an odor of bowel movement. The resident said he/she rarely got to use the toilet due to staff taking too long. The resident said he/she would just end up "messing" himself/herself and sitting in his/her own bowel movement. At 9:15 A.M., the resident's door was open and he/she could be heard from the hall yelling, "Please help! I need to go to the bathroom!" Certified Nursing Assistant (CNA) C entered the resident's room and asked the resident, "What is wrong?" The resident informed CNA C that he/she had to have a bowel movement and may have already been incontinent. CNA C left the resident's room and said he/she had to get more help. At 9:35 A.M., the resident was heard cursing and yelling, "Help!" from the hallway. The Resident Care Supervisor entered the resident's room and asked the resident, "Why are you yelling?" The resident said to the Resident Care Supervisor that he/she had to go to the bathroom. The Resident Care Supervisor left the room. At 9:45 A.M., CNA C, CNA D and the Resident Care Supervisor entered the resident's room. CNA D said to the resident, "I think you have already had a bowel movement and we will have to get you in bed to clean you up." At 10:01 A.M., the Resident Care Supervisor and CNA D transferred the resident to his/her bed using the Hoyer lift. The resident's brief was removed by CNA D and the resident was incontinent of a large amount of

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brown soft stool. CNA D and the Resident Care Supervisor provided perineum care (cleansing of the rectum and genitals, peri-care) and reapplied a clean brief to the resident. The resident said he/she was exhausted.

During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse (LPN) B said staff should explain to the resident why it may take longer than expected to provide care to the resident. The staff should not tell the resident they will be right back and not return in a timely manner. The resident should only have to wait ten to fifteen minutes to use the restroom. It shouldn't take a lot of time to get another staff member to assist with a Hoyer transfer. Leaving the resident in a soiled brief for more than ten to fifteen minutes was unacceptable.

During an interview on 4/9/25 at approximately 10:00 A.M., CNA E said a resident should not have to wait more than ten minutes to use the restroom or get cleaned up. Staff should be making rounds on residents frequently to anticipate the residents' needs. Staff should not tell a resident they will be right back and not return in a timely manner.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing (DON) said the resident should not have to wait more than five minutes to use the restroom. It should only take a few extra minutes to have another staff member assist with a Hoyer lift transfer. The resident sitting in the wheelchair with a soiled brief for an extended amount of time was unacceptable. She would expect staff to clean incontinent residents in a timely manner. Staff should leave the resident's call light on until the resident's needs are met.

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2. Review of the Resident #15's quarterly MDS, dated 12/9/24, showed:
-Cognitively intact;
-Required maximum assist from staff for toilet hygiene, bathing hygiene, and putting on and taking off foot wear;
-Diagnoses included heart failure, heart disease, diabetes and respiratory failure.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: the resident has diabetes;
-Intervention: weekly skin assessments with special attention to feet.

Review of the resident's medical record, showed:
-No skin assessments for February 2025 were completed;
-The resident's skin assessments, dated, 3/6/25 and 3/27/25, did not address the resident's feet or toenails;
-No further skin assessments, for March, 2025, were completed.

Observation and interview on 4/8/25 at 7:45 A.M. and 4/9/25 at 7:47 A.M., showed the resident lay in bed and his/her feet were exposed. The resident had a slight amount of swelling to his/her feet. Both feet were very red with some dryness. The resident's left foot toenails were approximately one half of an inch long, thick and jagged. The resident's large toenail on his/her left foot was approximately one inch long and pointed. The resident's right foot toenails were thick, jagged and short in length. The resident said he/she had a lot of right heel pain. The resident had never seen a podiatrist (foot doctor) and said staff seemed to "avoid" his/her feet.

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He/She had asked staff a couple of times to be placed on the podiatrist list over the last several months. The resident said his/her toenails had not been trimmed by staff and just broke off when they got long.

During an interview on 4/9/25 at 8:50 A.M., LPN B said the resident had a private caregiver who completed the resident's bathing. LPN B said the skin assessments for the residents were weekly and it included a head-to-toe assessment. LPN B did not normally add any assessment about the resident's toenails on the skin assessment. The podiatrist could only trim diabetic residents' nails. The nurses should let the Social Service Director (SSD) know when a resident needed to be seen by a podiatrist.

During an interview on 4/8/25 at 9:30 A.M., the SSD said the resident lived at the facility for years and had just signed a podiatry consent for treatment on 4/7/25. The resident had been added to the podiatry list for April, 2025. The nurses were expected to complete an assessment of the residents' feet and then let her know if a resident needed to be seen by the podiatrist.

3. Review of the Resident #42's quarterly MDS, dated 3/18/25, showed:
-Cognitively intact;
-Required maximum assist from staff for toilet hygiene, bathing hygiene, and putting on and taking off foot wear;
-Diagnoses included type two diabetes, morbid obesity, end state renal disease (kidney failure) and muscle weakness.

Review of the resident's care plan, dated 9/13/24,

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showed:
-Focus: resident has an ADL self-care performance deficit;
-Goal: resident will improve current level of function in ADLs through the review date;
-Interventions: check nail length and clean on bath day and as necessary. Report any changes to the nurse. The resident requires assistance by one staff with bathing/showering. Encourage the resident to use call light for assistance.

Observation on 4/07/25 at 11:06 A.M., showed the resident in his/her room. The resident's hair was disheveled and appeared oily.

Observation on 4/08/25 at 11:27 A.M., showed the was resident in bed and his/her feet were exposed. The resident's toenails were thick, yellow in color, and various lengths. The resident's hair was disheveled and appeared oily.

During an interview on 4/8/25 at 11:46 A.M., the resident said it had been at least four months since his/her last shower. He/She said he/she does not sweat a lot so it did not bother him/her as much as if he/she sweated more. But, he/she did feel gross. The resident said he/she would like to receive at least two showers a week. He/She had not seen a podiatrist since he/she arrived to the facility.

During an interview on 4/9/25 at 8:58 A.M., LPN B said he/she would expect the resident to be on the podiatrist list for his/her nail care due to being diabetic. He/She would expect the resident to receive at least two showers or bed baths a week. It was not acceptable for a resident to go four months without a shower. He/She said the resident received his/her showers on the evening

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F 677	Continued From page 14 shift. During an interview on 4/9/25 at 10:44 A.M., the DON said a toenail assessment should be included in the weekly skin assessment. She would expect the nursing staff to inform the SSD that a resident needed to be seen by a podiatrist. Nurses could trim diabetic residents' toenails. She would expect residents to receive at least two to three showers a week. She would expect staff to document if a resident refused a bath/or shower. During an interview on 4/9/25 at 11:43 A.M., the Administrator said she expected ADL care to be provided timely and per the scheduled times. She expected residents to receive at least two showers or bed baths a week. She expected staff to provide nail care or refer the resident to a podiatrist if needed.	F 677		
	MO00252290			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one resident	F 684		

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had physician's orders for a wound dressing (Resident #42) and failed to ensure skin assessments detailed all skin concerns (Residents #42 and #15). The sample was 15. The census was 58.

Review of the facility's skin assessment protocol, dated 12/3/20, showed:
-A skin assessment is to be completed weekly on all residents by the charge nurse. If a new pressure ulcer develops, the initial wound assessment must be done by the charge nurse. Prior to any other assessments, consultations or obtaining orders from the physician or nurse practitioner wound consultant, the charge nurse must document the following in the resident's electronic medical record (EMR): location of pressure ulcer, stage, length, width and depth, pain, and mobility status;
-The physician must then be notified and a treatment order obtained and/or an order for the resident to be seen and treated by the wound nurse practitioner consultant.

1. Review of Resident #42's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 3/18/25, showed:
-Cognitively intact;
-Requires maximum assist from staff for toilet hygiene, bathing hygiene, and putting on and taking off foot wear;
-Diagnoses included type two diabetes, morbid obesity, end state renal disease (kidney failure), and muscle weakness.

Review of the resident's care plan, dated 9/13/24, showed:
-Problem: the resident has diabetes;
-Goal: resident will have no complications from

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diabetes through the review date;
-Intervention: weekly skin assessments with special attention to feet.

Review of the resident's physician's orders, dated April 2025, showed no active orders for wound treatments for the resident's right lower leg.

Review of the resident's most recent skin assessment, dated 3/7/25, showed scattered scabbed areas all over the body from scratching.

During observation and interview on 4/8/25 at 11:25 A.M., the resident's left and right feet were scaly and had flakes of dry skin. Both of the resident's lower legs had deep crevices of dry skin and appeared leather-like. The resident's skin on both of his/her lower legs was discolored and had a purple hue. The resident's right lower leg had an undated white, border gauze (a specialized dressing). The dressing had a large shadow of dark maroon fluid. Licensed Practical Nurse (LPN) B removed the dressing slowly with wound cleaner. The dressing had adhered to the wound. When the dressing was removed, it showed maroon and yellow fluid on it. The dressing and wound had an odor. The wound appeared approximately quarter size and the wound bed was beefy red and moist. The resident said he/she had a history of vascular ulcers (open skin sores caused by poor blood flow) and said it had been months since the dressing was put on his/her leg. LPN B said there was no order for the treatment to the resident's right lower leg.

2. Review of Resident #15's quarterly MDS, dated 12/9/24, showed:
-Cognitively intact;

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-Requires maximum assistance from staff for toilet hygiene, bathing hygiene, and putting on and taking off foot wear;
-Diagnoses included heart failure, heart disease, diabetes and respiratory failure.

Review of the resident's care plan, in use at the time of survey, showed:
-Problem: the resident has diabetes;
-Intervention: weekly skin assessments with special attention to feet.

Review of the resident's skin assessments, showed:
-No skin assessments dated 2/1 through 2/28/25 were completed;
-A skin assessment, dated 3/6/25: Observation: Groin, slightly red; Both arms and legs have scratches and scabs;
-A skin assessment, dated 3/27/25: Skin intact: Yes; Areas of concern: No;
-The resident's skin assessments, dated 3/6/25 and 3/27/25, did not address the resident's feet;
-No further skin assessments, dated March, 2025, were completed.
-No skin assessments for April, 2025, were completed.

Observation and interview on 4/7/25 at 11:10 A.M., 4/8/25 at 7:45 A.M., and 4/9/25 at 7:47 A.M., showed the resident lay in bed with his/her feet exposed. The resident had a slight amount of swelling to his/her feet. Both feet were very red with some dryness. The resident said he/she had a groin rash that staff had been putting on some type of powder. The resident lifted his/her abdomen and exposed his/her groin. A slight red rash to the resident's bilateral (both) groin areas were present.

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F 684	Continued From page 18 During an interview on 4/9/25 at 8:50 A.M., LPN B said the resident has a private caregiver who completes the resident's bathing. LPN B said the skin assessments for the residents are weekly and it includes a head-to-toe assessment. Any skin condition should be on the skin assessment. During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing (DON) said the nurses are expected to complete weekly skin assessments. Any skin condition is expected to be added to the resident's skin assessment. The previous skin assessment should be reviewed prior to completing the skin assessment to determine if the skin condition is improving or deteriorating. If the current treatments orders are not working, she expected staff to reach out to the Wound Nurse and the physician. The DON expected dry skin to be documented on the skin assessment. She expected physician's orders to be in place for all skin treatments. She expected wounds to be treated per physician's orders. The DON expected wound treatments to be dated. During an interview on 4/9/25 at 11:15 A.M., the Administrator said she expected staff to follow the skin assessment policy. She expected physician's orders to be in place for all wounds. She expected staff to ensure residents' skin conditions are documented on the skin assessment.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		

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F 686	Continued From page 19 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) 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. This REQUIREMENT is not met as evidenced by: 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) had necessary treatments and services to promote healing (Resident #10). The sample size was 15. The census was 58. Review of the facility's Pressure Ulcer and Skin Breakdown policy, revised 3/26/14, showed: -The nursing staff and or Wound Nurse Practitioner will assess and document an individual's significant risk factor for developing pressure sores; -The wound nurse shall describe and document and report the following: -Full assessment of pressure sore including, location, stage, length, width, depth and presence of drainage or necrotic (dead) tissue; -Pain assessment; -The resident's mobility status; -Current treatments, including support surfaces; -All active diagnosis; -The nursing staff will examine the skin of a new admission for ulcerations or alterations of the	F 686		

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skin;
-The Wound Nurse Practitioner will assist the staff to determine the etiology (cause) and characteristics of the skin alteration.

Review of Resident #10's admission Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated, 2/21/25, showed:
-Cognitively intact;
-Dependent on staff for toileting hygiene;
-Requires maximum assist bed to chair transfers and rolling left to right;
-Diagnosis included hip fracture, renal disease and depression.

Review of the resident's medical record, showed:
-Admission date: 2/14/25;
-Discharge date: 3/31/25;
-Re-admission date: 4/4/25.

Review of the resident's baseline care plan, dated 4/4/25, showed it did not address the resident's skin condition.

Review of the resident's comprehensive care plan, in use at the time of survey, showed:
-Focus: The resident has potential impairment to skin integrity due to fractured left hip and decreased mobility;
-Interventions: Follow facility protocols for treatment or injury. Avoid scratching and keep hands and body parts form excessive moisture. Keep the skin clean and dry. Encourage good nutrition and hydration. Monitor and document location, size, and treatment of skin injury. Report abnormalities, failure to heal or signs of infection to physician. Weekly treatment documentation to include measurement of each area of skin

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breakdown's width, length, depth type of tissue and exudate (pus)and any other notable changes or observations.

Review of the resident's Braden Scale (a tool used to assess a resident's risk of developing a pressure wound), dated 4/4/25, showed the resident scored 15, indicating at risk.

Review of the resident's admission nursing assessment, dated 4/4/25 at 4:30 P.M., showed:
-Skin assessment:
-Integrity: Intact and bruising; Site: Sacrum (tailbone);
-No further description of the skin condition was addressed.

Review of the resident's physician order sheet (POS), showed:
-An order, dated 4/7/25, apply barrier cream to bottom for redness after each incontinent episode;
-An order dated 4/7/25, refer to outside wound company for wound care;
-An order, dated 4/8/25, cleanse area to bottom and apply Allevyn (a specialized wound dressing) or border gauze (a specialized wound dressing) as needed for shearing (friction on the skin that causes superficial skin removal);
-An order, dated 4/9/25, cleanse area to bottom and apply mupirocin (antibiotic ointment) cover with Allevyn dressing or border gauze, every Tuesday, Thursday, and Saturday for wound care;
-An order, dated 4/9/25, cleanse area to bottom and apply mupirocin, cover with Allevyn dressing or border gauze as need for shearing;
-No order for Skin Prep (a type of liquid that is used to prepare skin before applying an adhesive

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by forming a protective barrier) to be applied to the wound was noted.

During observation and interview on 4/7/25 at 10:01 A.M., the Resident Care Supervisor and Certified Nursing Assistant (CNA) D transferred the resident to his/her bed using the Hoyer lift (mechanical lift). The resident's brief was removed by CNA D and the resident was incontinent of a large amount of brown soft stool. On the resident's upper right buttock was a dark maroon colored, non-blanchable (returns to normal color after pressure released), moist, open wound. The wound was approximately the size of a quarter. The Resident Care Supervisor verified there was no dressing on the resident's buttock or that the dressing fell off in the resident's brief. The Resident Care Supervisor said she was going to inform the nurse about the wound on the resident and left the room. The Resident Care Supervisor returned to the room and continued with the resident's perineum care (peri-care, cleansing of the rectum and genitals) with CNA D. At 10:25 A.M., Licensed Practical Nurse (LPN) H entered the room. The resident was turned to his/her left side by the Resident Care Supervisor. LPN H sprayed the resident's wound with Skin Prep and dabbed the area of the wound with a gauze. LPN H then applied a border gauze and did not date the dressing.

Review of the facility's Wound Nurse progress notes, dated 4/8/25, showed the resident has a right buttock Stage Two (a partial thickness skin loss presenting as a shallow ulcer and a red or pink wound bed). Wound bed: pink and moist; Measurements: 1.5 centimeters (cm) length, 2.5 cm wide, and 0.5 cm depth.

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During an interview on 4/9/25 at 8:50 A.M., LPN B said on admission the description of the wound should be added to assessment. If there was any type of wound, nursing staff usually would use the facility phone and take a picture of it and send it to the Wound Nurse. The Wound Nurse would give further orders and recommendations. When the admission orders were being verified the nurse could describe the wound to the best of his/her ability to obtain orders. When any type of skin condition was found, orders should be obtained as soon as possible. All treatments that require a dressing should have a date on it when it was completed.

During an interview on 4/8/25 at 8:54 A.M., the Wound Nurse said today was the first time she saw the resident. The Wound Nurse said the resident had one right medial (towards the middle of the body) buttock Stage Two pressure injury wound. When she examined the resident there was no dressing on the resident's buttock pressure wound, only barrier cream.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing said the nurses did not stage a wound when first identified. That was the responsibility of the Wound Nurse. The nurses were expected to describe the wound and obtain measurements when the wound was newly identified in the resident's medical record. The nurse should have obtained orders for the wound when he/she was verifying admission orders with the physician. Interventions were expected to be in place such as frequent turning and any off loading devices. She would expect the skin assessment to be completed accurately and to include if any changes occurred with the wound. Skin assessment were done weekly and as

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F 686	Continued From page 24 needed. She would expect all treatments to be dated. The nurses could also send a picture to the Wound Nurse using the facility phone and obtain orders and recommendations. MO00252290	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident received adequate assistance to prevent accidents when staff transferred one resident improperly (Resident #10). The sample size was 15. The census was 58. Review of the facility's Safe Lifting and Movement of Residents policy, revised July 2017, showed: -In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriated techniques and devices to lift and move residents; -Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of the residents; -Manual lifting of residents shall be eliminated when feasible;	F 689		

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F 689	Continued From page 25 -Nursing staff, in conjunction with the rehabilitation staff shall assess individual residents' needs for transfer assistance on an ongoing basis; -Staff will document resident transferring and lifting needs in the care plan; -Such assessment shall include: -Resident preferences for assistance; -Resident's mobility (degree of dependency); -Resident's size; -Weight-bearing ability; -Cognitive status; -Whether the resident is usually cooperative with staff; -The resident's goal for rehabilitation, including restoring or maintaining functional abilities; -Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, slider board) and mechanical lifting devices; -Mechanical lifting devices shall be used for heavy lifting including lifting and moving residents when necessary. Review of the facility's Gait Belt policy, dated 6/1/01, showed: -Gait belts are used to promote safety in transfer, ambulation, and balance activities; -Gait belts must be used at all times when performing balance activities and while transferring or ambulating patients as a part of the patient's plan of care or when safety dictates. Review of Resident #10's, admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/21/25, showed: -Cognitively intact;	F 689		

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F 689	Continued From page 26	F 689		

-Dependent on staff for toileting hygiene;
-Required maximum assist for toilet transfers;
-Diagnosis included hip fracture, renal disease, and depression.

Review of the resident's care plan, in use at the time of survey, showed:
-Problem: The resident has bowel incontinence related to decreased mobility and muscle weakness;
-Interventions: Check the resident every two hours and assist with toileting as needed. Provide a bedpan or a bedside commode. Take the resident to the toilet the same time everyday the resident has a bowel movement;
-The resident's care plan did not address the residents' transfer status.

Review of the resident's physician order sheets (POS), dated, 4/9/25, showed:
-An order dated 4/4/25, Hoyer lift (a specialized mechanical lift) for all transfers:
-An order, dated 4/4/25, Toe touch weight bearing to left leg.

Observation on 4/7/25 at 5:00 P.M., showed the resident in the bathroom holding onto the grab bars and he/she held up his/her left leg. The resident's gait was unsteady, and the resident was struggling to hold onto the grab bars. While the resident was holding onto the grab bars, Certified Nursing Assistant (CNA) F held onto the resident under his/her left arm and pulled the resident's shorts up. After CNA F pulled the resident's shorts up, CNA F held the resident under his/her left arm, and by using the back of the resident's shorts, quickly pivoted the resident into a wheelchair which had a Hoyer pad located in the seat. The resident continued to hold his/her

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left left leg up during the pivot transfer. CNA F wore a gait belt and did not utilize it during the resident's transfer. CNA F told the resident "you have 'poop' on your shoe and I will clean it off". CNA F cleaned the resident's shoe and propelled the resident out of the bathroom and into his/her room. The resident said he/she was tired and denied any pain.

During an interview on 4/7/25 at 5:20 P.M., CNA F said he/she was in a hurry to get the resident on the commode because the resident said he/she had to urgently use the bathroom. He/She was not aware of the resident's transfer status or weight bearing status. CNA F was not told in report that the resident required a Hoyer lift. At a minimum CNA F said he/she should have used the gait belt that he/she was wearing while transferring the resident or wait and get another person to help. CNA F said he/she forgot to do that because of the resident's urgent need to use the bathroom.

During an interview on 4/7/25 at 5:30 P.M., Licensed Practical Nurse (LPN) G said CNAs should ask the nurse if they are unsure of the resident's weight bearing status or transfer status. The aides are supposed to carry a resident profile sheet in their pocket that focused on the resident's activities of daily living needs. The resident care sheet was updated daily by the Resident Care Supervisor.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nurses said she would expect staff to know what the resident's transfer status was prior to providing care. She would expect the staff to follow the physician orders and therapy recommendation for weight bearing status and

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F 689	Continued From page 28 transfer status.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure respiratory services provided were consistent with professional standards of practice for one resident (Resident #15). The sample size was 15. The census was 58. Review of the facility's Oxygen Administration policy, revised October, 2010, showed: -The purpose of this procedure is to provide guidelines for safe oxygen administration; -Verify that there is a physician's order for this procedure; -Review the resident's care plan to assess for any special needs of the resident; -Assemble the equipment and supplies as needed. Review of the facility's Continuous Positive Airway Pressure Support (CPAP, a machine that assists with breathing when breathing slows down or stops during sleep) policy, dated March, 2015, showed:	F 695		

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-Purpose:
-To provide the spontaneously breathing resident with CPAP with or without supplemental oxygen;
-To improve oxygenation in residents with respiratory insufficiency, obstructive sleep apnea (breathing slows down or stops during sleep) or restrictive lung disease;
-To promote resident comfort and safety;
-Preparation:
-Only a qualified properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask;
-Review the resident's medical record to determine his/her baseline oxygen saturation;
-Review the physician's order to determine the oxygen concentration and flow, and the pressure for the machine;
-General guidelines for cleaning:
-There are general guidelines for cleaning;
-Specific cleaning instructions are obtained from the manufacturer or supplier of the device;
-Documentation:
-A general assessment (including vital signs, oxygen saturation, respiratory, circulatory (blood perfusion around the body) and gastrointestinal (stomach and intestine) status prior to procedure;
-The time the CPAP was started and duration of therapy;
-Mode and settings;
-Oxygen saturation and flow;
-How the resident tolerated the procedure;
-Oxygen saturation during therapy.

Review of Resident #15's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/24, showed:
-Cognitively intact;

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-Required maximum assistance from staff for upper and lower body dressing;
-Required a non-invasive mechanical ventilator (a device that assists with breathing);
-Diagnoses included heart failure, heart disease, respiratory failure, depression and anxiety.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: The resident has shortness of breath related to respiratory failure; The resident wears a CPAP at night.
-Interventions: Monitor breathing patterns; Monitor and document breathing abnormalities;
-Focus: The resident is on a hypnotic therapy related to insomnia (inability to sleep) and sleep apnea;
-Interventions: CPAP on at night and off in morning;
-Focus: The resident has activities of daily living (ADL) deficit related to fatigue, impaired balance, and pain;
-Interventions: The resident may have oxygen 2-5 liters (L); CPAP on a night and off in morning.

Review of the resident's Physician Order Sheets (POS), dated 4/9/25, showed:
-An order dated 3/14/25, oxygen 3L continuously at all times;
-An order dated 3/14/25, Ipratropium-Albuterol inhalation solution 3 milligrams (mgs), 3 milliliter (mls), give every two hours as needed for shortness of breath;
-No order for the resident's CPAP machine.

Review of the resident's Treatment Administration Record (TAR), dated 4/1 through 4/7/25, showed:
-An order, undated, oxygen 3L continuously at all times, every shift for oxygenation;

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-On 4/1, 4/2, 4/3, 4/4, 4/5, 4/6 and 4/7/25, on day, evening and night shifts, oxygen 3L continuously was documented as completed.

Review of the resident's oxygen saturation levels, showed:
-On 4/3/25, oxygen saturation 96% (normal values, 90-100%) on oxygen via nasal cannula;
-No further oxygen levels documented dated, April 2025.

Observation and interview on 4/7/25 at approximately 10:30 A.M. and at 11:10 A.M., showed the resident lay in bed with an oxygen nasal cannula (tubing that delivers oxygen to the resident in his/her nose), dated 3/30/25, in his/her nose. The oxygen tubing was dated 3/30/25, connected to a concentrator (a machine that delivers the oxygen) next to the resident's bed, and the oxygen concentrator was on and set on 2L. The resident's respiratory equalizer (a mask that delivers breathing medication) face mask with tubing was draped over a lamp attached to the wall. In the resident's bed, the extension oxygen tubing was coiled and positioned next to the resident. The extension tubing was not connected to the resident and was dated 11/13/24. The resident said staff use the extension tubing in case he/she needs extra tubing for further distances. The resident had a CPAP machine on his/her nightstand.

Observation and interview on 4/8/25 at 7:45 A.M., showed the resident lay in bed with an oxygen cannula, dated 3/30/25, in his/her nose connected to the oxygen concentrator which was on and set on 2L. The resident's nebulizer face mask with tubing was draped over the lamp attached to the wall. The resident had a CPAP

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located on his/her nightstand. The resident's CPAP face mask lay on the floor next to the resident's bed. The resident said he/she just removed the mask, and the mask must have fallen on the floor.

Observation and interview on 4/8/25 at 1:45 P.M., showed the resident seated in the dining room in his/her wheelchair. The resident did not have oxygen on. The resident said he/she did not need oxygen and he/she uses it on an average of one hour a day. The resident said staff help him/her at night to place his/her C-PAP machine on his/her face and staff turn the machine on. Private Caregiver J said he/she only fills the water chamber before he/she leaves for the day and he/she does not clean it. The resident said he/she receives nebulizer treatments up to three times a day for shortness of breath.

During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse B said the resident's nebulizer mask should be stored on top of the nebulizer machine and he/she wasn't sure about how to clean the nebulizer mask. The resident's oxygen orders should read as needed and not continuously because the resident was not using oxygen very much. The oxygen saturation levels should be checked at least daily while the resident is weaned off the oxygen. All oxygen tubing and the nebulizer masks should be changed weekly by the night shift. The resident uses a CPAP machine at night but wasn't sure if the CPAP machine required any type of physician orders.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nurses (DON) said the night shift is responsible for changing the oxygen tubing and

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F 695	Continued From page 33 nebulizer mask weekly. The nebulizer mask should be rinsed with water after use, air dried on a paper towel and stored in a plastic bag next to the nebulizer machine. The oxygen the resident requires is expected to match the physician orders. The resident's oxygen levels should be checked at least daily, to make sure the resident can tolerate having the oxygen off. If the resident doesn't require oxygen continuously, then the oxygen orders are expected to be changed to reflect the resident's oxygen requirements. The DON expected physician orders related to the resident's CPAP machine.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one resident had physician's orders for dialysis (a procedure that cleanses the blood of its impurities) care and dialysis communication logs (Resident #10) and failed to ensure one resident had dialysis communication logs completed for all appointments (Resident #45). The sample was 15. The census was 58. Review of the facility's dialysis procedure, undated, showed: -The following must be done for residents each day they do out for dialysis: fill out page one of	F 698		

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the communication form. Send page one and two of the communication form with the resident for the dialysis unit to complete and return with the resident;
-If we do not receive page two of the form back when the resident returns, contact the dialysis unit and have them fax it to us.

1. Review of Resident # 10's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 2/21/25, showed:
-Cognitively intact;
-Diagnoses included hip fracture, renal disease, and depression;
-Received dialysis.

Review of the resident's care plan, in use at the time of survey, showed:
-Focus: The resident has end stage kidney disease and is dependent on dialysis;
-Interventions: Check and change dressing to dialysis site three times a week at access site. Do not draw blood or take blood pressure with the resident's left arm. Encourage resident to go for the scheduled dialysis appointments. Monitor intake and output; Monitor labs, and report to the doctor as needed. Monitor vital signs.

Review of the resident's medical record, showed:
-Admission date: 2/14/25;
-Discharge date: 3/31/25;
-Re-admission date: 4/4/25;
-No dialysis communication forms completed for February, March, and April, 2025.

Review of the resident's physician order sheets (POS), dated 4/4/25 through 4/9/25, showed no orders related to dialysis.

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During observation and interview on 4/7/25 at 5:10 P.M., the resident said he/she has an arterial venous (AV, a surgically created access port where the resident received dialysis) graft to his/her left arm for dialysis. The resident lifted his/her sleeve and showed the AV graft site on his/her left upper arm. The AV graft site was covered with an undated dressing. The resident said he/she went to dialysis three days a week at 10:30 A.M.

During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse (LPN) B said she wasn't sure if there should be dialysis orders in the physician orders.

During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing (DON) said there should be orders related to the resident's dialysis that include, where the resident goes to dialysis, time of dialysis and the site where the resident is receiving dialysis to ensure no blood pressures or blood work is not obtained using the arm with an AV graft.

2. Review of the Resident #42's quarterly MDS, dated 3/18/25, showed:
-Cognitively intact;
-Diagnoses included type two diabetes, morbid obesity, end stage renal disease (kidney failure), and muscle weakness;
-Received dialysis.

Review of the resident's care plan, dated 9/13/24, showed:
-Focus: Resident has end stage renal disease and dependence on renal dialysis;
-Goal: Resident will have no complications

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F 698	Continued From page 36 related to fluid overload through the review date; -Interventions: Daily weight, give medications as ordered by physician, monitor vital signs, observe dialysis shunt daily. Review of the resident's medical record, showed: -Two dialysis communication logs for February 2025; -One dialysis communication log for March 2025; -Three dialysis communication logs for April 2025. During an interview on 4/9/25 at 8:49 A.M., LPN B said dialysis communication logs should be filled out by the nurse and then sent with the resident when they went to dialysis. The log should then be filled out at dialysis and sent back with the resident. He/She would expect dialysis logs to be completed for every dialysis appointment and then scanned into the resident's electronic medical record. 3. During an interview on 4/9/25 at 10:00 A.M., the Administrator said she would expect dialysis communication logs to be completed every time a resident went to a dialysis appointment to ensure the resident's weight and vitals were being monitored. She would expect for residents to have physician's orders for dialysis care.	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		

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a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to establish a system of records for all controlled drugs with sufficient detail to enable an accurate reconciliation, for two out of two medication carts reviewed. This had the potential to affect all residents with controlled substance orders. The census was 58.

Review of the facility's Counting Narcotics policy, updated 8/5/11, showed:
-At the change of shift, an off-going nurse or Certified Medication Technician (CMT) and an oncoming Nurse or CMT must count all narcotics,

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F 755	Continued From page 38	F 755		

routine and as needed (PRN);
-The Nurses or CMTs counting must also verify that the count is correct and that the number of items (cards and bottles) is correct, on both green sheet and the count sheet;
-Any Nurse or CMT who had access to the medication cart being counted must also stay until the count is completed.

1. Review of Fountain View Terrace Hall one narcotic book count sheets, dated 3/1 through 3/31/25, showed:
-Twenty out of 93 shifts had no nurse or CMT signature on the shift change count;
-Thirty four out of 93 shifts only had one nurse or CMT signature on the shift change count.

2. Review of Fountain View Terrace Hall one narcotic book count sheets, dated 4/1 through 4/7/25, showed:
-Two out of 21 shifts had no nurse or CMT signature on the shift change count;
-Nine out of 21 shifts only had one nurse or CMT signature on the shift change count.

3. Review of Fountain View Terrace Hall two narcotic book count sheets, dated 3/1 through 3/31/25, showed:
-Twenty out of 93 shifts had no nurse or CMT signature on the shift change count;
-Forty out of 93 shifts only had one nurse or CMT signature on the shift change count.

4. Review of Fountain View Terrace Hall two narcotic book count sheets, dated 4/1 through 4/7/25, showed:
-Seven out of 21 shifts had no nurse or CMT signature on the shift change count;
-Seven out of 21 shifts only had one nurse or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265849	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKNIGHT PLACE EXTENDED CARE	TWO MCKNIGHT PLACE SAINT LOUIS, MO 63124

(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) COMPLETION DATE
F 755	Continued From page 39 CMT signature on the shift change count. 5. During an interview on 4/8/25 at 8:25 A.M., CMT A said the narcotic shift count is to be completed with one oncoming staff member and one off going staff member, every shift every day. 6. During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse (LPN) B said the narcotic shift count is to be completed with one oncoming staff member and one off going staff member, every shift, every day. 7. During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing (DON) said she expected staff to complete the narcotic shift count completely and accurately with one oncoming staff member and one off going staff member, every shift every day.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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F 761	Continued From page 40 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a system in place to ensure drugs and biologicals in the medication room refrigerator were stored at a proper temperature for one of one medication room observed. The census was 58. Review of the facility's Storage of Medications, revised April, 2007, showed: -The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; -The nursing staff shall be responsible for maintain medication storage and preparation areas in a clean, safe and sanitary manner; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location; -Medications must be stored separately from food and must be labeled accordingly. Observation and interview on 4/8/25 at 7:54 A.M., showed the Fountain View Hall medication room refrigerator contained insulin pens, insulin vials, eye drops, protein shakes, an open carton of cranberry juice, and small containers of applesauce. The refrigerator temperature log was located on a clipboard above the refrigerator and the monthly refrigerator temperature log was	F 761		

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MCKNIGHT PLACE EXTENDED CARE	TWO MCKNIGHT PLACE SAINT LOUIS, MO 63124

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F 761	Continued From page 41 dated November, 2024. There was no refrigerator temperature logs for December, 2024, January, February, March, or April, 2025. Certified Medication Technician A said the daily temperature log was to be completed by the night nurse. There should not be food stored in the refrigerator that contained residents' medications. During an interview on 4/9/25 at 8:50 A.M., Licensed Practical Nurse B said the daily refrigerator temperatures were to be completed by the night nurse. Food items should not be stored with the residents' medications. Temperature logs should be completed to ensure the efficacy of the medications. During an interview on 4/9/25 at 10:44 A.M., the Director of Nursing said the daily temperature logs for the medication refrigerators were the responsibility of the night nurse to complete. She would expect the temperatures to be checked and documented on the temperature log daily. Food should not to be stored with the residents' medications.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		

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F 812	Continued From page 42	F 812		

gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure floors and the ice cream freezer in the kitchen were clean. In addition, the facility failed to ensure proper hair restraints were worn. The census was 58.

Review of the facility's food service hygiene policy, dated 4/2024, showed:
-Policy: employees must meet acceptable standards of personal hygiene and appearance.
-Facial hair, including overgrown sideburns, mustaches and beards is to be clean and required to be completely covered wearing protective cover gear.

1. Observation on 4/7/25, of the kitchen, showed:
-At 9:17 A.M., the dry storage room had trash and food debris on the ground in various areas and a white powder spill on the floor in front of the bulk bin rack;
-At 9:19 A.M., the ice cream storage cooler had ice cream smears and build up on the doors and sides;
-At 9:21 A.M., the walk in refrigerator had food and trash debris on the floor in various areas and under the storage racks;
-At 9:23 A.M., the walk in freezer had food and trash debris on the floor in various areas and under the storage racks;

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F 812	Continued From page 43 -At 9:24 A.M., the floor under the dish washing sink had grime build up and trash debris. 2. Observation on 4/8/25, of the kitchen, showed: -At 6:19 A.M., the dry storage room had trash and food debris on the ground in various areas and a white powder spill on the floor in front of the bulk bin rack, -On 6:21 A.M., the ice cream storage cooler had ice cream smears and build up on the doors and sides; -At 6:22 A.M., the walk in refrigerator had food and trash debris on the floor in various areas and under the storage racks; -At 6:23 A.M., the walk in freezer refrigerator had food and trash debris on the floor in various areas and under the storage racks; -At 9:08 A.M., the floor under the dish washing sink had grime build up and trash debris. 3. Observation on 4/8/25, of lunch preparations, showed: -At 10:08 A.M., Dietary Aide K stood over the prep station where uncovered breakfast food was located. His/Her beard was approximately 1/2 inch long. He/She was not wearing a beard net; -At 10:08 A.M., Cook J was cutting up meat. His/Her beard was approximately 1.5 inches long, and he/she did not have on a beard net; -At 10:11 A.M., Cook J put burger meat on the skillet, without a beard net; -At 10:13 A.M., Cook J put hot dogs on the skillet top, without a beard net; -At 10:18 AM Dietary Aide L was cleaning dishes and putting them away. His/Her beard was approximately 1 inch long. He/She did not wear a beard net. During an interview on 4/9/25 at 7:17 A.M., Cook I	F 812		

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F 812	Continued From page 44 said he/she expected the floors to be clean and free from trash and debris. He/She expected the appliances to be clean. He/She expected staff to wear beard nets to avoid contaminating the food. During an interview on 4/9/25 at 9:17 A.M., the Dietary Supervisor said she expected the floors to be clean and free from trash and debris. He/She would expect the appliances to be clean. She expected staff to wear beard nets while in the kitchen. During an interview on 4/9/25 at 9:47 A.M., the Administrator said she expected the floors in the kitchen and walk ins to be clean and free from trash and debris. She expected kitchen appliances to be clean. She expected staff to wear beard nets while in the kitchen.	F 812		

Missouri Department of Health and Senior Services

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	18914A	A. BUILDING: _____ B. WING _____	C 04/09/2025

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A4059	19 CSR 30-85.042(50) Self-Administration of Medication Self-administration of medication is permitted only if approved in writing by the resident's physician, and it is in accordance with the facility's policy and procedures. II This regulation is not met as evidenced by: See the deficiency cited at F554.	A4059		
A4064	19 CSR 30-85.042(55) Medication Storage Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III This regulation is not met as evidenced by: Class III See the deficiency cited at F761.	A4064		
A4071	19 CSR 30-85.042(62) Controlled Substance Reconcile/Record The facility must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The system must enable the facility to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled. II/III This regulation is not met as evidenced by:	A4071		

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A4071	Continued From page 1 Class III See the deficiency cited at F755.	A4071		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II See the deficiencies cited at F684, F689, F695 and F698.	A4075		
A4076	19 CSR 30-85.042(67) Clean, Dry, Odor Free Each resident shall be clean, dry, and free of body and mouth odor that is offensive to others. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F677.	A4076		
A4077	19 CSR 30-85.042(68) Res Groomed/Dressed Appropriately Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III This regulation is not met as evidenced by:	A4077		

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A4077	Continued From page 2 Class III See the deficiency cited at F677.	A4077		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F686.	A4083		
A6012	19 CSR 30-87.020(12) Floor Surfaces All floors in the facility shall be clean and shall be maintained in good repair. Floors and floor coverings of all food-preparation, food-storage and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tile, durable grades of linoleum or plastic, or tight wood impregnated with plastic. Nothing in this section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons. III This regulation is not met as evidenced by: See the deficiency cited at F812.	A6012		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean	A7003		

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A7003	Continued From page 3 and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by: See the deficiency cited at F812.	A7003		
A8007	19 CSR 30-88.010(7) Res Rights/Rules Posted, Alz Unit Info Information regarding resident rights and facility rules shall be posted in a conspicuous location in the facility and copies shall be provided to anyone requesting this information. Informational documents which contain, but are not limited to, updated information on selecting an Alzheimer's special care unit or program shall be given by a facility offering to provide or providing these services to any person seeking information about or placement in an Alzheimer's special care unit or program. III This regulation is not met as evidenced by: See the deficiency cited at F574.	A8007		

PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 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
F 554	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	All medications were removed from resident #15's room.	
	Resident #15 and their private caregiver will be instructed to get approval from the nurse prior to purchasing any over-the-counter medications so that an order can be obtained from their physician, a self-administration medication assessment can be completed, and a proper in-room storage container can be obtained.	
	In-servicing of the policy and procedure for Self-administration of Medications and how storage of in-room medications will be done with all nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will monitor and document a sampling of residents' rooms for medication kept in the rooms that do not have an order or self-administration assessment completed to keep medications at bedside.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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.

PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 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
F 574	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	The Director of Social Services or Designee will be responsible for bringing the State book to the monthly Resident Counsel Meeting. During this meeting the Director of Social Services or Designee will turn the page to the listing of phone numbers to show and discuss with those in attendance. This shall be recorded in the Resident Counsel meeting minutes.	
	The Director of Social Services will have the Ombudsman's plaque from their office moved to the Magnolia Place Activity Room.	
	The Activity Director or Designee will provide the Ombudsman's phone number and State Hotline number to the bottom of the daily posted activity boards.	
	The Director of Admissions will include both phone numbers, State Hotline & Ombudsman, in the resident handbook that is given to residents at admission and annually.	
	Weekly for four weeks then monthly for three months the Director of Social Services will monitor for the placement of these phone numbers and complete a random interview with a sampling of residents to ensure they know the placement of these phone numbers.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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F 677	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Resident #10 has been toileted timelier. Resident #15 & #42 have been placed on the list for the next podiatry visit. Resident #42 was given a shower.	
	In-servicing of the policies and procedures on Answering Call Lights (timely response), Nail Care (foot), and Activities of Daily Living (showering) will be done with all nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of residents for call light response time, condition of toenails, and that showers are being given.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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F 684	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Residents #15 & #42 were seen by the consulting wound care team and new orders noted. Weekly skin assessments were completed.	
	For any wounds that develop between the consulting wound care team facility visits will be treated per the standing orders provided by the consulting wound care nurse practitioner and approved by the medical director.	
	In-servicing of the policy and procedure on Skin Assessments will be given to all licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of residents to ensure that weekly skin assessments were completed.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 2025

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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 686	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Resident #10 was seen by the consultant wound care team and new orders noted.	
	For any wounds that are present on residents on admission will be treated per the standing orders provided by the consulting wound care nurse practitioner and approved by the medical director.	
	In-servicing of the policy and procedure on Pressure Ulcer and Skin Breakdown will be done with all licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of residents with wounds to ensure they have wound treatment orders.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 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
F 689	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Resident #10 was assessed by physical therapy for the safest mode of transfer and that was added to the Resident Care List.	
	In-servicing of the policies and procedures on Safe Lifting and Movement of Residents, and Gait Belts will be done with all CNA & CMT staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of resident transfers to ensure a gait belt was utilized if appropriate and the resident was transferred properly.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
Date of Survey:	Survey Exit April 9, 2025

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F 695	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Resident #15's nebulizer and CPAP masks were cleaned and placed appropriately. The oxygen tubing was changed. The continuous 3L oxygen order was discontinued and replaced with a PRN oxygen order and a PRN oxygen saturation order was added per residents' physician.	
	In-servicing of the policies and procedures on Oxygen Administration, and Continuous Positive Airway Pressure Support (CPAP) will be done with all licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of residents that receive oxygen, nebulizer treatments, and use CPAP machines to ensure the residents have current orders and that the orders are being followed properly and the tubing is changed and cared for per policy.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
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PLAN OF CORRECTION

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F 698	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	An order for dialysis was placed in resident #10's chart. A reminder to complete the dialysis communication forms and send with the resident to dialysis, and documentation of location of the AV graft to monitor dressings and make sure the graft arm is not used for lab draws and blood pressures was placed on the nurses' MAR for residents #10 & #42.	
	In-servicing of the dialysis procedure will be done with all licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document a sampling of dialysis residents to ensure they have an order for dialysis and that the communication forms were sent with the resident to dialysis.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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Street Address, City, Zip:	Two McKnight Place, St. Louis, MO 63124
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F 755	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	The controlled medications were counted on both medication carts and there were no discrepancies.	
	In-servicing of the policy and procedure on Counting Narcotics will be done with all CMTs and licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit the narcotic shift count sheet for initials showing the count was completed.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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PLAN OF CORRECTION

Provider/Supplier Name:	McKnight Place Extended Care
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ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 761	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	Food items were removed from the medication room refrigerator. The temperature of the medication refrigerator was checked, and it was within the acceptable range to store medications.	
	In-servicing of the policy and procedure on Storage of Medications will be done with all CMTs and licensed nursing staff and documented by the Director of Nursing or Designee.	
	Weekly for four weeks then monthly for three months the Director of Nursing or Designee will audit and document the medication refrigerator temperature log for completeness and observe the medication refrigerator for any food items.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee Quarterly for the next six months.	
		5/20/2025

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F 812	This plan of correction is submitted as required under state and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a Facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
	All residents are potentially at risk.	
	The Executive Chef or designee will ensure daily cleaning tasks are completed to include removing trash and food debris on the floor and under racks in all areas of the kitchen to include the dry storage room, walk in refrigerator and walk in freezer. Under the dishwashing sink, grime and trash debris will be removed daily by dishwasher with follow up from the Executive Chef or designee.	
	The Executive Chef or Designee will ensure that the ice cream storage cooler is cleaned of any ice cream smears daily and defrosted weekly or as needed if indicated sooner.	
	The Executive Chef or designee will ensure that all staff with facial hair longer than a stubble or ¼" will wear a beard guard while working in the kitchen.	
	Weekly for four weeks then monthly for three months the Executive Chef will monitor for the use of beard guards, cleanliness of ice cream cooler and cleanliness under dishwashing sinks, under all shelving in dry storage area, under shelving in walk-in refrigerator and walk-in freezer.	
	The facility's continued and ongoing correction of this deficiency will be reviewed by the facility's Quality Assurance Committee quarterly for the next six months.	
		5/20/2025

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Provider/Supplier Name:	McKnight Place Extended Care	
Street Address, City, Zip:	Two McKnight Place St. Louis, MO 63124	
Date of Survey:	Survey exit April 9, 2025	
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ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This plan of correction is submitted as required under stand and federal law and does not constitute an admission on the part of the facility that the findings constitute a deficiency or that the scope and severity regarding any deficiencies cited are correctly applied. For the deficiencies cited during the survey, this facility has or will develop and implement a facility wide system to assure correction and continued compliance with the regulations.	
	Credible Allegation of Compliance:	
State tag #	Correction	
A4059	See the deficiency cited at F 554	5/20/2025
A4064	See the deficiency cited at F 761	5/20/2025
A4071	See the deficiency cited at F 755	5/20/2025
A4075	See the deficiency cited at F 684, F 689, F 695 and F 698	5/20/2025
A4076	See the deficiency cited at F 677	5/20/2025
A4077	See the deficiency cited at F 677	5/20/2025
A4083	See the deficiency cited at F 686	5/20/2025
A6012	See the deficiency cited at F 812	5/20/2025
A7003	See the deficiency cited at F 812	5/20/2025
A8007	See the deficiency cited at F 574	5/20/2025

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