Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of St Louis	3520 Chouteau Ave Saint Louis, MO 63103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided meet professional standards when one resident's physician order was not transcribed onto the physician order sheet timely (Resident #91). The sample was 23. The census was 90.Review of Resident #91's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/30/25, showed:-Moderately impaired cognition;-No rejection of care;-Resident had an indwelling catheter (a sterile tube inserted into the bladder to drain urine);-Diagnoses included renal (kidney) insufficiency, renal failure or end stage renal disease (ESRD, chronic irreversible kidney failure) and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow). Review of the resident's care plan, in use at the time of survey, showed:-Focus: had a left nephrostomy (a flexible tube inserted through the back into the kidney to drain urine when the normal urinary tract is blocked) related to obstructive uropathy;-Goal: will have no complications related to nephrostomy use;-Interventions included catheter care every shift, check tubing for kinks each shift, educate resident and/or family regarding indwelling catheter and care, observe for and report to medical doctor for signs and symptoms urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Review of the resident's Transfer Orders for Receiving Facility, admission date 10/21/25 and expected discharge date [DATE], showed:-Your discharge diagnosis was kidney stone;-General instructions: left nephrostomy tube dressing to be changed every 1-2 days and when soiled. Keep nephrostomy tube clamped. Call if patient has increased flank/back pain with tube clamped;-After a Percutaneous Nephrolithotomy (PCNL, procedure to remove kidney stone), a left nephrostomy tube remained in place, please keep this tube clamped. Change dressing every 24-48 hours and when soiled. If pain worsens on the left back/flank, please contact Genitourinary (GU, medical term for urinary specialist) for further instructions. Review of the resident's physician order summary, in use at the time of survey, showed:-A physician order for nephrostomy tube output every shift, start date 10/23/25;-A physician order to keep nephrostomy tube clamped, per urology every shift, start date was 11/10/25;-There was no order for a dressing change and no order prior to 11/10/25 to clamp the nephrostomy tube. Review of the resident's progress notes dated 10/23/25 through 10/31/25, showed:-On 10/23/25 at 5:39 P.M., resident arrived from hospital. All orders verified with medical doctor;-On 10/24/25 at 1:40 P.M., physician note, left nephrostomy tube to remain in place at discharge. Keep Percutaneous Nephrostomy (PCN, a medical procedure used to drain urine directly from the kidney when the normal flow is blocked) clamped. Change dressing every 24-48 hours and when soiled;-On 10/27/25 at 12:56 P.M., physician note, seen today. Urinary catheter and nephrostomy tube in place. Assessment/plan: left nephrostomy to remain in place until follow up with urologist. Review of the residents Medication and Treatment Administration Records (MAR and TAR) dated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of St Louis		STREET ADDRESS, CITY, STATE, ZIP CODE 3520 Chouteau Ave Saint Louis, MO 63103	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/25 through 10/31/25, showed a physician order for nephrostomy tube output every shift. Documentation showed: On day shift: five out of eight opportunities an output was documented; on evening shift: six out of eight opportunities an output was documented; on night shift: five out of nine opportunities an output was documented. Review of the resident's progress notes dated 11/1/25 through 11/10/25, showed:-On 11/3/25 at 3:01 P.M., indwelling catheter and nephrostomy tube patent and intact, both draining via gravity;-On 11/5/25 at 11:45 A.M., resident returned from doctor's appointment, no new orders, no paperwork sent with resident;-On 11/5/25 at 10:40 P.M., resident had an indwelling catheter and a nephrostomy tube, both draining to gravity;-On 11/7/25 at 4:02 P.M., has an indwelling and nephrostomy tube, both draining to gravity;-On 11/8/25 at 2:48 P.M., has an indwelling and nephrostomy tube, both draining to gravity;-On 11/9/25 at 11:52 A.M., has indwelling and nephrostomy tube, both draining to gravity;-On 11/10/25 at 11:10 A.M., physician note, seen today, indwelling and nephrostomy tube in place. Followed up with urology on Wednesday-failed trail void. Per urologist plan clamp nephrostomy tube. Nurse given orders today, not sent with resident last week. Review of the resident's MAR dated 11/1/25 through 11/10/25, showed:-A physician order for nephrostomy output every shift. Documentation showed on day, evening and night shift, eight out of nine opportunities, output was documented;-A physician order to keep the nephrostomy tube clamped every shift. The start date 11/10/25. During an interview on 1/15/26 at 1:43 P.M. Licensed Practical Nurse (LPN) E said when a resident is admitted to the facility, the nurse on the floor was responsible for entering the orders into the computer and completing the assessments. The hospital discharge orders are verified with the doctor or the nurse practitioner (NP). If a change was made during the reconciliation process, he/she would note it on the hospital discharge paperwork. When the doctor or NP made rounds at the facility, they make a note in the computer. They also enter their own orders into the computer. The nurse had to confirm the order to activate it. LPN E did not review the doctors or NP notes unless they said something like there were new orders. If a resident went out for an appointment and came back with no paperwork, he/she would call the provider to obtain the records and document it. When the resident admitted to the facility, he/she had an indwelling catheter and a nephrostomy tube, the nurse could not remember if the nephrostomy tube was clamped or not. During an interview on 1/15/26 at 2:28 P.M., the Nurse Manager said the nurse on the floor was responsible for admitting the residents. The after-visit summary is what they used for orders. The orders are verified with the doctor. The next day, admissions are audited by nurse management. When a provider visits the facility, they make notes in the progress notes. The Nurse Managers reviews their progress notes. Providers enter their own orders into the computer and the nurse is responsible for confirming the orders. Any nurse can confirm an order. If a resident went out to see a provider and returned with no paperwork, the nurse would call the office and document it in the progress notes. During an interview on 1/15/26 at 3:49 P.M. Registered Nurse (RN) N said the facility used the after-visit summary for the discharge orders. The nurse should read the whole document for orders. RN N said the nephrostomy tube should have been clamped, and the dressing should be changed every 24-48 hours, unless the orders changed when they were verified. If the tube was clamped there would be no output from the tube. During an interview on 1/16/26 at 11:01 A.M., the NP said the general instructions and care of sites should be verified when the resident is admitted . The NP looked at the progress notes and said the doctor verified the orders with the nurse on 10/23/25 and she saw the resident on 10/24/25 and wrote a note. The order for the tube to be clamped and the dressing changed should have been placed. If the tube was clamped there would be no output from the tube. During an interview on 1/16/26 at 9:09 A.M., RN Q said the resident had a nephrostomy tube because he/she had an obstruction. The tube was clamped to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see if the resident could void more on their own. If the tube was clamped there would be no output from the tube. Sometimes there may be a small amount of drainage from around the tube but that would not be measurable. The dressing around the tube was to help keep the area clean and dry. During an interview on 1/16/25 at 1:36 P.M., the Director of Nursing said the resident's orders were verified with the physician on admission. 2713882

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who required assistance with activities of daily living (ADL) received showers and personal care in accordance with their personal needs, for one of 23 sampled residents (Resident #56). The census was 90. Review of the facility's Activities of Daily Living (ADLs) policy, reviewed 9/10/24, showed:-Policy: The resident will receive assistance as needed to complete ADLs. Any change in the ability to perform ADLs will be reported to the nurse;-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. Review of Resident #56's medical record, showed diagnoses included hidradenitis suppurative (HS, a chronic painful skin condition causing recurring boils, blackheads, and painful lumps that form deep in hair follicles, often in skin folds leading to pus drainage, tunnels and inflammation. Common areas affected are buttocks and around the anus), muscle weakness and cancer. Review of the resident's admission minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/24/25, showed:-Mild cognitive impairment;-No behaviors;-Required partial/moderate assistance with showering/bathing;-Required supervision or touching assistance with personal hygiene;-Diagnoses included cancer. Review of the resident's care plan, revised 12/29/25, and in use during the time of the investigation, showed:-Focus: The resident has an ADL self-care performance deficit related to impaired balance, limited mobility and pain;-Goal: The resident will improve current level of function through the review date;-Interventions: The resident requires moderate assistance for bathing at least twice a week and as necessary. The resident requires personal assistance for personal hygiene. Review of the resident's shower calendar, showed the resident was admitted [DATE]. Showers and/or bed baths were documented as provided on 12/25/25, 1/5/26, 1/8/26, 1/10/26 and 1/14/26. During observation and interview on 1/12/26 at approximately 11:30 A.M., the resident lay in bed on his/her stomach. The resident's hair was approximately eight inches long and appeared matted and unkempt. An odor of bowel movement was present throughout the resident's room. The resident said he/she was admitted to the facility about three weeks ago. He/she had pain due to boils on his/her buttocks. The boils leaked and caused an odor, pain and discomfort. He/she had not had a shower since being admitted to the facility. Observation on 1/12/26 at 5:43 P.M., showed the resident lay in bed on his/her stomach. An odor was present in the resident's room. He/She said he/she was not offered a shower or bed bath today. Observation on 1/13/26 at 2:33 P.M., showed the resident lay on his/her stomach in bed and said he/she just received the treatment to his/her wounds. The wound nurse cleansed the area surrounding the wound. The resident said he/she was not offered a bed bath or shower. Observation on 1/14/26 at 3:11 P.M., showed the resident lay in bed on his/her stomach asleep. The resident's hair appeared matted and unkempt. During an observation and interview on 1/15/26 at 10:39 A.M. and 3:51 P.M., the resident lay in bed on his/her stomach. The resident's hair was matted and unkempt. The resident said no staff had offered to wash his/her hair since he/she was admitted to the facility. He/She was able to walk to the bathroom and attempted to wash him/herself but could not reach behind him/herself to clean or could not wash his/her own hair. Staff had observed the resident at the sink washing him/herself, but no one had offered to assist. The resident wanted a shower or bed bath and wanted his/her hair washed. During an observation and interview on 1/16/26 at 9:46 A.M., the resident was observed in bed on his/her stomach. The smell of bowel movement was present in the resident's room. His/her hair appeared matted and unkempt. The resident said last night, he/she was offered a bed bath, but when they attempted to provide it, there were issues with the water temperature. He/she was moved to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another room for the bed bath, but there was a mix up with another resident in the room. He/she asked to be moved back to his/her room and never received the bed bath. The resident said this upset him/her and he/she expected more but did not want to get anyone in trouble. During an interview on 1/16/26 at 9:43 A.M., Certified Nursing Assistant (CNA) O said he/she was familiar with the resident and he/she was able to stand on his/her own. The resident needed some assistance with showers or bed baths. The resident needed his/her hair washed and treated. Staff was expected to offer the resident two showers per week. The resident did not refuse care. During an interview on 1/16/26 at 9:59 A.M. and 12:36 P.M., CNA I said he/she was assigned to the resident and was familiar with the resident. The residents received two showers per week. CNA I checked the resident's shower schedule and said, the resident is not due for a shower today. The resident received showers on Mondays and Thursdays on evening shifts. When asked about the resident's hair, CNA I said he/she has an afro. What do you expect? If the resident wanted his/her hair washed, he/she would wash the resident's hair. During an interview on 1/16/26 at 10:13 A.M., Registered Nurse (RN) P said the resident needed assistance with showers and personal care. The resident was to receive at least two showers per week. Hair care was part of receiving a shower or bed bath. RN P was not sure what staff was doing about the resident's hair. During an interview on 1/16/26 at 1:36 P.M., the Regional Nurse, Regional [NAME] President and Operations Specialist said the resident should have received at least two showers per week, including washing the resident's hair, if he/she requested it. 2713882