STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265838	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Post Acute	1201 Garden Plaza Drive Florissant, MO 63033

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure proper foot/wound care was performed for one resident (Resident #3) who had a wound to the great toe and a blister to the second toe. The resident's great toe wound became infected. The facility also failed to ensure the resident's second toe blister was documented on the resident's skin assessments. The sample was 10. The census was 95. Review of the facility's foot care policy, dated 10/2022, showed: -Policy statement: Residents receive appropriate care and treatment in order to maintain mobility and foot health; -Policy implementation: Residents are provided with foot care and treatment in accordance with professional standards of practice. Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/31/25, showed: -Diagnoses included: Epilepsy (seizure disorder), history of stroke, cognitive communication deficit, and muscle weakness; -Severe cognitive impairment. Review of the resident's care plan, in use at the time of the investigation, showed: -Focus: Resident is at risk for skin breakdown; -Goal: Resident will be compliant with treatments and intervention measures to prevent skin breakdown; -Interventions: Administer medication as ordered. Administer treatments as ordered, assist to turn and reposition as indicated/tolerated. Review of the resident's comprehensive skin assessments, showed: -Skin assessment, dated 5/23/25, an open area noted on great toe, left foot. Resident denies pain. Wound team notified and they will assess. Second toe blister was not noted on the skin assessment; (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin assessment, dated 5/30/25, an open area noted on great toe, left foot. Resident denies pain. Wound team notified and they will assess. Second toe blister was not noted on the skin assessment; -No comprehensive skin assessment completed on 5/22/25. Review on 6/3/25, of the resident's Physician's Orders Summary (POS), showed no treatment orders for the resident's left great toe wound or the second toe blister. Review on 6/3/25, of the resident's progress notes, showed: -A late entry note for 5/22/25, created on 6/3/25 by the Director of Nursing (DON), showed upon assessment of patient, it was noted that patient had an area to the top of his/her left great toe. The area was open 0.2 cm (centimeters) by .1 cm without drainage. Physician made aware and gave orders to leave wound open to air and patient not to wear his/her shoes at this time because shoes are too tight. Patient's sister made aware of wound and that shoes need to be replaced. She stated she would work on getting him/her new shoes. Physician wishes for the contracted wound care company to see patient. Wound team updated and to notify the contracted wound care company and get approval for patient to see them; -A note, dated 6/3/25, written by the DON, wound culture (laboratory test to determine if wound is infected) obtained of the resident's left great toe, placed for laboratory to pick up. Review of the resident's skin monitoring shower sheets, showed: -On 5/22/25 the resident received a shower. The resident's great toe wound was noted on the sheet to notify the nurse. The wound on the second toe was not noted; -On 5/26/25 the resident received a bed bath. The resident's great toe wound was noted on the sheet. The wound on the second toe was not noted; -On 5/29/25 the resident received a shower. The resident's great toe wound was noted on the sheet. The wound on the second toe was not noted. Review of the facility's most recent resident wound report, dated 5/27/25, showed the resident and his/her big toe wound and second toe blister were not listed. Observation and interview on 6/3/25 at 10:46 A.M., showed the resident lying in bed awake. The resident's left foot was wrapped with gauze. The wrap was dated 6/3/25. The resident said he/she did not remember what happened to his/her toe. Observation on 6/4/25 at 8:18 A.M., of the resident's left foot, showed: -The great toe had an open wound on the lower left portion of the resident's toenail. The toenail, where the wound was located, was absent. The skin surrounding the wound was reddened. The area surrounding the lower left nail had maroon drainage; -The second toe had an intact blister on the underside of the toe. During observation and interview on 6/3/25 at 11:18 A.M., the resident's sister said she was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed on 5/22/25 that the resident had a new wound on his/her great toe. The DON told her the wound was caused by the resident wearing shoes that were too small. The resident's sister felt that the wound was not caused by the shoe but something else. She was also concerned that the resident's wound was not covered with a treatment once it was discovered on 5/22/25. A picture on the sister's phone, timestamped 5/22/25, of the resident's left foot, showed the resident's great toe had an open wound. The lower left portion of the resident's toenail was absent, and the skin underneath was reddened. The area surrounding the lower left nail had maroon drainage. The resident's second toe had an unopened blister on the bottom side of the toe. She took the picture of the resident's foot after being notified of his/her wound. The DON did not mention the blister on the resident's second toe. During an interview on 6/4/25 at 10:41 A.M., Licensed Practical Nurse (LPN) A said that 5/22/25 was the day where the resident's great toe wound was first noted during the resident's shower. He/She did not know how the wound occurred. He/She was unaware until 6/3/25 that the resident had a blister on his/her second toe. A thorough skin assessment should have been done on 5/22/25 after the resident's great toe injury was observed. During an interview on 6/4/25 at 10:30 A.M., the resident's Physician said he/she was not aware of the resident's great toe wound or the blister on the resident's second toe. The Physician spoke with the nurse practitioner, who was also unaware of the resident's wounds. The Physician was on vacation on and around 5/22/25 and did not give the DON any orders or instructions for the resident's toe wounds. The Physician would have wanted to be made aware of the wounds and would have expected the great toe wound to be covered to prevent infection. During an interview on 6/4/25 at 10:47 A.M., the DON said that the resident's Physician gave an order for the resident's great toe wound on 5/22/25 for the wound to be left uncovered until the wound management company could assess the resident's left great toe. She said the resident's toe wound happened due to the resident's shoes being too tight. She called the physician's exchange and spoke with someone she thought was the resident's Physician, but she couldn't be sure. The resident does not propel himself/herself in his/her wheelchair and requires assistance. The wound on the resident's great toe is infected and the resident is now on antibiotics as of 6/4/25. The resident's great toe wound was not covered but was left open to air. The first day the resident's toe wound was covered/treated was 6/3/25. During an interview on 6/4/25 at 11:26 A.M., the wound management company's wound nurse said 6/3/25 was his/her first appointment with the resident. The resident's left great toe has an infected wound. He/She had to perform debridement (the removal of dead skin and foreign material from a wound) under the toenail where the wound was located. He/She would have expected the wound to be covered to prevent infection. During an interview on 6/4/25 at 1:36 P.M., the DON said she would expect for skin assessments to be complete and accurate. She would have expected staff to do a complete skin assessment of the resident once the resident's great toe wound was noted. The DON expected the resident's second toe blister to be found on the skin assessment completed on 5/23/25. She would have expected the nurse to obtain a treatment order once the resident's great toe wound was discovered. MO00254686