

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER McKnight Place Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE Two McKnight Place Saint Louis, MO 63124	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Review of the facility's ADL policy, dated 3/2018, showed:</p> <ul style="list-style-type: none"> -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 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. <p>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:</p> <ul style="list-style-type: none"> -Cognitively intact; -Dependent on staff for toileting hygiene; -Required maximum assist for toilet transfers; -Diagnoses included hip fracture, renal disease and depression. <p>Review of resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> -Focus: The resident has bowel incontinence related to decreased mobility and muscle weakness; <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265849	If continuation sheet Page 1 of 8

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Interventions: Check the resident every two hours and assist with toileting as needed;</p> <p>-Provide a bedpan or a bedside commode. Take the resident to the toilet the same time everyday the resident has a bowel movement.</p> <p>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 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 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>2. Review of the Resident #15's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Required maximum assist from staff for toilet hygiene, bathing hygiene, and putting on and taking off foot wear;</p> <p>-Diagnoses included heart failure, heart disease, diabetes and respiratory failure.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: the resident has diabetes;</p> <p>-Intervention: weekly skin assessments with special attention to feet.</p> <p>Review of the resident's medical record, showed:</p> <p>-No skin assessments for February 2025 were completed;</p> <p>-The resident's skin assessments, dated, 3/6/25 and 3/27/25, did not address the resident's feet or toenails;</p> <p>-No further skin assessments, for March, 2025, were completed.</p> <p>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. 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>3. Review of the Resident #42's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -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. <p>Review of the resident's care plan, dated 9/13/24, showed:</p> <ul style="list-style-type: none"> -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. <p>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.</p> <p>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.</p> <p>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.</p> <p>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 shift.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>MO00252290</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Review of the facility's Pressure Ulcer and Skin Breakdown policy, revised 3/26/14, showed:</p> <ul style="list-style-type: none"> -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: <ul style="list-style-type: none"> -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 skin; -The Wound Nurse Practitioner will assist the staff to determine the etiology (cause) and characteristics of the skin alteration. <p>Review of Resident #10's admission Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated, 2/21/25, showed:</p> <ul style="list-style-type: none"> -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. <p>Review of the resident's medical record, showed:</p> <ul style="list-style-type: none"> -admission date: 2/14/25; -discharge date : [DATE]; <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-re-admission date: 4/4/25.</p> <p>Review of the resident's baseline care plan, dated 4/4/25, showed it did not address the resident's skin condition.</p> <p>Review of the resident's comprehensive care plan, in use at the time of survey, showed:</p> <p>-Focus: The resident has potential impairment to skin integrity due to fractured left hip and decreased mobility;</p> <p>-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 breakdown's width, length, depth type of tissue and exudate (pus)and any other notable changes or observations.</p> <p>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.</p> <p>Review of the resident's admission nursing assessment, dated 4/4/25 at 4:30 P.M., showed:</p> <p>-Skin assessment:</p> <p>-Integrity: Intact and bruising; Site: Sacrum (tailbone);</p> <p>-No further description of the skin condition was addressed.</p> <p>Review of the resident's physician order sheet (POS), showed:</p> <p>-An order, dated 4/7/25, apply barrier cream to bottom for redness after each incontinent episode;</p> <p>-An order dated 4/7/25, refer to outside wound company for wound care;</p> <p>-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);</p> <p>-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;</p> <p>-An order, dated 4/9/25, cleanse area to bottom and apply mupirocin, cover with Allevyn dressing or border gauze as need for shearing;</p> <p>-No order for Skin Prep (a type of liquid that is used to prepare skin before applying an adhesive by forming a protective barrier) to be applied to the wound was noted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>MO00252290</p>		