STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265120	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Sophia Health & Rehabilitation Center	936 Charbonier Road Florissant, MO 63031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview and record review, the facility failed to ensure a resident who was frequently incontinent of bowel and bladder received appropriate incontinence care and services to prevent prolonged exposure to urine when staff applied two adult briefs (incontinence products) following an incontinent episode. The resident's incontinent products became heavily saturated with urine, causing the resident discomfort (Resident #2). The sample size was 10. The census was 161. Review of the facility's Skin Integrity Policy, revised 7/5/24, showed:Purpose: To establish best practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate;Responsibility: Nursing Assistants, Licensed Nurses, & Nursing Administration;Policy:-Only certified pressure relief mattresses shall be utilized;-Certified pressure relief seat cushions shall be available and utilized as per the care plan;-Skin evaluations shall be completed upon admission and routinely, as per the care plan, to monitor skin integrity;-Skin integrity risk factors will be evaluated upon admission and routinely, as per the care plan;-Appropriate interventions will be initiated based on the risk factors identified;-Residents shall be repositioned frequently, as per the care plan, to provide pressure relief; -Incontinence care shall be provided timely after each episode of incontinence;-Lotion and moisture barrier products shall be available and applied as per the care plan. Minimize, as much as possible, any friction or vigorous rubbing of the skin while providing care;-Any skin abnormalities noted shall be communicated to the licensed nurse. The licensed nurseshall notify the provider as needed for appropriate skin care orders;-Encourage proper hydration and nutrition. Communicate with nutrition services as needed for additional nutritional needs;-Staff shall be educated on skin integrity best practices. Review of Resident #2's care plan, revised 11/18/25, showed:-Focus: Activity of Daily Living (ADL) self-care and mobility performance deficit: Resident experiences fluctuations in abilities day to day and time of day;-Goal: Resident will maintain current level of function with ADLs through the review date;-Interventions: Personal Hygiene: One staff assist. Toileting: Dependent on staff for one to two assist. Bed mobility: Dependent on staff for one to two assist. Observe/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course and declines in function. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/16/26, showed:-Cognitively intact;-Dependent. A helper completed the activities for the resident, for toileting, personal hygiene, and upper and lower body dressing;-Substantial/Maximum assistance for resident to roll left and right;-Frequently Incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding) of bladder ;-Frequently Incontinent (two or more episodes of bowel incontinence, but at least one continent bowel movement) of bowel ;-Diagnoses included diabetes, anemia (decrease in number of red blood cells), high blood pressure, morbid (severe) obesity, and generalized muscle weakness. Observation on 4/30/26 at 11:27 A.M., showed Certified Nursing Assistant (CNA A) entered Resident #2's room to provide incontinence care. CNA A gathered towels to clean the resident and a brief, washed his/her hands, and put on gloves. The CNA removed the resident's brief and noted the top brief was dry, but there was a second brief under the first one, saturated with urine. CNA A said he/she checked on the resident earlier, but he/she did not know the resident was wearing two briefs. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was a line on the front of the brief that changed colors if it got wet. The CNA said he/she just looked at the top brief and thought the resident was dry. CNA A said it was from the night shift. CNA A finished with care, washed his/her hands, and left the room with the trash. During an interview on 4/30/26 at 11:35 A.M., the resident said he/she was not aware of the two briefs. This was the first time he/she had incontinence care today, but not the first time the CNA was in the room to check on the resident. The resident said he/she did not want to have a urinary infection. During an interview on 4/30/26 at 11:40 A.M., CNA A said this was not the first time he/she had seen a resident with two briefs. Sometimes he/she would find a second brief inside the first brief, like an insert or used as an incontinence pad. CNA A said residents should not have two briefs on because sitting in urine could cause skin breakdown or an infection like urinary tract infections. The CNA said he/she did not know the resident had two briefs on and just assumed the resident was still dry. During an interview on 4/30/26 at 11:45 A.M., Licensed Practical Nurse (LPN) B said he/she was not told about residents with two briefs. That should have been reported to the nurse. It was not sanitary and could have caused a skin break down. During an interview on 4/30/26 at 11: 50 A.M., LPN C said the residents should have been checked on frequently if they needed incontinence care. If a resident had two briefs, it could have caused skin breakdown, and staff could not tell if they were wet or soiled. During an interview on 4/30/26 at 12:15 P.M., CNA D said he/she would not place two briefs on a resident and would report to a nurse or supervisor if he/she found a resident with two briefs. It could have caused skin breakdown or infections. During an interview on 5/1/26 at 11:14 A.M., the Director of Nursing (DON) said the resident should not have had two briefs on them. This could have caused skin breakdown and prolonged staff having to provide incontinence care and change the brief. There should never have been two briefs on a resident. During an interview on 5/1/26 at 11:35 A.M., the Administrator said she would not expect a resident to wear two briefs. This could cause skin irritations or infections. There were some residents that it may have been care planned for, due to comfort. The staff should have been aware of that preference so they could have provided incontinence care. Resident #2 did not have that care planned, and the CNA was not aware if it was a preference. 29873882991034

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services were provided in accordance with professional standards of practice. One resident had a wound identified on the sacral area with same-day documentation indicating there were no open areas and no treatment orders were obtained (Resident #9). One resident had a skin assessment identifying an open area with measurements, but no additional documentation or treatment orders for three days until the resident was transferred to the hospital for an unrelated change in condition (Resident #1). One resident had a dressing in place to an open area on the left knee with no documentation of a nursing assessment or treatment orders (Resident #8). Two residents had physician orders for skin treatments that were not documented as completed (Residents #6 and #7). The sample size was 10. The census was 161. Review of the facility's Physician Orders policy, reviewed 9/28/22, showed:Policy: To provide guidance and ensure Physician Orders are transcribed and implemented in accordance with Professional Standards, State & Federal Guidelines;Responsibility: Licensed Nurses, Nursing Administration & Director of Nursing;Procedure:-Physician Orders shall be provided by Licensed Practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe Orders;-Orders must be Recorded in the Medical Record by the Licensed Nurse authorized to transcribe such Orders;-Physician Orders must be documented clearly in the Medical Record. The required components of a Complete Order:--Date and Time of Order;--Name of Practitioner Providing Order;--Name and Strength of Medication/Treatment;--Quantity/Duration;--Dosage/Frequency;--Route of Administration;--Indication/Diagnosis;--Stop Date, if Indicated;-Physician Orders that are missing required components, are illegible or unclear must beclarified prior to implementation.-Physician Order Sheet (POS) will be maintained with current Physician Orders as New Orders are received. Discontinued Orders will be marked as discontinued with the date, and all new Orders will be written in the appropriate area on the POS with the date the order was received;-Physician Orders will be transcribed to the appropriate Medication Administration Record (MAR/eMAR) or Treatment Administration Record (TAR/eTAR);-Medication will be ordered from the Pharmacy to ensure prompt delivery. Medications available from the Emergency Drug Supply (E-Kit) or Automatic Dispensing Unit (ADU) shall be utilized for the first dose until a supply arrives from Pharmacy, if available;-Physicians and Physician Extenders will review and signature their Physician Orders at least every 30 days, or as required by State Regulations;-Pharmacy monthly review of the Physician Orders will be completed to assure appropriateness, accuracy, and completeness; -Telephone/ Verbal Orders:--Telephone/Verbal Telephone Orders may only be received by a Licensed Nurse;--Telephone/Verbal Orders should contain the required components;--Telephone/ Verbal Orders should be read back and verified with the prescriber;--The Licensed Nurse is required to transcribe the Order accurately in the Medical Record, Physician Order Sheet (POS) and on the appropriate MAR/eMAR or TAR/eTAR;--The Telephone/ Verbal Orders are required to be signed by the ordering Physician within 30 days; -Written/Faxed Orders:--Written/Faxed Orders requires a Physician Signature to constitute a valid Order;--The Written/ Faxed Orders should contain required components;--Written/ Faxed Orders that are missing required components, illegible or are unclear must be clarified prior to implementation;-The Licensed Nurse is required to record the Order in Point Click Care (Electronic medical record (PCC)) the POS and on the appropriate MAR/eMAR or TAR/eTAR;-The Written/Fax Order will be maintained in the Medical Record. Review of the facility's Skin Integrity Policy, revised 7/5/24, showed:-Purpose: To establish best practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate;-Responsibility: Nursing Assistants, Licensed Nurses, & Nursing Administration;-Policy:-Only certified pressure relief mattresses shall be utilized;-Certified pressure relief seat cushions shall be available and utilized as per the care plan;-Skin evaluations shall be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed upon admission and routinely, as per the care plan, to monitor skin integrity;-Skin integrity risk factors will be evaluated upon admission and routinely, as per the care plan. Appropriate interventions will be initiated based on the risk factors identified;-Residents shall be repositioned frequently, as per the care plan, to provide pressure relief; -Incontinence care shall be provided timely after each episode of incontinence;-Lotion and moisture barrier products shall be available and applied as per the care plan. Minimize, as much as possible, any friction or vigorous rubbing of the skin while providing care;-Any skin abnormalities noted shall be communicated to the licensed nurse. The licensed nurseshall notify the provider as needed for appropriate skin care orders;-Encourage proper hydration and nutrition. Communicate with nutrition services as needed for additional nutritional needs;-Staff shall be educated on skin integrity best practices. 1.Review of Resident #9's care plan, revised 1/16/26, showed:-Focus: Activity Daily Living (ADL) self-care performance deficit related to dementia;-Goal: Resident will maintain current level of function with ADL's through the review date;-Interventions: Bed mobility-requires staff assistance to turn and reposition in bed. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/16/26, showed:-Mild cognitive impairment;-Dependent. A helper completed the activities for the resident, for toileting, personal hygiene, and shower/bath;-Diagnoses include end stage renal disease (ESRD), diabetes, non-Alzheimer's dementia, depression, and Schizophrenia (a chronic and severe brain disorder that affects a person's ability to interpret reality, causing disruptions in thought, processes, behaviors and emotions). Review of the resident's electronic Physician Order Sheet (ePOS), dated April 2026, showed no physician order for weekly skin assessments. Review of the resident's Medication Administration Record (MAR), dated April 2026, showed: -No order for weekly skin assessment;-No order for any treatment to the resident's sacral area. Review of the resident's medical record, showed a skin assessment, dated 5/1/26 at 9:49 A.M. No skin concerns at this time. Observation on 5/1/26 at 10:05 A.M., showed the resident lay in bed asleep. A linen cart was in the resident's room. Certified Nursing Assistant (CNA) F entered the resident's room. CNA F stated he/she had already checked on the resident this morning and provided care. CNA F washed his/her hands and put on gloves. CNA F informed the resident he/she was going to provide care to the resident and rolled the resident to the resident's left side. The CNA unfastened the resident's brief and removed it. The brief had blood on the inside around the sacral area. The brief stuck to that area as the CNA removed the brief. CNA F said it was not new. They had put cream on it, and it was getting better. The CNA wiped the area with a washcloth and put Calmoseptine cream (moisture barrier cream) on the resident. The CNA turned the resident to his/her back and placed a new brief on the resident. During an interview on 5/1/26 at 10:10 A.M., Registered Nurse (RN) H said he/she believed Resident #9 had an open area. The skin assessments were done weekly. Observations on 5/1/26 at 11:10 A.M., showed the Director of Nursing (DON) entered the resident's room. She washed her hands and placed gloves on. The DON turned the resident to his/her side and removed the resident's brief. The DON verified the open area and said, no stage but would call that area open. There was slough (soft, moist, yellowish or white tissue found in wounds, consisting of dead cells) over the top. It was unstageable, but not something that developed overnight. She would expect the skin assessment to be accurate, and it was not appropriate for the resident's skin assessment completed today to have shown no open areas. During an interview of 5/1/26 at approximately 11:55 A.M., the Regional Nurse Consultant (RNC) said she assessed the wound on the resident. She believed it could have been a Kennedy ulcer (specialized skin wounds that can appear, often on the sacrum or tailbone, in the final days or weeks of life as part of natural, unavoidable bodily decline). They could show up within hours. She in-serviced and educated nursing staff. Most were not aware of those types of ulcers. She also talked to hospice to see if they were aware of any open areas to make sure nothing was missed. She would expect any skin assessment completed to be accurate. 2.Review of Resident #1's face sheet, showed: -admission date, 4/1/26;-discharge date to hospital, 4/28/26;-Diagnoses included dementia, ESRD, Chronic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obstructive Pulmonary Disease (COPD, lung disease), and heart failure. Review of the resident's care plan, dated 4/16/26, showed:-Focus: ADL self-performance deficit:-Goal: Resident will maintain current level of function with ADLs through the review date;-Interventions: Bathing/showering, dressing, and toilet use one person assist. Review of the resident's ePOS, dated April 2026, showed:-An order dated 4/1/26. Complete skin observation tool form on day shift. Every day shift every Monday, Thursday;-No orders for skin treatments or wound treatments. Review of the resident's medical record, showed:-A skin assessment, dated 4/21/26, no new skin issues at this time;-A skin assessment, dated 4/25/26, Right Buttock Pressure, Length: 2.5 centimeters (cm), Width: 1.5 cm, Depth: Not Applicable (N/A), Stage: N/A. Review of the resident's Treatment Administration Record (TAR), dated April 2026, showed no orders for skin treatments or wound treatments. Review of the resident's medical record, showed no progress notes related to skin assessment or physician notification on 4/25/26. During an interview on 4/30/26, at 10:55 A.M., LPN E said if the resident had anything open on his/her right buttock, there should have been some orders, even for Calmoseptine cream. LPN E opened the resident's TAR and verified no orders in the medical record. During an interview on 4/30/26 at 11:19 A.M., LPN C said he/she completed the skin assessment on the resident. The open area was just a scab, not open. It was more like moisture. There was some discoloration where the scab had fallen off. LPN C states he/she let the physician and resident's family know and put in a nurse's note. During an interview on 5/1/26 at 11:22 A.M., the DON said if it was just a scab and before it was a scab, it had to be opened. If it was just scab, they still had to do something, like skin prep. There should have been something in there for orders. Initially even for one treatment, a scab would have been healed, and the skin assessment would have shown an open area. 3. Review Resident #8's care plan, revised 11/7/25, showed:-Focus: Resident has a pressure ulcer to his/her right thigh and is at increased risk for wound decline and infection;-Goal: Residents will pressure ulcer will show signs of healing and remain free of infection by/next review date;-Interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new area of skin breakdown, administer treatments as ordered and monitor effectiveness, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of the resident's quarterly MDS, dated [DATE], showed:-Mild cognitive impairment;-Dependent. A helper completed the activities for the resident, for toileting, personal hygiene, and shower/bath;-Diagnoses include non-Alzheimer's dementia, depression, high blood pressure and malnutrition. Review of the resident's medical record, showed a skin assessment, dated 4/18/26. Dry skin bilateral lower extremities. No skin integrity issues noted. Review of the resident's wound notification form, dated 4/24/26, and signed by the wound nurse, showed:-Date: 4/24/26;-Time: 10:00 A.M.;-Wound location: Left knee;-Description of wound: Skin tear to left knee;-Stage (if applicable): Blank;-Was physician notified: Yes, Date/Time: 4/24/26 at 10:05 A.M.;-Family notified: Yes, Date/Time: 4/24/26 at 6:00 P.M. Review of the resident's medical record, showed no progress notes related to skin assessment or physician notification on 4/25/26. Review of the resident's ePOS, dated April 2026, showed:-Weekly Skin Assessment, every night shift every Wednesday;-No orders for wound treatments to the resident's left knee. Review of the resident's Treatment Administration Record (TAR), dated April 2026 , showed no left knee wound treatment orders. Review of the resident's medical record, showed a skin assessment, dated 5/1/26. Left knee (front), Skin tear, Length: 3.5 cm, Width: 2.5 cm, Depth: 0.1 cm, Stage: II (a partial-thickness skin loss involving the outer (epidermis) and part of the inner (dermis) skin layers). Review of the resident's ePOS, dated May 2026, showed an order, dated 5/1/26 at 11:52 AM., Left knee clean with normal saline or wound cleanser, pat dry. Apply xeroform and border gauze daily and as needed if soiled or dislodged. Review of the resident's TAR, dated May 2026, showed a treatment order on 5/2/26 8:00 A.M., Left knee. Clean with normal saline or wound cleanser, pat dry. Apply xeroform and border gauze daily and as needed if soiled or dislodged. One time a day for wound care. During an interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 4/30/26 at 10:55 A.M., LPN E said nurses were responsible for skin assessments on shower days. He/She did some of them on Wednesdays. If they found anything, they would fill out a wound notification form. LPN E provided a wound notification form for Resident #8 dated 4/24/26. The nurse signed it and had 24 hours to assess the wound after receiving the form. Observation on 5/1/26 at 10:13 A.M., showed the resident in his/her room. The resident sat in his/her wheelchair. The resident had a foam dressing to his/her left knee, dated 4/30/26. Observation and interview on 5/1/26 at 11:22 A.M., showed the DON entered the resident's room. She verified the resident had a foam bandage, dated 4/30/26. The DON put gloves on and peeled back the foam bandage to see xeroform strip under the foam bandage. The DON said the resident should have had weekly skin assessments completed as ordered. The resident should have had orders for wound care if there was dated dressing. Any open area should have been noted. 4.Review of Resident #6's comprehensive MDS, dated [DATE] showed:-Severe cognitive impairment;- Substantial/maximal assistance. Helper does more than half the effort for shower/bathing;- Partial/moderate assistance. Helper does less than half the effort for personal hygiene;-Dependent. Helper does all the effort for toileting;-Diagnoses include aphasia (inability to express speech), stroke, seizures, and Schizophrenia. Review of the resident's care plan, revised 4/9/26, showed:-Focus: Resident has a wound to his/her sacrum that he/she is receiving treatment;-Goal: Residents will remain without complications over through the next review;-Interventions: Observe for signs of infection, document and alert physician as indicated, provide treatment per current order. Refer to physician orders for details., wound doctor to follow wounds. Review of the resident's medical record, showed:-A skin assessment, dated 4/23/26 at 7:08 A.M., Coccyx (other) wound. Area current with treatment in place. Followed by the wound nurse;-A skin assessment, dated 4/30/26 at 10:47 P.M, Sacrum, Pressure, Length: 2 cm, Width: 2 cm, Depth: 0.1 cm, Stage: II. Review of the resident's ePOS, dated April 2026, showed:-Weekly Skin Assessment, every night shift every Thursday;-An order, dated 4/3/26 and discontinued 4/24/26. Sacrum clean with wound cleanser, apply xeroform, cover with border dressing. Change daily and as needed if soiled or dislodged;-An order, dated 4/24/26 and discontinued 4/27/26. Sacrum clean with soap and water, pat dry. Apply zinc oxide daily and as needed if soiled or dislodged. Twice daily;-An order, dated 4/27/26. Sacrum clean with soap and water, pat dry. Apply zinc twice a day and as needed for skin protection. Twice daily. Review of the resident's TAR, dated April 2026, showed:-An order, dated 4/3/26 and discontinued 4/24/26. Sacrum clean with wound cleanser, apply xeroform, cover with border dressing. Change daily and as needed if soiled or dislodged.-Blank: 7:00 A.M. 4/3, 4/5, 4/6, 4/7, 4/10, 4/12, 4/13, 4/19, 4/22, 4/24/26;-An order, dated 4/24/26 and discontinued 4/27/26. Sacrum clean with soap and water, pat dry. Apply zinc oxide daily and as needed if soiled or dislodged. Twice daily;Blank: 7:00 A.M. 4/26 and 4/27/26;-An order, dated 4/27/26. Sacrum clean with soap and water, pat dry. Apply zinc twice a day and as needed for skin protection. Twice daily.Blank: 8:00 P.M. 4/30/26. On 5/1/26 at 12:20 P.M., Review of the resident's TAR, dated May 2026, showed:-An order, dated 4/27/26. Sacrum clean with soap and water, pat dry. Apply zinc twice a day and as needed for skin protection. Twice daily.Blank: 8:00 A.M. 5/1/26. Observation and interview on 5/1/26 at 10:56 A.M., showed LPN E entered the resident's room to perform the dressing change. LPN E said the area had opened up so he/she would get xeroform. The orders were in the POS to clean the area twice a day. He/She was not sure what transpired or why it was not completed as ordered. LPN E was not sure if that was the reason the area opened up. The resident did have a Foley catheter (a thin, flexible, sterile tube inserted through the urethra into the bladder) and had moisture associated damage which appeared to be sore at times. They would treat with the xeroform and bordered dressing. 5. Review of Resident #7's care plan, revised 1/19/26, showed:-Focus: Resident has diabetic wound of the right plantar, lateral foot and a diabetic wound of the left distal plantar foot;-Goal: Residents will have no complications related to ulcer through the review date;-Interventions: Monitor document wound, weekly treatment documentation, monitor document report any signs/symptoms of infection. Review of the resident's quarterly MDS, dated [DATE], (continued on next page)

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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 - Some	showed:-No cognitive impairment;-Diagnoses included diabetes, paraplegia (paralysis affecting lower half of the body, depression, and anxiety. Review of the resident's medical record, showed a skin assessment, dated 4/23/26, Right antecubital (IV/Implanted port), Left buttock surgical incision, Other (specify) right stump. No new skin issues noted. Wounds are being treated by wound care. Review of the resident's ePOS dated April 2026, showed:-An order, dated 4/3/26, mupirocin external ointment, apply to affected area topically in the morning for infection;-An order, dated 4/3/26 and discontinued 4/27/26, left post thigh cleanser with wound cleanser, apply xeroform to surgical incision, pack Dakin's (mild, diluted antiseptic used to clean skin and prevent infections) soaked gauze, secure with ABD (abdominal pads), and secure with tape. Change daily and as needed if soiled or dislodged;-An order, dated 4/3/26 and discontinued 4/27/26, right plantar foot. Cleanse with wound cleanser, apply xeroform, cover with ABD, wrap with kerlix, and secure with tape. Change daily and as needed if soiled or dislodged;-An order, dated 4/29/26, left post thigh cleanse with Dakin's (antiseptic cleanser), apply collagen, 4x4 gauze and cover with ABD dressing daily and as needed if soiled or dislodged;-An order, dated 4/29/26, wound vac to left posterior thigh every shift for wound treatment;-An order, dated 4/30/26, left hip clean with Dakins solution, pat dry. Apply collagen and cover with bordered dressing every other day and as needed if soiled or dislodged;-An order, dated 4/30/26, right planter foot. Clean area with soap and water. Apply xeroform and ace wrap every other day and as needed. Review of the resident's TAR, dated April 2026, reviewed on 5/1/26 at 12:33 P.M., showed:-An order, dated 4/3/26, mupirocin external ointment, apply to affected area topically in the morning for infection;-Blank 4/5, 4/12, 4/17, 4/18, 4/22, 4/26, 4/29, and 4/30/26;-An order, dated 4/3/26 and discontinued 4/27/26, left post thigh cleanser with wound cleanser, apply xeroform to surgical incision, pack Dakin's soaked gauze, secure with ABD, and secure with tape. Change daily and as needed if soiled or dislodged;Blank: 7:00 A.M. 4/4, 4/5, 4/12, 4/17, 4/18, 4/22, 4/26, and 4/27/26;-An order, dated 4/3/26 and discontinued 4/27/26, right plantar foot. Cleanse with wound cleanser, apply xeroform, cover with ABD, wrap with kerlix, and secure with tape. Change daily and as needed if soiled or dislodged;Blank: 7:00 A.M. 4/4, 4/5, 4/12, 4/17, 4/18, 4/22, 4/26, and 4/27/26;-An order, dated 4/29/26, left post thigh cleanse with Dakin's, apply collagen, 4x4 gauze and cover with ABD dressing daily and as needed if soiled or dislodged;Blank: 8:00 A.M. 4/30/26;-An order, dated 4/29/26. Wound vac (a medical device that promotes healing by applying gentle suction to the wound) to left posterior thigh every shift for wound treatment;-Blank 7:00 A.M. 4/29/26 and 4/30/26; 7:00 P.M. 4/30/26;-An order, dated 4/30/26. Left hip clean with Dakins solution, pat dry. Apply collagen and cover with bordered dressing every other day and as needed if soiled or dislodged;Blank: 8:00 A.M. 4/30/26;-An order, dated 4/30/26. Right planter foot. Clean area with soap and water. Apply xeroform and ace wrap every other day and as needed;-Blank 8:00 A.M. 4/30/26. 6.During an interview on 4/30/26 at approximately 11:05 A.M., LPN G said nurses were responsible for skin assessment. If anything new was found, they would fill out the wound notification form. Then notify physician, management, and family. The physician should provide orders. This should be done on the same day. LPN G said he/she would not be surprised if a couple treatments or skin assessments were missed. He/She has been on vacation and just returned. 7. During an interview on 5/1/26 at 11:35 A.M., the Administrator said she would expect skin assessments to be done as ordered and accurate. A blank MAR/TAR in the medical record meant treatment was not given as required. She would expect a note as to why the treatment was not completed and for staff to follow physician orders. If a resident had a dressing, there should have been treatment orders in the medical record. If an open area was noted on the skin assessment, then physician notification should be documented with skin assessment. It should have been in there immediately. 2991034