STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265170	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Chesterfield	14855 North Outer 40 Road Chesterfield, MO 63017

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge summary was completed, including a recapitulation of the resident's stay and final summary of the resident's status at the time of discharge (Resident #7). The sample was 14. The census was 168. Review of the discharge or transfer policy, dated January 2021, showed: -Purpose: -To provide prompt and safe discharge/transfer of a resident from the facility and to ensure continuity of care through provisions of pertinent resident information; -To provide orientation for a resident being discharged /transferred to ensure a safe and orderly transition home or to a new living environment; -Procedure: -A discharge summary observation will be completed for all residents who: -Discharge to a private residence/home or independent retirement community; -Transferred to another facility; -The nurse will obtain an order from the physician for transfer/discharge or a resident as well as release of medications; -discharged to residence/home or independent retirement community: -Discharge summary; -Any prescriptions; -Follow up physician appointments or labs; -If home care is ordered, fax, scan or email the following to the home care of choice: (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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Discharge summary observation, Physician Order Sheet (POS), face sheet, advance directives/living will, nurse notes, therapy notes, lab/x-ray reports, most recent Minimum Data Set and Care Plan, physician progress notes, list of medications and copy of the Medication Administration Record (MAR), skin testing; -Reconcile the pre-admission and post discharge medications and review the medication regimen with the resident and/or representative. Call the resident's pharmacy of choice if medications need to be ordered; -If being discharged home or to an independent retirement community and the meds are bubble packaged, refer to the discharge plan for med set-up policy; -If transportation is being provided by an emergency transportation complaint, the notification to Emergency Medical Services (EMS) personnel if the resident is an at risk behavioral health patient; -Prepare the resident for transfer/discharge. Pack all personal items and document on the inventory form; -The nurse will complete a progress note in the medical record, that includes: -Physician; -Physician discharge order, including time and date the order was obtained; -List of medications sent with the resident/family member; -Disposal/returned medications; -Location resident was discharged /transferred to; -Who transported the resident (ambulance, family etc); -Diagnoses of resident and reason for discharge/transfer; -Signature of nurse completing the summary; -Resident and/or resident representative must sign the discharge summary observation and the POS; -Copy of signed discharge summary and POS will be scanned into the electronic health record (EHR). Review of Resident #7's medical record, showed: -admitted to the facility: 11/14/24; -discharged : 3/18/25; -Diagnoses included vascular disease, heart failure, left shoulder cuff tear, long term use of diuretics and anticoagulants and stroke. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the POS, showed: -An order dated 3/18/25: discharge home with medications, home health, and therapy; -Atorvastatin (used for heart disease) 20 milligram (mg). Take one tablet daily; -Bumetanide (used for edema) take one tablet daily; -Cyclobenzaprine (used for muscle relaxant) 5 mg. Take one tablet three times a day; -Dilitazem (used for blood pressure) 30 mg. Take one tablet every six hours; -Eliquis (used to thin the blood) 5 mg. Take one tablet twice a day; -Furosemide (used for edema) 40 mg. Take one tablet once a day; -Levofloxacin (antibiotic) 500 mg. Take once tablet twice a day; -Lidocaine patch (used to treat pain) 4 percent (%). Apply once patch twice a day to left shoulder; -Mirtazapine (used for depression) 7.5 mg. Take once daily at bedtime; -Simbrinza (used to treat eye dryness) 0.2%. Apply one drop in both eyes twice daily; -Vancomycin (antibiotic) powder 900 micrograms (mcg)/mg. Apply daily to clean right toe, cover with dry dressing; -Warfarin (blood thinner) 4 mg. Take one tablet daily at bedtime. Review of the resident's care plan, dated 11/18/24, showed: -Problem: discharge plans: the resident has a goal of returning to prior living arrangements at home with family support; -Goal: the resident will transition into the community; -Approach: referrals as needed, nursing to provide teaching and evaluations, provide frequent feedback to resident/family on progress. Review of the progress notes, showed: -On 11/18/24 at 2:41 P.M., a social worker (SW) note: care conference held today with family, therapy and nursing. The resident had been living independently prior to the hospital. The resident may not be able to return home due to several health concerns at present time. He/She has some current skin conditions the facility is managing. SW will follow for discharge planning; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/27/24 at 12:22 P.M., a social service note: care plan meeting held with resident, family and therapy. The resident and family agreed to remain at the facility while a space at an assisted living (AL) level II is pursued. The family was notified the resident will not be able to return home alone, as he/she needs a level of supervision. Referrals sent to agreeable facilities; -On 12/16/25 at 11:03 A.M., a social service note: the resident's family continued to be referred to an assisted living facility. However, most decline due to wound care needs, and AL facilities are recommending resident remain in house until the wounds resolve; -On 3/7/25 at 3:17 P.M., a nurse note: the resident's prothrombin ratio and international normalized ratio (PT/INR, measures how long it takes blood to clot) reported to the physician. New order received to continue 4 mg daily; -No further progress notes in the resident's medical record. Review of the physician's Discharge summary, dated [DATE], showed: -admission date: 11/14/24; -discharge date : [DATE]; -Diagnoses: peripheral vascular disease, heart failure, atrial fibrillation (a-fib, is an irregular heart rhythm), malnutrition; -discharged home with home health, therapy, nursing, meds and belongings; -Signed: 3/21/25. During an interview on 4/10/25 at 11:04 A.M., the Director of Nursing said when a resident discharges home or to another care facility, the electronic medical record should have a discharge summary from all departments. The summary should include the medications, recapitulation of stay, if home health is ordered and what company, list of medications and how many were sent with the resident, and any follow up appointments.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy to provide the necessary care to prevent pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for one resident who was at high risk for pressure ulcers and developed a new pressure ulcer (Resident #10) and for a resident who was at risk for pressure ulcers and had an existing pressure ulcer (Resident #11). The sample size was three. The census was 168. Review of the Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, Chapter 3, Section M, defines the different stages of pressure as follows: -Stage I: an observable, pressure related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in skin temperature, tissue consistency, sensation, and/or a defined area of persistent redness; -Stage II: Partial thickness loss of dermis (the inner layer that makes up skin) presenting as a shallow open ulcer with a red-pink wound bed, without slough (non-viable yellow, tan, gray, green or brown tissue). May also present as an intact or open/ruptured blister; -Stage III: full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining (destruction of tissue or ulceration extending under the skin edges) or tunneling (a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound); -Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color) may be present on some parts of the wound bed. Often includes undermining and tunneling. Review of the facility's Wound Care Protocol, dated 7/23, showed: -Prevention and early interventions goals: To identify residents at risk for pressure ulcers and to create an environment to promote the prevention of pressure ulcers; -Prevention: Turn and reposition; Manage moisture and shear (a horizontal force that causes the bony prominence to move across skin causing it to tear); Charge nurse responsible for reviewing each risk factor and potential causes individually and provide interventions written on the care plan; -Treatment: Offer routine toileting; -For residents with Stage I or Stage IV pressure ulcers: adjust turning schedule to eliminate turning to compromised area; reduce shearing forces; use positioning devices to avoid placing resident on an ulcer; turn and reposition, offer routine toileting. 1. Review of Resident #10's care plan, dated 1/30/25, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Incontinent of bowel and bladder related to history of incontinence, reduced cognition, mobility deficits and need for assistance with all transfers and lower body clothing management and hygiene. Interventions included: check for incontinence frequently and provide prompt perineal care (peri-care, washing the front and back of the hips, genitals, anal area and buttocks) to prevent skin damage; -Problem: Deficit in activities of daily living (ADLs) functioning and mobility and required assistance. Interventions included: Assist with repositioning in bed and in wheelchair frequently; -Problem; At risk for pressure ulcers. Interventions included: history of Stage II pressure ulcer to coccyx (tailbone); Monitor skin for any redness, bruises or open areas. Review of the resident's Braden scale assessment (for predicting pressure ulcer risk) dated 2/8/25, showed the resident was at high risk. Review of the resident's Continuity of Care Document, dated 4/8/25, showed: -Diagnoses included atrial fibrillation (irregular heart rhythm), dementia, chronic kidney disease (CKD, impaired kidney function) and stroke; -Received hospice (end of life care) services. Review of the resident's Medication Administration Record (MAR), dated 3/9/25 through 4/8/25, showed: -An order dated 2/6/24, complete weekly skin assessment once a day on Tuesday, was completed as ordered. On 4/1/25, there was no skin issues reported; -An order, dated 1/30/25, for Calmoseptine ointment (a skin barrier treatment containing zinc oxide), apply to left and right buttock after each incontinence episode, every shift. Documentation showed the treatment was completed as ordered. Observation on 4/8/25 at 7:27 A.M., showed: -The resident lay on his/her bed on top of an alternating pressure mattress (APM, specialty mattress used to reduce, eliminate and help treat pressure ulcers); -Licensed Practical Nurse (LPN) A and Certified Nursing Assistant (CNA) B performed perineal care on the resident, removing a urine soaked brief; -The resident had an area of red skin located on his/her lower right gluteal (buttock) which had an open area located within the boundaries of the red skin; -LPN A applied Calmoseptine on the resident's right and left buttocks; -LPN A and CNA B finished dressing the resident and transferred the resident to his/her wheelchair; -The wheelchair had a special pressure relieving cushion in the seat of the chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 7:39 A./M., LPN A said: -The area on the resident's right lower gluteal measured 4.9 centimeters (cm) by 2.6 cm with a small area measuring 1.1 cm by 0.6 cm which had the first layer of skin gone, exposing a red wound bed; -He/She was not allowed to stage pressure ulcers per facility directions but per his/her nursing knowledge, the wound on the resident's right lower gluteal was a Stage II pressure ulcer; -It was a new wound; -The Wound Nurse was responsible for completing wound treatments every Monday, Wednesday and Friday, and the nurses were responsible for completing wound treatments on Tuesday, Thursday, the weekends and any time the Wound Nurse was not able to complete treatments; -The Wound Nurse was responsible for completing wound assessments on all residents every Tuesday; -Nurses were responsible for completing all skin assessments; -He/She expected CNAs to alert any new skin issues to the nurses so they could get assess, inform the Primary Care Physician (PCP) and family, as well as get new orders. Observation on 4/8/25 at 8:55 A.M., showed the resident sat flat on his/her buttocks in his/her wheelchair, in the dining room eating breakfast. Review of the Hospice Visit Documentation, dated 4/8/25, showed: -Hospice CNA arrived at 9:24 A.M. and left at 10:47 A.M.; -There was no other documentation of the visit found. Observation on 4/8/25 at 11:37 A.M., at 12:05 P.M., at 12:20 P.M., at 12:57 P.M. and at 1:13 P.M., showed the resident in the dining room, sitting flat on his/her buttocks in his/her wheelchair. The resident was eating lunch. Observation on 4/8/25 at 1:19 P.M., showed the resident was in his/her bedroom, sitting flat on his/her buttocks in his/her wheelchair with a visitor. During an interview on 4/8/25 at 1:34 P.M., CNA B said: -The CNA from Hospice came to give the resident a bed bath that morning around 9:00 A.M. and finished at roughly 10:45 A.M.; -The resident had been sitting flat on his/her buttocks in his/her wheelchair since the Hospice Aide left that morning; -He/She had not provided any incontinence care or repositioned the resident since 7:27 A.M.; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She should have asked the visitor if it was okay to perform incontinence care after the resident finished with lunch; -The resident was at greater risk of skin breakdown if not repositioned or checked for incontinent episodes at least every two hours. During an interview on 4/8/25 at 1:47 P.M., LPN A said: -He/She expected CNAs to reposition and check residents for incontinent episodes at least every two hours to prevent skin breakdown; -Residents needed to be kept clean and dry to decrease the risk of skin breakdown, prevent pressure ulcers and prevent the risk infection of existing pressure ulcers; -He/She expected CNAs to alert him/her if the resident had not received incontinent care before a visitor arrived as he/she would have intervened and asked the resident and their visitor if they could perform care first; -The Hospice CNA came and gave the resident a bed bath that morning at approximately 10:30 A.M. During an interview on 4/8/25 at 2:05 P.M., the Hospice Registered Nurse (RN) said: -The resident refused the Surveyor's request to watch the Hospice RN and CNA B provide incontinent care to the resident; -They laid the resident down in the bed from his/her wheelchair and removed a moderately to heavily urine soaked brief before perineal care; -The resident had a Stage II pressure ulcer located on his/her right buttock which measured 0.5 cm by 0.5 cm.; -The Hospice RN saw the resident earlier that day but wanted to come back to assess the resident's buttocks as she was informed by a nurse there was an area of concern. Review of the resident's progress notes, showed: -On 4/8/25 at 2:05 P.M., a nurse wrote he/she assessed the resident and noted an area was found on the resident's right buttock, non-blanchable, with the first layer of skin gone. It measured 2.6 centimeters by 0.6 centimeters. The nurse reported the new skin alteration to the Hospice Nurse, the Wound Nurse, the PCP and family; -On 4/8/25 at 5:26 P.M., the Hospice RN wrote she assessed the resident's right buttock and noted a small opened Stage II pressure ulcer was present on the inner part of the buttock measuring 0.5 cm by 0.5 cm with no depth. The PCP was informed with orders to apply ointment with zinc oxide on the open area every brief change until healed. Observation on 4/9/25 at 7:15 A.M. and at 8:12 A.M., showed the resident sat in his/her wheelchair, on a pressure relieving pad, in front of the nurses station. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/9/25 at 9:06 A.M., showed the resident in the dining room, eating breakfast. The resident's position was unchanged; He/She sat in his/her wheelchair. There were no positioning pillows or wedges present. At 9:24 A.M., 9:36 A.M., 9:55 A.M., 10:10 A.M., 10:17 A.M., 10:32 A.M., 10:40 A.M., 10:45 A.M., 10:55 A.M., 11:05 A.M., and at 11:14 A.M., the resident sat in his/her wheelchair in his/her bedroom. There were no positioning pillows or wedges present. During an interview on 4/9/25 at 11:28 A.M., the Hospice RN said: -She expected nursing staff to reposition the resident while he/she was in his/her wheelchair with pillows or offer to lay the resident down at least every two hours to prevent pressure ulcers; -She expected nursing staff to check the resident at least every two hours for incontinence episodes and provide perineal care to prevent pressure ulcers; -Hospice services were extra care for the resident and the facility staff were still responsible for providing care to the resident as per their policies and per nursing professional standards; -The lack of repositioning and lack of incontinence care could have contributed to the resident's new Stage II pressure ulcer found on his/her right buttock on 4/8/25. Review of the Wound Management note, dated 4/11/25, showed: -Seen for evaluation of an ulcer on his/her buttock discovered on 4/8/25. The ulcer is being treated topically with barrier cream. Healing complicated by incontinence and immobility; -Right buttock: Type: Pressure Ulcer/Injury: Stage 1 Intact (Skin Reddened with no Blanch) (no open ulcers). Measurements: 5.5 x 6.5 cm; -Left buttock: Type: Pressure Ulcer/Injury: Stage 1 Intact (Skin Reddened with no Blanch) (no open ulcers). Measurements: 5.5 x 4.0 cm; -Goal: Adequate offloading to alleviate pressure for optimal wound healing and Comfort Care to maintain quality of life and dignity; -Plan: Will continue to treat his/her buttocks topically with Remedy Protect Zinc Oxide Paste every shift and as needed (PRN). Staff is going to be sure to lie him/her down in bed periodically throughout the day and provide incontinent care as needed. Caregivers educated on skin care, positioning and wound care. 2. Review of Resident #11's Braden Score, dated 10/9/24, showed the resident was at high risk for pressure ulcers. Review of the resident's care plan, dated 11/29/24, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Pressure Ulcer; The resident had an alteration in skin integrity and required wound monitoring. Interventions included: The resident preferred to be on his/her back and was educated on the importance of repositioning for better wound healing; Apply treatments per physician orders; Keep clean and dry as possible, minimize skin exposure to moisture; Offer and assist resident to turn and reposition frequently. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No behaviors present; -Dependent on assistance from staff for toileting, dressing, personal hygiene, bed mobility and transfers; -At risk for pressure ulcers; -One unhealed Stage IV pressure ulcer present; -Diagnoses included kidney disease, chronic obstructive pulmonary disease (COPD, lung disease), heart disease and respiratory failure. Review of the resident's progress notes, showed: -On 3/31/25 at 12:25 P.M., the resident was seen by outside wound company and no new orders were given; -On 4/7/25 at 2:42 P.M., the resident was seen by an outside wound company and new orders were given; -There was no documentation the resident was offered repositioning or educated on increased risk of pressure ulcers without repositioning. Review of the resident's outside wound company wound report, dated 4/7/25, showed a Stage IV pressure ulcer was located at the resident's sacrum (triangular bone located above the coccyx (tailbone)), 100% pink granulation tissue (new tissue) present in wound bed, measuring proximal area (located closer to trunk of body) 0.6 cm by 0.7 cm by 0.1 cm deep and distal area (away from trunk of body) measuring 1.0 cm by 1.0 cm by 0.2 cm with moderate amount of sero-sanguinous (composed of serum and blood) exudate (drainage) present. Review of the resident's MAR, dated 3/9/25 through 4/8/25, showed: -An order, dated 7/21/23, to complete weekly skin assessments once a day on Tuesdays, was completed as ordered; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 2/24/25 through 4/7/25, to cleanse sacral ulcer with normal saline, apply Sorbagon silver (AG, a calcium alginate dressing used to manage moderately to heavily exudating (drainage) wounds) to proximal ulcer, apply Triad (ointment for wound care) to ulcer at the six o'clock position and cover with foam dressing twice a day and as needed. Documentation showed the treatment was administered as ordered; -An order, dated 4/7/25, to cleanse sacral ulcer with normal saline, apply Sorbagon AG, cover with bandage twice a day and as needed. Documentation showed the treatment was administered as ordered. Observation on 4/8/25 at 8:05 A.M., showed the resident asleep, flat on his/her back, on top of an APM. Observation on 4/8/25 at 8:26 A.M., showed: -The Wound Nurse and CNA B gave perineal care to the resident after removing a visibly heavily soaked with urine brief; -The Wound Nurse and CNA B turned the resident to his/her left side, exposing a bandage located on the resident's sacrum, dated 4/7/25; -The resident had bowel movement located on his/her anus and right and left buttocks; -The Wound Nurse instructed the CNA to remove the bandage from the resident's sacrum; -The bandage had dried brown matter on the outside edges of the dressing; -CNA B used a wet cleansing cloth and wiped the bowel movement from the resident's anus up towards the open wound; -The Wound Nurse administered the wound treatment to the sacral wound after CNA B completed perineal care; -They put a clean brief on the resident and covered him/her with a blanket, leaving the resident lying on his/her bed, flat on his/her back. During an interview on 4/8/25 at 8:35 A.M., the Wound Nurse said: -He was not allowed to stage pressure ulcers until he completed his Wound Nurse certification per facility directions but per his nursing knowledge, the resident had a Stage IV pressure ulcer located at his/her sacrum; -The outside wound company evaluated and treated the resident's Stage IV pressure ulcer every Monday; -He described the resident's Stage IV pressure ulcer as having a 100% pink wound bed, with one area of depth, with a scant amount of sero-sanguineous exudate; (continued on next page)

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	265170	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens of Chesterfield	14855 North Outer 40 Road Chesterfield, MO 63017

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was admitted with the Stage IV pressure ulcer located on his/her sacrum and it had improved greatly since admittance. Observation on 4/8/25 at 1136 A.M., at 11:56 A.M., showed the resident asleep in his/her bed, flat on his/her back. Observation on 4/8/25 at 12:20 P.M. through 12:40 P.M., showed CNA B in the dining room assisting residents with lunch. Observation on 4/8/25 at 12:43 P.M., showed the resident sat up in his/her bed, with the head of the bed elevated approximately 45 degrees, listening to his/her phone. The resident did not have any wedges or positioning pillows underneath him/her and sat flat on his/her buttocks. Observation on 4/8/25 at 1:15 P.M., showed the resident sat up in his/her bed, flat on his/her buttocks, with the head of the bed elevated approximately 90 degrees. The resident's bed tray was positioned over him/her and the resident was eating lunch. During an interview on 4/8/25 at 1:16 P.M., the resident said: -He/She did not think staff had changed his/her brief since the morning when the Wound Nurse was present and changed his/her treatment; -He/She did not have any pillows or wedges underneath him/her to reposition him/her off of his/her buttocks; -He/She could change his/her position in the bed by using the bed remote; -He/She required assistance to move/roll in the bed. Observation on 4/8/25 at 1:40 P.M., showed the resident lying in bed, flat on his/her back. CNA B removed the resident's blankets and pulled back his/her gown to expose the resident's brief. The brief was visibly soaked with urine, with the material bunching up in clumps underneath the outermost layer of the brief. There was a strong odor of urine present. During an interview on 4/8/25 at 1:42. P.M., CNA B said he/she had not provided incontinence care since 8:00 A.M. that morning and had not repositioned the resident during his/her shift. He/She should have checked the resident frequently for incontinence and repositioned the resident every two hours to prevent further skin breakdown and deterioration of the resident's existing pressure ulcer. He/She would get help from another CNA and provide incontinence care to the resident. Review of a documented interview, dated 4/16/25, submitted by the facility and with CNA B, showed he/she assisted Resident #11 with peri care, brief change and repositioning before lunch and after lunch. At 2-2:30 the resident was given a full bed bath with the assistance of a fellow CNA and CNA B. CNA B states the resident does not use the call light when he/she is incontinent, but has full control over the bed remote and often repositions the head and foot of the bed. CNA B states although resident prefers his/her back, the resident allows CNA B to place pillows under hips to reposition. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/9/25 at 7:14 A.M., showed the resident asleep, lying on his/her APM, positioned flat on his/her back. Observation on 4/9/25 at 8:13 A.M., showed: -The resident sat up in his/her bed, positioned flat on his/her buttocks; -LPN C administered medications to the resident; -There was a strong odor of urine emitting from the resident. Observation on 4/9/25 at 8:22 A.M., showed: -The resident lay flat on his/her back in his/her bed; -LPN C removed the covers from the resident and pulled back the resident's gown, exposing his/her brief; -The resident's brief was visibly soaked with urine, bulging between the resident's thighs; -There was a strong odor of urine emitting from the resident; -LPN C covered the resident back up with his/her gown and covers. During an interview on 4/9/25 at 8:24 A.M., LPN C said: -The resident's brief was wet with urine; -LPN C could not say he/she smelled any urine from the resident but he/she smelled pee all day long. During an interview on 4/9/25 at 8:39 A.M., the resident said: -He/She could feel the brief was wet, and could feel the wetness against his/her skin; -He/She was not sure if the wetness was bothering him/her but preferred to get changed. Observation on 4/9/25 at 8:42 A.M., showed: -The resident received incontinence care from LPN C and CNA D; -The nursing staff removed the resident's visibly urine soaked brief from the resident and performed perineal care; -The resident was then rolled to his/her left side with assistance from the nursing staff, exposing his/her buttocks which had dried brown matter stuck to them; -The resident was laying on an absorbent pad which was visibly dirty with brown matter; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's sacral Stage IV pressure ulcer had a treatment on it, dated 4/8/25; -The bottom and left sides of the treatment were not secured to the resident's skin and were yellow in color with brown matter visible at the edges; -LPN C confirmed the brown matter on the edges of the treatment and on the resident's buttocks was bowel movement; -LPN C removed the treatment from the sacral Stage IV pressure ulcer and showed there was fecal matter on the inside of the treatment as well; -LPN C performed perineal care on the resident, cleaning him/her of the bowel movement; -LPN C cleaned the sacral Stage IV pressure ulcer wound and applied the treatment as ordered; -LPN C failed to adhere the bottom edge of treatment to the resident's skin, leaving the bandage open; -The LPN and CNA put a new, clean brief on the resident and positioned the resident on his/her back; -LPN C and CNA D failed to remove the absorbent pad from underneath the resident, which was visibly dirty with brown matter; -LPN C and CNA D left the room. Observations on 4/9/25 at 9:04 A.M., 9:25 A.M., 9:36 A.M., 9:55 A.M., 10:10 A.M., 10:17 A.M., 10:32 A.M., 10:40 A.M., 10:45 A.M., 10:55 A.M., 11:05 A.M., and at 11:24 A.M., showed the resident lay in his/her bed, flat on his/her back. Review of a documented interview, dated 4/16/25, submitted by the facility and with CNA E, showed he/she was the assigned CNA for Resident #11 on 4/9/2025. CNA E was pulled from Division 700 at approximately 0730. He/She received report and began preparing for breakfast. CNA E stated he/she changed and performed peri care after breakfast, before lunch and after lunch. CNA E's shift ends at 1:30 P.M. CNA E stated the resident verbalized preferring to lay on his/her back. CNA E encouraged resident to offload and allowed a pillow to be placed under resident's hip, alternating each hip with each ADL care. During an interview on 4/10/25 at 9:56 A.M., the Wound Nurse said: -He expected nurses to ensure treatments were sealed/adhered to the resident's skin to prevent the risk of bowel movement or urine, or any other bacteria, from entering into the pressure ulcer, which could lead to infection and risk delay of the healing process; -He expected nursing staff to wipe bowel movement away from the resident's sacral Stage IV pressure ulcer to avoid getting bowel movement into the pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He expected nursing staff to lay the resident on clean absorbent pads which were free from urine or bowel movement to prevent the risk of infection or delay the healing process of the resident's pressure ulcer. 3. During an interview on 4/8/25 at 1:34 P.M., CNA B said: -He/She was assigned to both Residents #10's and #11's care today from 7:00 A.M. through 3:00 P.M.; -Residents who were dependent on staff for care needed to get repositioned and checked for incontinent episodes every two hours in order to prevent pressure ulcers. During an interview on 4/8/25 at 1:47 P.M., LPN A said: -He/She expected CNAs to reposition and check residents for incontinent episodes at least every two hours to prevent skin breakdown; -Residents needed to be kept clean and dry to decrease the risk of skin breakdown, prevent pressure ulcers and prevent the risk infection of existing pressure ulcers. During an interview on 4/9/25 at 11:07 A.M., and on 4/10/25 at 9:56 A.M., the Wound Nurse said: -He expected nursing staff to check residents for incontinent episodes at least every two hours to ensure they were kept clean and dry, and more often if the residents had heavy urine incontinence; -It was important to keep residents clean and dry to prevent skin breakdown and to decrease the risk of deterioration and infection of existing pressure ulcers; -He expected nursing staff to reposition residents off of bony prominences at least every two hours to prevent skin breakdown and to improve blood flow throughout residents' tissues; -He expected nursing staff to get residents up and out of their wheelchairs to prevent pressure ulcers and to help heal existing pressure ulcers, even if the resident was on hospice, as the goal was to prevent any harm to the resident; -He expected nursing staff to continue to offer repositioning to residents, even if they refuse and if their refusals were care planned; -Nursing staff had a responsibility to continue to educate residents on the importance of repositioning to prevent pressure ulcers and to try to figure out why the resident was refusing repositioning in order to put appropriate interventions in place; -He expected nursing staff to write progress notes showing they continued to offer repositioning and educated the residents on importance of repositioning so nursing staff could see the pattern of refusals and what interventions were tried. During an interview on 4/9/25 at 11:52 A.M. and at 1:20 P.M., the Director of Nursing (DON) said: -She expected staff to have knowledge of and to follow facility policies; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected staff to prevent pressure ulcers and promote healing of existing pressure ulcers by repositioning residents, checking them for incontinence episodes and performing perineal care if needed at least every two hours; -She expected nursing staff to offer to lay residents down or reposition them while they were in a wheelchair at least every two hours to help prevent pressure ulcers and promote healing of existing pressure ulcers; -She expected staff to offer residents repositioning and continued education on the importance of repositioning for pressure ulcer prevention and healing throughout their shift and to include their refusal in a care plan with appropriate interventions; -She expected nursing staff to keep residents' treatments free of any bowel movement to prevent the risk of infection and delayed healing of existing pressure ulcers. MO00243017 MO00243255 MO00248943