STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265175	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Joplin	2700 East 34th Street Joplin, MO 64803

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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 - 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** 34906 Based on interview and record review, the facility failed to provide pressure ulcer care and monitoring per standards of practice when staff failed to follow physician orders for treatment of an unstageable pressure ulcer (occurs when the base of a full-thickness tissue loss wound is covered by a layer of dead tissue that prevents staging of the ulcer) to one resident's (Resident #1's) coccyx (tailbone area), failed to update the treatment after a visit to the wound clinic, and failed to complete a weekly wound assessment of the resident's pressure ulcer. The resident developed a subsequent infection of his/her pressure ulcer that required hospitalization . The facility census was 68. Review of the facility assessment guideline titled, Assessments, dated January 2024, showed the following:: -Braden Scale (skin risk assessment completed by facility staff) completed within 24 hours of admission and then weekly for four weeks; -Weekly wound assessment; -Daily pressure ulcer monitoring will include an evaluation of the ulcer if no dressing is present; an evaluation of the status of the dressing if present (intact, drainage, leaking); status of the area surrounding the ulcer that can be observed without removal of the dressing; presence of possible complications such as signs of increasing of are of ulceration or soft tissue infection; and presence of pain. Review of the facility's policy/procedure titled, Wound Care, revised October 2010, showed the following: -The purpose of the procedure was to provide guidelines for the care of wound to promote healing; -Verify that there is a physician's order for the procedure; -The following information should be documented in the resident's medical record: the type of wound care provided; the date and time the wound care was given; the name and title of the of the individual performing the wound care; any change in the resident's condition; all assessment data (wound bed color, size, drainage, etcetera) obtained when inspecting the wound; any problems or complaints by the resident related to the procedure; if the resident refused the treatment and the reason why; and the signature and title of the person recording the data. (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 0686 Level of Harm - Actual harm Residents Affected - Few	1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included post coronary artery bypass graft (CABG - a medical procedure to improve blood flow to the heart), muscle weakness, and difficulty in walking. Review of the resident's admission assessment (body diagram), dated 04/18/24, completed by the facility's wound nurse, showed the wound nurse drew a circle over the resident's coccyx area with a number one, indicating an unstageable pressure ulcer to the area. Review of the resident's Wound Management Detail Report, dated 04/28/24 at 5:39 P.M., completed by the facility's wound nurse, showed the following: -Date/time identified: 04/18/24 at 5:38 P.M.; -Wound Type: Pressure ulcer; -Wound Location: Coccyx; -Present on Admission: Yes -Length: 11.0 centimeters (cm) in length (head to toe direction); -Width: 2.0 cm in width (side to side direction); -Can depth be measured: No; -Exudate (drainage) amount: Light -Exudate type: Serous (clear, amber, thin, and watery); -Stage: Unstageable due to presence of slough (a yellow or white, soft, wet, or dry material that can appear in the wound bed during the inflammation phase of healing); -Tissue Type: Slough; -Skin surrounding the wound: Dark purple or rusty discoloration. Review of the resident's April 2024 Physician Order Sheet (POS) showed the following: -An order, dated 04/18/24, for staff to cleanse the affected area to the coccyx, pat dry, apply a Mepilex (silicone adhesive foam) sacrum (area of the low back directly above the coccyx) dressing. Staff to change every three days on the day shift; (6:00 A.M. to 6:00 P.M.) and daily, as needed, if missing or soiled; -An order, dated 04/18/24, for wound care company to evaluate and treat the resident as indicated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's April 2024 Treatment Administration Record (TAR) showed the following: -An order, dated 04/18/24, for staff to cleanse the affected area to the coccyx, pat dry, and apply a Mepilex sacrum dressing once a day (6:00 A.M. - 6:00 P.M.) every three days; -The nurses did not initial completion of the treatment on 04/18/24, the day of admission to the facility. Review of the resident's Braden Scale for Prediction of Pressure Sore Risk (Acuity), dated 04/19/24, showed staff assessed the resident as not at risk for the development of a pressure ulcer. Review of the resident's April 2024 TAR showed the nurses did not initial completion of the ordered treatment on 04/19/24 or 04/20/24. Review of the resident's April 2024 TAR showed the following: -On 04/21/24, Registered Nurse (RN) B initialed completion of the ordered treatment with a comment of Late Administration: Other, Comment: Done on night shift. (Three days after the initial treatment order was received.); -The nurses did not document completion of the treatment on 04/22/24 and 04/23/24; -On 04/24/24, RN B initialed completion of the treatment with a comment of Late Administration: Other, Comment: Done on night shift; -The nurse did not document completion of the treatment on 04/25/24. Review of the resident's wound care clinic office visit, dated 04/25/24, showed the following: -Wound Site: Sacrum; -Cause: Pressure; -Onset: 04/10/24; -Care started: 04/25/24; -Length 4.3 cm, width 2.5 cm, Depth 1.1 cm; -Stage: 4 (a full thickness skin loss that extends to muscle, bone, tendon, or ligament); -Depth: Full thickness; -Amount of Drainage: Moderate; -Drainage type: Yellow/Tan; -Slough: 26-50%; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Necrotic (black, brown, or dark dead tissue) : 26-50%; -Sacrum cleansed with soap; -Odor after cleansing: None/Absent; -Mechanical debridement (removal of dead tissue using physical force) performed with gauze and saline. -Exposure: Subcutaneous tissue (the innermost layer of skin/fat) exposed; -Peri wound skin: Denuded (loss of the skin's outer layer); -Sharp debridement (the removal of dead tissue using a sharp instrument, such as a scalpel) performed by a physician; -Patient instructions: Any wound can become infected. Signs of infection include: redness, red streaks, swelling, pus, drainage, warmth in the area of the wound, fever, or increased pain or tenderness. Call the wound center if you have any questions; -Clean the wound as directed. Apply medication to the wound as directed. Dress with supplies as directed by the nurse and physician. Change dressing as directed; -After debridement you may see some bleeding. If bleeding occurs, hold pressure on the wound and re-bandage wound. If bleeding does not stop, call the wound center or go to the nearest emergency room ; -Please schedule a follow-up appointment in one week; -Orders faxed or sent to the facility. Review of the resident's wound care clinic referral form, dated 04/25/24, showed the following: -Diagnosis of pressure ulcer of sacral region, stage 4; -Wound care orders signed by the wound care physician on 04/25/24 as follows: Nursing home to perform wound care every other day and as needed (PRN). Cleanse sacrum with soap and water. Irrigate with normal saline (NS). Apply skin prep to periwound. Apply Alginate Silver (a highly-absorbent, antibacterial dressing), then cover with Mepilex Border sacrum; -Call the clinic with any questions. Review of the resident's medical record showed staff did not document the weekly wound assessment due to be completed on 04/25/24 (one week after the resident's initial wound assessment). Review of the resident's New Patient History and Physical, completed by the facility physician, dated 04/25/24, showed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Chief complaint included pressure ulcer of the coccyx; -Resident has a pressure ulcer on his/her coccyx and wound care is following him/her. Review of the resident's April 2024 POS showed an order, dated 04/25/2, for nurses to complete weekly skin observation assessments on Thursdays on 6:00 P.M. - 6:00 A.M. shift. Review of the resident's April 2024 TAR showed the following: -An order, dated 04/18/24, to cleanse affected area to the coccyx, pat dry, apply a Mepilex sacrum dressing once a day (6:00 A.M. - 6:00 P.M.) every three days; -Staff did not initial completion of the treatment on 04/25/24 and 04/26/24; -Staff did not update the resident's treatment order based on the wound care clinic's orders for treatment from 04/25/24. Review of the resident's Braden Scale for Prediction of Pressure Sore Risk (Acuity), dated 4/26/24, showed the following: -Staff assessed the resident as at risk for the development of a pressure ulcer; -Pressure reducing device for chair and bed. Review of the resident's weekly skin observation sheet, dated 04/26/24, showed the following: -Resident current pressure ulcer risk score 17 (at risk); -Pressure reducing device to bed. Review of the resident's April 2024 TAR showed the following: -An order, dated 04/18/24, to cleanse affected area to the coccyx, pat dry, apply a Mepilex sacrum dressing once a day (6:00 A.M. - 6:00 P.M.) every three days; -On 4/27/24, Licensed Practical Nurse (LPN) C documented: Not administered: Other, Comment: Order changed per wound clinic; -Staff did not update the resident's treatment order based on the wound care clinic's orders for treatment from 04/25/24. Review of the resident's progress note dated 04/28/24, at 10 :30 A.M., showed a nurse documented the following: -Resident was alert and oriented, pleasant, and cooperative. He/she able to voice needs. Skin was warm/dry. Temperature measured 101.6 degrees Fahrenheit (F) (average normal temperature is 98.6 degrees F). Staff administered Tylenol and temperature is now 99.6 degrees F. Resident asked how he/she felt, and resident replied, I feel alright. Medications as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's April 2024 TAR showed the following: -An order, dated 04/18/24, to cleanse affected area to the coccyx, pat dry, apply a Mepilex sacrum dressing once a day (6:00 A.M. - 6:00 P.M.) every three days; -Staff did not document completion of the treatment on 04/28/24 and 04/29/24; -Staff did not update the resident's treatment order based on the wound care clinic's orders for treatment from 04/25/24. Review of the resident's progress note dated 04/29/24, at 11:37 P.M., showed a nurse documented the following: -Resident started on intramuscular (IM - into the muscle injections) antibiotic for patchy left lung opacities (hazy gray areas on an X-ray that may indicate a concern, such as pneumonia or other respiratory disorder). IM injection given to the resident's left upper arm. The resident shared that he/she does not have much appetite. No adverse reaction noted or reported. Review of the resident's April 2024 TAR showed the following: -An order, dated 04/18/24, to cleanse affected area to the coccyx, pat dry, apply a Mepilex sacrum dressing once a day (6:00 A.M. - 6:00 P.M.) every three days; -On 04/30/24, LPN A initialed completion of the treatment (six days after the last documented treatment); -Staff did not update the resident's treatment order based on the wound care clinic's orders for treatment from 04/25/24. Review of the resident's progress note dated 04/30/24, at 10:24 A.M., showed a nurse documented the following: -Resident's emergency contact called the facility to request an update on the resident's condition. This nurse informed the resident's emergency contact of the resident's hemoglobin (red blood cells that carry oxygen from the lungs to the rest of the body) levels as well as the chest X-ray and antibiotics. The emergency contact expressed thankfulness for the prompt reply. No complaints of pain or discomfort. The resident began oral antibiotics this shift. No signs/symptoms of adverse reaction. Lung sounds diminished. Resident remains on room air. oxygen saturation is 93 %. Vital signs are within normal limits. Fluids encouraged. Review of the resident's progress note dated 04/30/24, at 3:52 P.M., showed a nurse documented the following: -The physician returned call related to resident's hemoglobin blood test result of 7.1 grams/deciliter (g/dL) (normal range 13.8-17.2 g/dL); (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Verbal orders for labs erythrocyte sedimentation rate (ESR - a non-specific indicator or inflammation or infection in the body) and a C-Reactive protein (CRP - an indication of inflammation in the body). Review of the resident's progress note dated 04/30/24, at 4:28 P.M., showed a nurse documented the following: -Resident having decreased blood pressure this shift; -Notified the resident's physician via phone call; -Verbal physician order to discontinue amlodipine (a medication used in the treatment of high blood pressure) and lisinopril (a medication used in the treatment of high blood pressure and heart failure); -Monitor blood pressure every shift for one week and then routinely; -Continue Coreg (a medication used in the treatment of high blood pressure and heart failure) 25 milligrams (mg) twice daily; -Add parameters to Coreg, do not give if blood pressure less than 110/60 millimeters of Mercury (mm/Hg) or if pulse less than 60 beats per minute. Review of the resident's progress note dated 04/30/24, at 8:58 P.M., showed an on-call physician documented the following: -Was called because the resident had been spiking a fever of 102.2 F; -The resident apparently has a decubitus (pressure ulcer) to his/her coccyx with foul smelling discharge and has been coughing and a recent chest x-ray showed a patchy infiltrate in the left lung; -The resident is indicating a cough and is already on ceftriaxone (an antibiotic); -On-site examination was by the nurse and the resident was evaluated by the physician via video with the assistance of the nurse; -Alert/awake, not in any significant distress; -Lungs per nurse good air entry bilaterally and no wheezing or crackles; -Heart sounds regular per nurse; -Able to move arms and legs; -Assessment: 1. pneumonia, 2. possible infected decubitus (pressure ulcer); -Plan: 1. pneumonia- resident is being sent to the hospital for further evaluation and advise; 2. possible infected decubitus pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note dated 04/30/24, at 9:30 P.M., showed RN B documented the following: -Resident had a fever and puking. Vital signs were as follows: Temperature = 102.2 degrees F, pulse oximetry = 87 % on room air (normal range = 95-100 %), heart rate = 97 beats per minute (normal range = 60-100), and blood pressure 142/71 mm/Hg (normal = 120/80 mm/Hg). Nurse called the on-call physician and shared what was going on with the resident. The physician advised the resident to be sent out to the hospital for further evaluation and treatment, resident agreed. The nurse called the hospital emergency room to give report and called the ambulance for transport. Resident transferred from his/her bed to the stretcher with two staff assisting from the facility and two ambulance staff assisting. Review of the resident's hospital emergency department visit documentation, dated 05/01/24, showed the following: -Seen by provider on 04/30/24, at 10:48 P.M.; -Presents in the emergency department due to fever, increased weakness. According to emergency medical services (EMS) report the patient did have a recent CABG about three weeks ago, and was at the nursing home for rehabilitation. Patient does express increased weakness, mild cough, and occasional shortness of breath, but otherwise declines physical complaints. Patient is also found to have a stage IV sacral decubitus ulcer. This was discussed with general surgery who recommended admission to the hospital with surgical consultation; -Impression/Diagnosis: Sacral decubitus ulcer, stage IV, generalized weakness. Review of the resident's hospital brief provider note, dated 05/01/24, showed the following: -Examination of the resident's sacral decubitus ulcer revealed a large, deep, gangrenous (dead tissue caused by infection or lack of blood flow) sacral decubitus ulcer, at least 10 cm in diameter, with dark, gray, gangrenous tissue throughout and a foul odor; -Recommended surgical debridement of wound. During interviews on 06/20/24, at 11:00 A.M. and 2:18 P.M., the wound nurse said the following: -Upon arrival from the hospital, the resident had a Mepilex dressing on his/her coccyx. The nurse removed the dressing and discovered an unstageable pressure ulcer; -The pressure ulcer was covered with slough and therefore he/she could not determine the depth of the wound; -He/she contacted the physician and obtained treatment orders; -He/she assessed the resident's wound and changed the resident's dressing; -He/she did not document the dressing change; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The wound nurse assessed the resident's wound on admission, but he/she then took off work for the remainder of the resident's stay at the facility; -He/she typically completed wound assessments weekly on any resident pressure ulcers; -During the resident's stay, on 04/25/24, facility staff transported the resident to an out of the facility wound clinic for treatment; -In the past, the wound clinic frequently asked the facility to leave other residents' dressings in place until their return to the wound clinic. During an interview on 06/20/24, at 11:25 A.M., LPN A said the following: -He/she cared for the resident a few times and remembered the resident had a pressure ulcer to his/her coccyx; -The resident went to a wound clinic for treatment; -He/she was unsure if any nurses at the facility measured or assessed the resident's pressure ulcer while the wound nurse was off work. During an interview on 06/20/24, at 2:27 P.M., the Director of Nursing (DON) said the following: -On 04/25/24, LPN A received a verbal phone order from the wound clinic to leave the resident's treatment in place, but LPN A did not document the order. During an interview on 06/20/24, at 2:31 P.M., LPN A said the following: -After the resident's return, the wound clinic called and told LPN A not to remove the resident's coccyx dressing because the treatment would be done at the wound clinic on the next weekly visit; -LPN A passed the information on in verbal report to the night nurse, but did not document any change in the resident's treatment order. During an interview on 06/20/24, at 3:05 P.M., LPN C said the following: -He/she did not recall ever seeing the resident's pressure ulcer; -He/she recalled during a shift to shift report, the off going nurse informed him/her not to remove the resident's coccyx dressing during a change of shift report because the wound clinic would be completing the treatment; -LPN C was unsure which day he/she heard this information. During an interview on 06/20/24, at 3:11 P.M., Registered Nurse (RN) B said the following: -He/she changed the dressing on the resident's coccyx, but did not recall any odor from the wound until 04/30/24; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 04/30/24, the resident developed a fever, despite staff administration of ordered antibiotics for a respiratory infection; -The nurse became concerned the resident's fever might be an indication of something serious; -He/she contacted the on-call physician, and the on-call physician conducted a virtual visit with the resident; The resident exhibited increased weakness, vomiting, and a the nurse assessed a foul odor coming from his/her coccyx pressure ulcer; -RN B did not recall the appearance of the resident's pressure ulcer. During an interview on 06/24/24, at 12:37 P.M., the Transportation Director said the following: -On 04/25/24, he/she accompanied the resident to the wound clinic; -After the appointment, the wound clinic staff tried to give orders verbally to the Transport Director to not change the resident's pressure ulcer dressing for 24 hours, but he/she informed the wound care clinic staff they would need to give any orders to the facility nurse, as he/she was not a nurse; -Upon return to the facility, the Transportation Director relayed this information to the facility nurse, LPN A. During an interview on 06/24/24, at 11:15 A.M., the Director of Nursing (DON) said the following: -Staff admitted the resident to the facility on [DATE] from the hospital, but the hospital did not inform the facility of the resident's coccyx pressure ulcer upon admission to the facility and the hospital discharge paperwork did not contain an order for treatment to the pressure ulcer; -On 04/18/24, the wound nurse observed the resident's coccyx pressure ulcer and obtained a physician's order for treatment; -The wound care nurse was then off work starting on 04/19/24 for several days; -If the wound nurse or any nurse was unable to initial a pressure ulcer treatment order as completed, he or she should document the wound care performed in a progress note in the resident's medical record; -If the resident went to the wound clinic and the wound clinic did not send any paperwork back with the resident, then the nurse on duty should call the wound clinic and request the wound clinic to send the information; -The nurse working on 04/25/24, LPN A, said the wound clinic called and informed LPN A not to change the resident's dressing, but LPN A failed to document the conversation or write an order to hold the treatment; (continued on next page)

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