STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265349	A. Building B. Wing	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Center for Rehab and Healthcare	2001 Jefferson Parkway Harrisonville, MO 64701

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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** 09895 Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #1) with a facility acquired pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) that became infected requiring antibiotic therapy had weekly assessments of his/her skin and to ensure assessment, staging and measurements and description of the wound bed and drainage, and that the resident's care plan was revised to address his/her coccyx (tailbone) pressure and his/her pressure ulcer infection, and failed to ensure weekly licensed nurse skin assessments and weekly wound documentation for one sampled resident (Resident #8) admitted to the facility with two unstageable (not stageable due to coverage of the wound bed with slough - tan/yellow dead tissue or eschar - dry, black hard dead tissue) pressure ulcers, out of eight sampled residents. The facility census was 71 residents. Review of the facility Wound Policy, undated showed: -Licensed nursing staff would complete a head-to-toe skin assessment weekly and as needed. -The skin assessment would be documented on a skin assessment form; any unusual findings would be documented on the form with a follow up note in the nurse's notes further describing the area of concern. -Consult wound care providers when appropriate. -Until wound care providers can assess and order treatment, the treatment is determined based on tissue type and drainage. -For moderate to heavily draining wounds, calcium alginate (a wound dressing that maintains a moist wound environment that helps remove non-living tissue and promotes heeling) is appropriate, cover with a secondary dressing to hold in place; change as needed for soiling or drainage. -For highly exudating (drainage that seeps out) wounds, cover with non-adherent (absorbent, gauze specially constructed to not stick to a healing wound) dressing, change as needed for soiling or drainage. (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 - Minimal harm or potential for actual harm Residents Affected - Few	-For wounds that have slough (moist material, usually cream or yellow in color that is a by-product of the inflammatory phase of wound healing) or UNSTABLE (soft, not firmly attached) eschar (a collection of dry, dead tissue within a wound that is typically dry, black, firm, and usually adhered to the wound bed and edges) present, a debridement (removal of damaged tissue or foreign objects from a wound) agent is required, change dressing daily and as needed for soiling or drainage. -For deep or tunneling wounds, fill the open space with calcium alginate rope or other packing agent; loosely pack; cover with secondary dressing. -All orders must be approved by a physician within 24 hours of discovering the open area or change in treatment. -Nurses may not diagnose, just describe. -Measurements must be completed weekly by the same licensed person when at all possible. -At the time a skin issue is discovered it must be measured; length width and depth must be documented if using measuring instrument. -It is acceptable to measure using common household objects (i.e., dime size, quarter size, size of half dollar) until actual measurements can be obtained per facility protocol. -A wound assessment should be documented in the nurse's notes (or other documentation location) with each dressing change. -It is recommended to chart on a TAR or other location that the dressing is intact every shift that a dressing change is not performed. 1. Review of Resident #1's Hospice (end of life care) Consent showed he/she was admitted to hospice services on 2/14/23 (prior to his/her facility admission). Review of the resident's facility care plan dated 6/1/23 showed: -No identification that he/she was at risk for or developed a pressure ulcer. -No care plan interventions to address the resident's open coccyx pressure ulcer. -No identification or interventions to address that the resident developed an infection in his/her open coccyx pressure ulcer. Review of the resident's electronic medical record (EMR) Assessments section including from 9/1/23 through 11/15/23 showed: -No weekly licensed nurse skin assessments. -No weekly wound documentation regarding the resident's coccyx open 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	Review of the resident's progress notes dated 9/1/23 through 11/15/23 showed no progress notes that described the resident's pressure ulcer stage, measurements, wound bed, tissue type and color, drainage, odor. Review of the resident's Medication Administration Records (MAR) and Treatment Administration Record (TAR) for 9/1/23 through 9/30/23 showed no documentation of treatment for the resident's coccyx. Review of the resident's MAR and TAR for 10/1/23 through 10/31/23 showed no documentation of treatment for the resident's coccyx. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 11/15/23 showed: -He/She was admitted to the facility on [DATE]. -He/She was severely cognitively impaired. -He/She had no pressure ulcers and no other open/injured skin problems. -He/She received hospice services. Review of the resident's Order Summary Report (Physician's Orders) for active orders as of 1/5/24 showed: -Medihoney (Wound/Burn Dressing External Gel - medical grade honey in a moisture-retentive suspension that supports the removal of dead tissue and provides a moist wound environment that and aids in wound healing), apply to coccyx topically every day shift every other day shift for wound care, dated 11/21/23. -No physician's order for Calcium Alginate. -Note: This was the first information in the resident's medical record that showed the resident had a pressure ulcer. Review of the resident's electronic medical record EMR Assessments section including from 11/15/23 through 12/5/23 showed: -No weekly licensed nurse skin assessments. -No weekly wound documentation regarding the resident's coccyx open pressure ulcer. Review of the resident's MAR and TAR for 11/1/23 through 11/30/23 showed documentation that Medihoney Wound/burn Dressing Dermal dressing gel, apply to coccyx topically every day shift every other day was administered on 11/21/23, 11/23/23, 11/25/23, 11/27/23, 11/29/23. Review of the resident's progress notes dated 11/15/23 through 12/5/23 showed no progress notes that described the resident's pressure ulcer stage, measurements, wound bed, tissue type and color, drainage, odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's MAR and TAR for 12/1/23 through 12/31/23 showed documentation that Medihoney Wound/burn Dressing Dermal dressing gel, apply to coccyx topically every day shift every other day was administered every other day from 12/1/23 through 12/31/23. Review of the resident's EMR Assessments section including from 12/5/23 through 1/5/24 showed: -No weekly licensed nurse skin assessments. -No weekly wound documentation regarding the resident's coccyx open pressure ulcer. Review of the resident's progress notes dated 12/5/23 through 1/5/24 showed: -No progress notes that described the resident's open coccyx pressure ulcer stage, measurements, wound bed, tissue type and color, drainage, odor. -No progress notes that documented the change in the resident's open coccyx pressure ulcer and change in treatment to include Calcium Alginate. Review of the facility Weekly Wound Report dated 12/19/23 showed: -Areas to identify resident room number, name, type of wound, site (location on body) of wound, acquired in house (at the facility), date acquired (date of wound onset), stage (the system used by healthcare providers to determine the severity of a pressure ulcer), the length, measurements, description, if a treatment was in place and ant lab tests. -Two resident's had surgical wounds, one resident had a wound classified as other and no residents with pressure ulcers. -Resident #1's name and coccyx wound were not documented on the report. Review of the resident's licensed nurse progress note dated 12/21/23 at 10:33 A.M. showed: -Wound care to coccyx done as ordered. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/23/23 at 3:07 P.M. showed: -The resident's wound care was completed by the Licensed Practical Nurse (LPN). -The licensed nurse spoke with the resident's spouse by telephone. -The resident's spouse asked if the resident's coccyx wound was better than the previous day. -The licensed nurse told the resident's spouse that the resident's coccyx wound did not look worse from three days prior when he/she had last worked. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/26/23 at 1:20 P.M. showed: -The wound nurse completed the resident's coccyx wound treatment and noted drainage with foul odor. -The resident's Nurse Practitioner (NP) was present at the facility and ordered one gram of Rocephin (an antibiotic) intramuscular (IM) for five days for wound infection. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's progress note dated 12/26/23 at 1:51 P.M. showed: -Hospice was updated regarding the new antibiotic order. -The resident's spouse was updated regarding new orders. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/27/23 at 2:48 P.M. showed: -The resident continued on Rocephin IM (antibiotic) for infected coccyx wound. -Wound care was performed, coccyx with open area with foul odor and small amount of dark green drainage. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/28/23 at 5:38 A.M. showed: -The resident continued on IM antibiotic for coccyx infection. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/28/23 at 10:32 A.M. showed: -Resident remains on Rocephin IM for wound infection. -Treatment was done by the wound nurse, the wound remained with drainage and foul odor. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's licensed nurse progress note dated 12/29/23 at 5:14 A.M. showed: -He/she continued on antibiotic for wound infection. -His/her dressing was intact with minimal drainage noted. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/29/23 at 12:21 P.M. showed: -He/she remained on IM Rocephin. -Wound care was done by in house wound nurse. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 12/30/23 at 11:20 A.M. showed: -Wound care was done by wound nurse. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 1/1/24 at 7:12 P.M. showed: -The dressing on the resident' coccyx was changed. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 1/2/24 at 12:42 P.M. showed: -Wound care was done by wound nurse. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's licensed nurse progress note dated 1/4/24 at 1:39 P.M. showed: -Wound care was done by wound nurse. --NOTE: Documentation did not include the description of the resident's coccyx wound, pressure ulcer stage, and/or measurements. Review of the resident's hospice notebook on 1/5/24 showed no documentation of the resident's open coccyx pressure ulcer measurements, wound bed, tissue type, drainage/odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 1/5/24 at 10:52 A.M. showed: -The resident was covered and lying in bed on his/her left side in bed. -On the resident's overbed table were wound care supplies including Medihoney and calcium alginate. -LPN A was present in the resident's room and said the resident had a large open wound on his/her coccyx; he/she had just completed the resident's wound care using Medihoney and calcium alginate; the resident's open coccyx wound had a foul odor and had been recently treated with an antibiotic. During an interview on 1/5/24 at 11:07 A.M., LPN A said: -At the end of his/her shift on 1/4/24 the wound nurse had told him/her to use calcium alginate along with the Medihoney for the resident's wound treatment. -He/She used Medihoney and calcium alginate for the resident's wound care on 1/5/24. -There was no order in the resident's EMR for calcium alginate. -He/She tried to call the wound nurse on 1/5/24 regarding an order for calcium alginate but there was no answer. Observation and interview with the Director of Nursing (DON) on 1/5/24 2:04 P.M. showed: -The resident was lying in his/her bed. -The resident had an open pressure ulcer that had slough (moist material, usually cream or yellow in color that is a by-product of the inflammatory phase of wound healing) in the wound bed, undermining (damage under the tissue that is larger than what appears at the surface - a pocket of dead space) at the wound edges and a foul odor. -The DON measured the resident's coccyx wound and said it measured 7 centimeters (cm) long by 5 cm wide with a depth of 1.5 cm, had 50% - 60 % slough in the wound bed, and there was undermining at the wound edges. -The resident's physician would be contacted for updated orders for the resident's coccyx wound. During an interview on 1/5/24 at 2:05 P.M. the Administrator and DON said: -They had not been aware the resident had an open pressure ulcer on his/her coccyx until asked regarding the resident's open coccyx pressure ulcer. -The Administrator had just called the wound nurse and the wound nurse had told him/her the resident's wound was being documented by the hospice nurse. -There was no assessment documentation in the resident's hospice notebook regarding the resident's open coccyx 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	-The wound nurse was responsible for assessing and documenting residents' pressure ulcers, documenting his/her findings in the resident's EMR and on the Weekly Wound Report. -The resident's open coccyx pressure ulcer assessment was not documented in the resident's EMR. -The resident's open coccyx pressure ulcer assessment was not documented on the Weekly Wound report. Review of the resident's telephone physician order dated 1/5/24 at 2:32 P.M. showed: -Flush and clean wound on coccyx with normal saline, apply skin prep (a solution that forms a film to protect the skin by reducing friction) to peri (surrounding) skin; apply Santyl (a prescription medicine that removes dead tissue from wounds so they can start to heal) to wound bed and pack with calcium alginate; cover with abdominal dressing (a thick dressing used for padding and for absorbing fluids that drain from open wounds) twice daily and as needed/soiling. -Wound is 7 cm long by 5 cm wide by 1.5 cm deep. --NOTE: The order was obtained after the wound was observed by the state surveyor. During an interview on 1/5/23 at 2:45 P.M. the Administrator and DON said: -The resident's wound should have been assessed and documented weekly in his/her EMR and on the Weekly Wound Report. -The DON should have been notified when the skin on the resident's coccyx opened and with changes in the resident's coccyx wound. -The Administrator said the wound nurse had been aware for a long time that all wounds whether the resident is on hospice or not have to be assessed and documented in the resident's EMR and on the Weekly Wound Report. -The LPN/Wound Nurse could not stage a wound but could measure and describe wounds and document the resident's wound; the Wound Nurse could have gotten a facility Registered Nurse (RN) to stage the resident's wound; there were RNs at the facility and also a corporate RN was available when needed. -The Wound Nurse should have discussed the resident's wound weekly in Risk Meetings, including reviewing if there had been changes in treatments and worsening or improvement of the resident's wound. -Licensed nurses should have completed and documented weekly skin assessments and for the resident. During an interview on 1/11/24 at 10:35 A.M. the facility wound nurse said: -The resident developed an open pressure ulcer sometime in November 2023. -He/She had thought that because the resident was on hospice, the hospice was assessing the resident's wound and documenting the assessment in the resident's hospice notebook. (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 notified the practitioner (NP) and obtained an order for treatment with Medihoney. -The resident's pressure ulcer worsened, got larger and had new depth and on 1/4/24 he/she talked with the NP and got an order to add calcium alginate to the resident's pressure ulcer treatment orders; he/she did not write the NP's order for calcium alginate in the resident's EMR but told another licensed nurse to treat the resident's pressure with Medihoney and calcium alginate; he/she thought the LPN would have written the order for calcium alginate. -He/She should have written the order for calcium alginate. -Previously the resident's open coccyx wound had been treated with an antibiotic due to drainage and a foul odor and there continued to be drainage and a foul odor on 1/4/24. -Prior the resident's coccyx having an open area, Calmoseptine (an effective, multipurpose moisture barrier ointment that protects and helps heal skin irritations) was used to protect his/her skin from frequent loose stools. --Note: There was no documentation in the resident's EMR regarding the use of Calmoseptine on the resident' coccyx prior to the physician's order for Medihoney. -He/She had not entered an assessment of the resident's coccyx wound in the resident's EMR and had not documented the resident's pressure ulcer on the facility Weekly Wound Report. -He/She had discussed the resident's open coccyx pressure wound in the weekly Risk Meetings a couple of times but had not discussed the resident's open pressure ulcer each week in the Risk Meetings. -He/she should have measured the resident's coccyx wound each week and should have entered the measurements along with a description of the wound bed, any drainage, odor and the surrounding skin condition in the resident's EMR. -As an LPN, he/she could not stage pressure ulcer but could measure pressure ulcers and document the measurements along with a description of the resident's wound bed, drainage and odor. -He/She could have gotten a facility Registered Nurse (RN) to go with her to assess and provide a stage for the residents open coccyx pressure ulcer. -He/She should have documented the resident's coccyx wound weekly on the facility Weekly Wound Report and each time she was at the Risk Meeting, he/she should have reported on the condition of the resident's pressure ulcer and if there had been improvement or worsening. During a telephone interview on 1/16/24 the resident's hospice RN case manager said: -The resident had received hospice services beginning on 2/14/23, prior to his/her facility admission when he/she was at another facility and hospice services continued after his/her facility admission. -The facility notified him/her regarding the resident's pressure ulcer, he/she could not recall the date of the notification but said the resident had the pressure ulcer for some time. (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 was admitted with unstageable pressure injuries on his/her right and left ischial areas. -He/She was to have weekly skin assessments per the schedule. -He/She was seen by the facility wound nurses. Review of the resident's progress notes dated 8/25/23 through 1/9/24 showed no progress notes that described the resident's open coccyx pressure ulcer stage, measurements, wound bed, tissue type and color, drainage, and if odor was present. Review of the facility Weekly Wound Report dated 12/19/23 showed the resident's name and pressure wound were not documented on the report. Review of the resident's licensed nurse progress late entry note dated 1/10/23 showed: -He/She returned from hospital. -A later undated late entry showed the area on his right hip was a pressure wound that was 5 cm long by 3.5 cm wide, no odor was noted and the area had pink granulation tissue. -His/Her outer right foot had a 1 cm by 1.5 cm raised area that appeared to be a callous. Observation on 1/18/24 at 1:34 P.M. showed: -The resident had an open pressure ulcer on his/her right ischial area that appeared to be about 5 cm by 3.5 cm, there was no drainage; there was a large area of scar tissue around the open area with an appearance of a former deep pressure ulcer. -The resident's left ischial area had no open areas and a large area of scar tissue with an appearance of a former deep pressure ulcer. -The resident had a dry callous area on his/her right foot that was about 1 cm by 1.5 cm. During an interview on 1/18/24 at 1:52 P.M. the wound nurse said: -When admitted , the resident had very large deep pressure ulcers on the back of both hips. -The resident's left hip was healed and his/her right hip pressure area was nearly healed; the callous on the resident's right foot was unchanged. During an interview on 1/19/24 at 2:14 P.M. the wound nurse said: -The resident had been on hospice since his/her admission to the facility. -He/she had not documented the resident's pressure ulcers because he/she had thought the hospice nurses were documenting the resident's wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265349	A. Building B. Wing	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Years Center for Rehab and Healthcare	2001 Jefferson Parkway Harrisonville, MO 64701

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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	-He/she now knew he/she was responsible for documenting all resident pressure ulcers whether the resident was on hospice or not on hospice. -He/she was also responsible for ensuring all resident pressure ulcer assessments are entered onto the facility weekly pressure ulcer report. During an interview on 1/19/23 at 10:35 A.M. the resident's physician said: -The facility wound nurse should have assessed and documented the resident's pressure ulcers weekly. -The facility wound nurse should have tracked the resident's pressure ulcers weekly on the facility pressure ulcer weekly tracking form. MO00228716 MO00230413