

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Waynesville		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Birch Lane Waynesville, MO 65583	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42815</p> <p>Based on interview, and record review, facility staff failed to maintain professional standards of practice when staff failed to complete and document wound care treatments for three resident's (Resident #1, #2 and #3) out of three sampled residents. The facility census was 78.</p> <p>1. Review of the facility's Treatment Orders Policy, dated 07/29/24, showed staff are directed as follows:</p> <ul style="list-style-type: none"> -Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices; -A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; -The policy did not contain direction for staff in regard to documenting treatments in the resident's medical record. <p>2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/21/24, showed staff assessed the resident as cognitively intact and rejected care one to three days during the seven day look back period.</p> <p>Review of the resident's Physician Order Sheet (POS), undated, showed an order to clean buttocks with normal saline and apply Triad Hydrophillic Cream (cream used to help maintain a moist healing environment) every day and night shift and an order to clean the buttocks with normal saline and apply Triad Hydrophillic Cream three times a day.</p> <p>Review of the resident's Treatment Administration Record (TAR), dated 11/01/24 to 11/30/24, showed it did not contain documentation staff provided the physician ordered treatment to the buttocks as ordered on 11/02/24.</p> <p>Review showed the resident's TAR, dated 11/01/24 to 11/30/24, did not contain documentation staff provided the physician ordered treatment to the buttocks as ordered on 11/17/24, 11/24/24, 11/25/24 or 11/29/24.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's POS, undated, showed an order to cleanse the perineal area with normal wound cleanser, apply zinc oxide generously and leave open to air on day shift every other day.</p> <p>Review showed the TAR, dated 11/01/24 to 11/30/24, did not contain documentation staff applied zinc oxide and leave open to air as odered on 11/02/24.</p> <p>3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as severe cognitive impairment and did not reject care.</p> <p>Review of the resident's POS, undated, showed an order to apply barrier paste three times a day, an order to apply skin prep to right and left heel daily every day and an order to apply Clobetasol Propionate Cream 0.05% (cream used to relieve redness, itching, swelling, or other discomfort caused by certain skin conditions) to right arm topically two times a day.</p> <p>Review showed the resident's TAR, dated 11/01/24 to 11/30/24, did not contain documentation staff applied barrier paste as ordered on 11/01/24, 11/12/24, 11/16/24, or 11/25/24.</p> <p>Review of the resident's TAR, dated 11/01/24 to 11/30/24, did not contain documentation staff applied skin prep to the resident's right and left heel as ordered on 11/14/24 or 11/27/24.</p> <p>Review of the resident's TAR, dated 11/01/24 to 11/30/24, did not contain documentation staff applied Clobetasol Propionate Cream 0.05% to right arm topically as ordered on 11/26/24.</p> <p>4. Review of Resident #3's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact and did not reject care.</p> <p>Review of the resident's POS, undated, showed an order to apply zinc paste to coccyx every shift and an order to apply skin prep to left lateral ankle every day .</p> <p>Review of the resident's TAR, dated 11/01/24 to 11/30/24,did not contain documentation staff provided applied zinc paste to the coccyx and an order to apply skin prep to left lateral ankle every day as ordered on 11/24/24 and 11/25/24.</p> <p>5. During an interview on 12/05/24 at 11:54 AM, Licensed Practical Nurse (LPN) A said staff are directed to document completed wound care on the resident's TAR. He/She said if a treatment was not documented in the resident's medical record, the nurse should complete the treatment and notify the physician. He/She said there should never be a lack of documentation on the TAR because there are codes to enter if the resident did not receive the treatment. He/She did not know there were missing treatments.</p> <p>During an interview on 12/05/24 at 1:38 P.M., the Director of Nursing (DON) said he/she expected staff to follow the physician orders for wound care and complete treatments as ordered. He/She said the orders are documented in the resident's TAR. He/She said if staff noticed a missing treatment, he/she should report to himself/herself. The DON said he/she would investigate the missing treatment to verify if the treatment was completed or not. He/She said if there was a missing treatment, he/she would conduct an in-service with the nursing staff. He/She said if a treatment was not completed, there was a potential the wound would not heal as quickly as he/she would like. He/She said he/she did not know there were missing treatments.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/05/24 at 1:39 P.M., the administrator said if staff noticed missing documentation on a resident's TAR, the nurse would contact the physician and up the chain of command. He/She said the nurse who received the order was responsible to enter the order into the resident's medical record. He/She said staff are directed to follow physician orders and provide treatments according to the orders. He/She said staff are to document if a treatment was completed or the reason the treatment was not completed. He/She said the concern with missing treatments was the potential the wound not heal as quickly as he/she would like. He/She said staff did not notify him/her there were missing treatments. He/She said the nursing leadership is to monitor for missing treatments. He/She said there were interim nursing leaders during the period of the missing treatments, but since have hired a full-time leader.</p> <p>MO00246040</p>		