

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Festus Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 627 Westwood Drive South Festus, MO 63028	

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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49999</p> <p>Based on observation, interview, and record review, the facility failed to provide wound treatments as ordered by the wound clinic, and notify the physician of the resident's non-compliance with wound treatment and the worsening of a wound for one resident (Resident #1) out of four sampled residents. The facility census was 116.</p> <p>Review of facility's policy titled, Prevention of Pressure Injuries, dated April 2020, showed:</p> <ul style="list-style-type: none"> - Evaluate, report and document potential changes in the skin; - Review the interventions and strategies for effectiveness on an ongoing basis. <p>Review of facility's policy titled, Pressure Injury Risk Assessment, dated March 2020, showed the following information should be recorded in the resident's medical record utilizing facility forms: If the resident refused the treatment; The reason for refusal and the resident's response to the explanation of the risks of refusing the procedure; The benefits of accepting the available alternatives; Document family and physician notification of refusal; Documentation in the resident's medical record addressing the physician notification if new skin alteration noted with change of plan of care, if indicated; Notify attending physician if new skin alteration noted; The date and time and type of skin care provided, if appropriate; Any change in the resident's condition, if identified; If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risk of refusing the procedure, the benefits of accepting and available alternatives; Notify the supervisor if the resident refuses the procedure.</p> <p>Review of facility's policy titled, Wound Care, dated October 2010, showed:</p> <ul style="list-style-type: none"> - Verify that there is a physician's order for this procedure; - Document if the resident refused the treatment and the reason why. <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> - Resident admitted on [DATE]; <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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), central cord syndrome (an incomplete traumatic injury to the portion of the spinal cord that runs through the bones of the neck which results in weakness in the arms more so than the legs), pressure ulcer (an injury to skin and underlying tissue resulting from prolonged pressure on the skin), neuromuscular dysfunction of the bladder (a loss of bladder control resulting from brain, spinal cord, or nerve problems), obesity (a disorder that involves having too much body fat), indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine), quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), colostomy (an opening for the colon, or large intestine, through the abdomen), and blindness in the left eye.</p> <p>Review of the resident's care plan, dated 05/10/24, showed:</p> <ul style="list-style-type: none"> - Resident with impaired skin integrity related to comorbidities; - Administer treatments as ordered and monitor for effectiveness; - Resident prefers for treatments be completed before breakfast or dinner. Does not want treatments completed after the night time medication pass; - Assess/record/monitor wound healing weekly. Measure length, width and depth where possible; - Assess and document status of the wound perimeter, wound bed and healing progress; - Report improvements and declines to the physician; - Encourage the resident to accept care and allow treatments be completed, educate on need to do treatments; - Educate on adverse effects that may occur if continues to refuse care; - Monitor/document/report as needed (PRN) any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth), stage; - Provide treatment to wound as ordered. <p>Review of the resident's consulting wound clinic progress report/order, dated 05/29/24, showed:</p> <ul style="list-style-type: none"> - Measurement and description for the center midline coccyx pressure injury: 1.5 centimeters (cm) x 0.5 cm x 0.1 cm with 100 percent (%) granulation tissue (new growth of small blood vessels and connective tissue) with well defined wound edges, 0% necrotic (dead) tissue, redness around the wound and moderate light red/pink drainage; - Measurement and description for the left lateral lower leg pressure injury: 7.5 cm x 4.5 cm x 0.1 cm. with 1 cm of undermining from 11 to 12 o'clock with 100% slough and necrotic tissue with distinct wound edges, redness around the wound, and heavy light red/pink drainage; <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- A treatment order for the Stage 3 pressure injury (full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed) to the center midline coccyx (small triangular area below the spine): Cleanse the wound with cleanser and pat dry with gauze. Apply collagen (helps stimulate new tissue growth) to the wound bed, followed by oil emulsion (white petroleum) gauze (PRN). Cover with foam with silicone bordered dressing (highly absorbent foam with waterproof backing) three times weekly and PRN for soiled or loose dressing. Use bordered gauze between scheduled dressing changes and PRN for soiled or loose dressing. Secure dressing with tape as needed;</p> <p>- A treatment order for the unstageable pressure injury (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer can't be confirmed because it is obscured by slough (soft and/or moist dead tissue) or eschar (thick, dry, and leathery dead tissue)) to the left lateral (outer) lower leg: Cleanse the wound with cleanser and pat dry with gauze. Apply Medihoney (helps with the removal of dead tissue and aids in wound healing) to the wound bed, followed by calcium alginate (helps maintain a moist wound environment). Cover with absorbent pad dressing three times weekly and PRN for soiled or loose dressing and wrap with rolled gauze. Secure the dressing with tape as needed.</p> <p>Review of the resident's consulting wound clinic progress report/order, dated 06/05/24, showed:</p> <p>- Measurement and description of the center midline coccyx pressure injury: 1 cm x 0.8 cm x 0.1 cm with 90% granulation tissue, 10% necrotic tissue with non visible wound edges, redness around wound, and moderate light red/pink drainage. Wound increased in size;</p> <p>- Debridement (the removal of dead and other types of unwanted tissue) provided to the left lateral lower leg unstageable pressure injury with the necrotic tissue removed. The left lateral lower leg pressure injury now a Stage 3;</p> <p>- Measurement and description of the left lateral lower leg pressure injury: 8.5 cm x 2 cm x 0.1 cm with 90% granulation tissue, 10% slough and necrotic tissue with distinct wound edges, redness around wound, and heavy light red/pink drainage;</p> <p>- A treatment order for the Stage 3 pressure injury to the center midline coccyx: Cleanse the wound with cleanser and pat dry with gauze. Apply collagen to the wound bed, followed by oil emulsion gauze (PRN). Cover with foam with silicone bordered dressing three times weekly and PRN for soiled or loose dressing. Use bordered gauze between scheduled dressing changes and PRN for soiled or loose dressing. Secure dressing with tape as needed;</p> <p>- A treatment order for the Stage 3 pressure injury to the left lateral lower leg: Cleanse the wound with cleanser and pat dry with gauze. Apply Medihoney to the wound bed, followed by calcium alginate. Cover with absorbent pad dressing three times weekly and PRN for soiled or loose dressing a wrap with rolled gauze. Secure dressing with tape as needed.</p> <p>Review of the resident's Physician's Order Sheet (POS), dated 06/25/24, showed:</p> <p>- An order for the consulting wound clinic for a wound care evaluation and treatment, dated 05/06/24;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - An order for the Stage 3 pressure injury to the coccyx: cleanse with a wound cleanser, pat dry, apply collagen, calcium alginate, and bordered silicone dressing three times a week and PRN, every day shift every Monday, Wednesday, Friday, dated 05/15/24; - No documentation of an order for the Stage 3 pressure injury to the left lateral lower leg; - The facility failed to update the physician's orders for the Stage 3 pressure injuries to the coccyx and the left lateral lower leg from the consulting wound clinic for 05/29/24 and 06/05/24. <p>Review of the resident's Treatment Administration Record (TAR), dated 06/01/24 through 06/25/24, showed:</p> <ul style="list-style-type: none"> - An order for the Stage 3 pressure injury to the coccyx: cleanse with a wound cleanser, pat dry, apply collagen, calcium alginate, and bordered silicone dressing three times a week and PRN, every day shift every Monday, Wednesday, Friday, dated 05/15/24; - No documentation of the wound care treatment provided for the Stage 3 coccyx pressure injury on 06/10/24, 06/17/24, and 06/19/24, with three out of 10 opportunities missed; - No documentation of an order and no wound care treatments provided to the left lateral lower leg pressure injury with ten out of ten opportunities missed; - The facility failed to update the TAR with the orders for the Stage 3 pressure injuries to the coccyx and the left lateral lower leg from the consulting wound clinic for 05/29/24 and 06/05/24; - The facility failed to provide the correct treatments as ordered by the consulting wound clinic. <p>Review of the resident's progress notes showed:</p> <ul style="list-style-type: none"> - No documentation the resident's physician was notified the resident refused and/or didn't receive wound care treatments on 06/10/24, 06/17/24, or 06/19/24; - On 06/12/24 at 11:29 A.M., the resident refused to be seen for wound rounds with the consulting wound clinic; - No documentation the resident's physician was notified of the resident's refusal to be seen by the wound consulting clinic. <p>Observation of the resident on 06/25/24 at 10:50 A.M., showed:</p> <ul style="list-style-type: none"> - An overwhelming wound odor when the resident's door was opened; - The resident lay on his/her back on the bed. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/25/24 at 10:51 A.M., Resident #1 said he/she did not want to be seen by the wound clinic because they were unprofessional. He/She did not care if they controlled his/her wound care orders. He/She said the nurses at the facility could do his/her dressing changes. The facility staff was told by him/her that he/she no longer wanted to be seen by the consulting wound clinic staff.</p> <p>During an interview on 06/25/24 at 1:34 P.M., Certified Nurse Assistant (CNA) A said the wound odor in Resident #1's room was always strong and the resident wouldn't let staff keep the door open.</p> <p>During an interview on 06/25/24 at 1:35 P.M., Licensed Practical Nurse (LPN) B said he/she completed the wound care treatments to the resident's coccyx and the left lateral lower leg pressure injuries on 06/21/24, and he/she documented the treatments when completed. He/She did not notice an odor coming from the resident's coccyx wound when Resident #1's dressing was changed on 06/21/24. LPN B thought the odor came from the resident's colostomy. There were times the resident did refuse wound care. He/She documented it when the resident refused the wound care. LPN B waited until the resident refused the wound care a few times before contacting the physician. He/She followed the physician's orders for the wound care.</p> <p>During an interview on 06/25/24 at 3:17 P.M., the Administrator and Director of Nursing (DON) said the facility's wound nurse was responsible for adding and updating the wound orders in the resident's medical record. The DON and Administrator said they would expect the physician to be notified if a resident refused care.</p> <p>During an interview on 06/26/24 at 1:48 P.M., the resident's primary physician said he/she wasn't notified by the facility that Resident #1 refused his/her wound care treatments or to be seen by the wound clinic. He/She would expect to be notified if a resident was refusing dressing changes or refusing to be seen by the wound clinic. He/She would expect the facility to provide the correct wound treatment orders and to document the wound treatment orders when provided or declined by the resident. The wound care clinic provider would be responsible for the wound care orders.</p> <p>Complaint #MO237452</p>		