STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265404	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on observation, interview and record review, the facility failed to completely assess and document one resident's (Resident #1) skin upon admission to the facility and notify the resident's physician of a scab (crust that forms over a sore or wound) on the resident's left heel at the time of the resident's facility admission, failed to ensure treatments were completed for the resident's left heel and edema (swelling) in the resident's legs, failed to ensure weekly licensed nurse skin assessments and completion of and licensed nurse review of Certified Nurse (CNA) shower sheets, failed to notify the resident's physician of the resident's left heel skin breakdown to his/her legs, and failed to ensure the resident's emergency room physician's instruction for the resident's anticoagulant medication to be held for two doses and then resumed was reviewed by a licensed nurse and written on the resident's Physician's Orders Sheet (POS) and Medication Administration Record (MAR) resulting in the resident receiving one dose of his/her anticoagulant medication during the time it was to be held, out of four sampled residents. The facility census was 49 residents. Review of the facility Bath, Shower/Tub policy revised February 2018 showed: -Document: --The date and time the shower/tub bath was perform the name and title of the individual(s) who assisted the resident with the shower/tub bath; --If the resident refused the shower/tub bath, the reason(s) why and the interventions taken; --The signature and title of the person recording the data. -Notify the physician of any skin areas that may need to be treated. Review of the facility Change in a Resident's Condition or Status policy revised February 2021 showed: -The facility promptly notifies the resident's physician of changes in the resident's medical/mental condition and/or status. -Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. (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 0684 Level of Harm - Actual harm Residents Affected - Few	-The nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility Admission Notes policy revised September 2021 showed: -When a resident was admitted to the facility, the admitting nurse must document information as may apply in the nurse's notes, admission form, or other appropriate place, as designated by facility protocol including the general condition of the resident upon admission. -A statement indicating that the nursing history and preliminary assessment was completed or had been started. -No specific instruction to assess and document the resident's skin. Review of the undated facility Weekly Skin Integrity Review form showed: -Areas to indicate skin was intact, bruises, rash, blisters, redness, skin tear and instruction to see reverse side for comments and open area new or old with instruction to proceed to Wound Documentation form. -A body map (a chart showing the front and back of the body upon which to mark locations of skin abnormalities). -Areas for Assessment of Skin Concerns/Measurements/Description for a four-week time frame. Review of the facility Adverse Consequences and Medication Errors policy revised February 2023 showed: -A medication error was defined as the preparation or administration of drugs which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 1. Review of Resident #1's Face Sheet showed: -He/she was admitted to the facility on [DATE]. -He/she had diagnoses hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body). Review of the resident's Admission Nursing Evaluation dated 1/5/24 showed: -He/she had two scabs on his/her right foot, a scab on his/her lower legs and weeping edema of his/her left lower leg. -There was a notation to see the nurse's note. Review of the resident's Nurse's Progress Notes dated 1/5/24 showed no mention of his/her skin. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Daily Skilled Nurse's Note dated 1/5/24 showed no assessment of his/her skin. Review of the resident's Daily Skilled Nurse's Note dated 1/6/24 through 1/31/24 showed no mention of/assessment of his/her heels/toes. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) dated 1/12/24 showed: -He/she had mild cognitive impairment. -He/she had no skin sores. Review of the resident's Physician's Orders Sheet (POS) for January 2024 showed: -Diagnoses of chronic kidney disease, stage 3 and partial paralysis on his/her left side. -No physician's order for treatment of his/her including scabbed areas and weeping edema in his/her legs or skin tears. Review of the resident's January 2024 Treatment Administration Record (TAR) showed: -Weekly skin assessment by wound nurse (dated 1/5/24) with no notes regarding any wounds. -Weekly skin assessment signed off as completed on 1/12/24 with no notes regarding any wounds. -An undated notion on the back of the TAR dated of an existing area on his/her left lower leg, skin tear, and treatment in place. Note: there was no physician's order on his/her January POS to treat a skin tear on his/her left leg and no treatment for a skin tear documented on his/her January 2024 TAR. -Weekly skin assessment signed off as completed on 1/19/24 without notation on the back of the TAR regarding findings of the skin assessment. -Weekly skin assessment signed as completed on 1/26/24 with notation on the back of the TAR dated 1/26/24 of an open area and bruise on his/her left knee. Review of the resident's February 2024 POS showed the following orders dated 2/5/24: -Lasix (medication that treats swelling) 20 milligrams (mg) and potassium 10 milliequivalents (mEq - the unit of measure used for minerals in the blood) daily. -Cleanse his/her left leg open area with normal saline (cleansing solution), Xeroform (non-stick dressing that maintains a moist environment to promote wound healing); cover with bordered gauze (a protective dressing); there was no frequency for the order. Review of the resident's February 2024 POS showed the following physician's orders dated 2/10/24: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Discontinue previous left leg wound treatment. -Cleanse his/her left leg with wound cleanser (WC - a gentle cleanser for wounds at all stages of the healing process) or normal saline (NS - a cleanser that helps remove dirt and debris from wounds and promotes healing), wrap leg with Kerlix (rolled woven gauze) then wrap with ace bandage (elastic compression wrap bandage) daily for weeping edema and as needed for soilage. Review of the resident's Skin Monitoring Comprehensive Certified Nursing Assistant (CNA) Shower Review (CNA Shower Sheet) dated 2/12/24 showed: -The resident had edema in his/her left leg. -The charge nurse signature and date were blank. Review of the resident's February 2024 TAR showed: -Weekly skin assessment signed off as completed on 2/17/24 and a notation on the back of the TAR dated 2/17/24 of multiple open areas on his/her lower left leg from weeping edema. -Left lower extremity cleanse with WC/NS, Xeroform (fine mesh gauze) to wound beds, cover with ABD (gauze pad dressing) and wrap with Kerlix (rolled woven gauze dressing), then wrap with elastic wrap on Monday, Wednesday and Friday for weeping edema dated 2/19/24. Review of the resident's February 2024 POS showed the following physician's orders dated 2/19/24 showed: -Cleanse lower left leg with WC or NS (WC/NS). -Xeroform to wound beds, cover with ABD, wrap with Kerlix, then wrap with elastic wrap - Monday, Wednesday and Friday and as needed for soiling. Review of the resident's February 2024 POS showed the following physician's order dated 2/21/24 showed: -Contracted wound care consultant company to follow up to his/her left lower leg ulcer. -Note: There was no documentation that showed this consult was completed. Review of the resident's February 2024 POS showed the following physician's orders dated 2/21/24 showed: -Get venous doppler (a diagnostic test used to check blood circulation in the large veins in the legs/arms) regarding his/her left lower leg edema. --Note: There was no documentation that showed the venous doppler was completed. -Lasix 20 mg by mouth daily for 14 days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Potassium chloride. Review of the resident's Nurse's Progress Notes dated 2/25/24 showed: -His/her heel (no identification of which heel, no measurements or further description) was now dark in color. -Will get resident set up to be followed by wound company. Review of the resident's Nurse's Progress Notes dated 2/27/24 showed: -Upon assessment the resident's left heel, toes to affected area were purple in color. -There was a small amount of drainage (no description of color/odor of the drainage). -His/her left purple heel had an open area (there was no measurement or further description of the open area). -His/her physician was notified of the status of his/her left leg and ordered the resident be sent to emergency room for further evaluation. Review of the resident's Nurse's Progress Notes dated 2/27/24 at 1:15 PM. showed: -Dressing removed from residents left lower leg due to residents two middle toes being discolored. -Upon further removal of dressing his/her heel was observed splitting at the upper back area. -The licensed nurse notified the Director of Nursing (DON) and the Corporate Nurse. -Resident sent to hospital non-emergent (a medical condition requiring treatment within 2-24 hours). Review of the residents February 2024 POS showed the following order dated 2/27/24 to send resident to hospital stat (immediately) for further evaluation. Review of the resident's hospital records for his/her 2/27/24 admission showed his/her primary diagnosis was cellulitis (a deep infection of the skin caused by bacteria that usually affects the arms and legs; normal skin can be affected, but it usually happens after some type of injury causes an opening in the skin) with gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection). Review of the resident's Nurse's Progress Notes dated 3/1/24 showed: -He/she had vascular surgery amputating two toes. -Additional surgery being discussed at hospital. Review of the resident's hospital Operative Report dated 3/6/24 showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-His/her preoperative and postoperative diagnoses were critical limb ischemia (a severe blockage in the arteries of the lower legs which markedly reduces blood-flow) with nonhealing open sores of both lower legs and nonrevascularizable arterial perfusion (blockage of and inability to restore normal oxygenated blood flow) of both feet. -Procedure was above the knee amputation (surgical removal) of both legs. Review of the resident's hospital discharge summary dated 3/9/24 showed: -He/she was admitted on [DATE] with admitting diagnoses of severe sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), group A strep bacteremia, necrotizing fasciitis (an aggressive skin and soft tissue infection that causes death of the muscle and tissues under the skin), and treatment of above the knee amputation of both legs. -Atherosclerotic Peripheral Vascular Disease (ASVD -disease or disorder of the circulatory system outside of the brain and heart), non-healing wounds of both lower legs. -He/she would be discharged to the long-term care facility with ongoing intravenous (access into a large vein for administration of fluid or medication) antibiotics. Review of the resident's Nurse's Progress Notes dated 3/10/24 showed: -He/she was readmitted to the facility and arrived at or about 5:00 P.M. -Refer to Admission Skin Assessment. -Note: Review of the resident's medical record showed no Admission Skin Assessment for 3/10/24. Record review of the resident's care plan dated 3/10/24 showed: -He/she needed assistance with his/her activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting). -He/she had surgical incisions from amputations of both his/her legs above the knees secondary to nonhealing ulcerations, poor circulation, atherosclerosis (hardening of arteries) and poor revascularization. -He/she needed incision care (monitoring for infection and daily cleansing), pain medication, and assistance with positioning. Review of the resident's March 2024 POS showed the following orders dated 3/10/24: -May readmit resident to skilled services. -Place midline (also called a midline catheter is a long, thin, flexible tube that is inserted into a large vein in the upper arm. It is used to safely administer medication into the bloodstream) for IV (intravenous) antibiotic. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Ampicillin/sulbactam (antibiotic medications) 95 milligrams (mg) IV every eight hours for severe sepsis dated 3/10/24 -Micafungin (antifungal medication) 50 IV daily every eight hours for severe sepsis. -Cleanse incisions (surgical cuts) with WC, pat dry, apply 4 inch by 4 inch (4X4) gauze, Kerlix and elastic wrap, daily. Review of the resident's Nurse's Progress Notes dated 3/17/24 showed the resident's Durable power of Attorney (DPOA- person previously named to make decisions for an individual in the event of inability to make wishes known) was contacted and gave verbal permission for resident to be seen by the consultant wound company. Observation on 4/5/24 at 9:58 A.M. showed the resident: -Was alert and lying in bed with a low air loss mattress (LAL - a mattress that provides airflow to help keep skin dry as well as to relieve pressure with alternating air cells that expand and contract to shift pressure). -He/she had bilateral above the knee amputations. -He/she said that he/she had previously had strokes that resulted in limitations in moving his/her arms. -Now with not having his/her legs it was more difficult for him/her to move in bed; also, he/she needed the head of his/her bed up to help him breathe and without his/her lower legs, he/she kept sliding down in his/her bed. During an interview on 4/5/24 at 10:07 A.M. Licensed Practical Nurse (LPN) A said: -He/she had not been the charge nurse on the resident's hall until after April 1, 2024. -He/she had passed medications on the resident's hall prior to April 1, 2024, but had not had other duties on the resident's hall. -He/she only given the resident his/her medications and had not done weekly licensed nurse skin assessments and had not seen or assessed the resident's skin prior to the week of April 1, 2024. During an interview on 4/8/24 at 2:45 P.M. the Director of Nursing (DON) and Assistant Director of Nursing (ADON) said: -The DON and ADON were not employed at the facility prior to the resident's bilateral above the knee amputations. -In January 2024 the previous DON had instructed licensed nursing staff to discontinue highlighting weekly skin assessments on residents' TARs. -This resulted in charge nurses no longer completing weekly skin assessments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The DON started his/her employment at the facility in late February 2024; in late March 2024, he/she discovered that the wound nurse had not been doing his/her job, including that he/she had not been completing weekly licensed nurse skin assessments and had not been assessing and documenting on resident wounds week; shortly thereafter the wound nurse's employment was terminated, and the ADON left his/her position. -Weekly licensed nurse skin assessments had not been completed for the resident or for any of the other residents at the facility since February 1, 2024. -As of April 2024, the new ADON was now ensuring weekly skin assessments were completed for all residents and that weekly wound documentation was completed on all resident wounds. During an interview on 4/11/24 at 10:58 A.M. the ADON said the facility located only one shower sheet dated 2/12/24 for the resident prior to 2/27/24. 2. Review of the resident's April 2024 POS showed: A diagnosis of atrial fibrillation (AFib - an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). -Eliquis (Apixaban - blood thinner for use in patients with AFib to reduce the risk of blood clots and stroke) five milligrams (mg) dated 1/5/24. Review of the resident's hospital emergency room record dated 4/4/14 showed: -He/she was seen for hematuria (blood in his/her urine). -Hold the next two doses of Eliquis, may resume Eliquis in the evening on April 5, 2024. Review of the resident's April 2024 POS on 4/5/24 showed: -A diagnosis of atrial fibrillation (AFib - an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). stroke). -No physician's order to hold two doses of his/her Eliquis and resume his/her Eliquis in the evening on April 5, 2024. Review of the resident's MAR on 4/5/24 showed: -No instructions dated 4/4/24 to hold two doses of his/her Eliquis and to resume his/her Eliquis in the evening on April 5, 2024. -No documentation the resident's Eliquis had been given on his/her 4/4/24 evening dose or on his/her 4/5/24 morning dose. -No documentation that any of the resident's morning medications had been given on 4/5/24. Review of the resident's hospital record dated 4/4/24 showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Hold the next two doses of Eliquis. -May resume Eliquis tomorrow evening, 4/5/24. Review of the resident's April 2024 POS and MAR on 4/5/24 showed: -No physician's order or instruction to hold his/her Eliquis for two doses. -No physician's instruction to resume his/her Eliquis tomorrow evening, 4/5/24. During an interview with on 4/5/24 at 3:28 P.M. Certified Medication Technician (CMT) A CMT A said: -He/she gave the resident all of his/her morning medications, including his/her Eliquis. -He/she usually signed medications as given on the MARs immediately after giving medications to each resident but had not done so that morning with this resident; he/she had been distracted from his/her normal routine. -He/she did look at the resident's MAR as he/she was preparing his/her medications and did not see any instruction to hold the resident's Eliquis. -He/she also had not been told the resident's Eliquis was to be held for two dosed and then resumed on the evening on 4/5/24. During an interview on 4/5/24 at 3:38 P.M., LPN A said: -The resident went to the emergency roiagnom on [DATE] and returned in the evening on 4/4/24. -He/she was not told in report any information that the resident's Eliquis was to be held. -The night licensed nurse should have reviewed the paperwork from the hospital emergency room , called the resident's physician and gotten an order to hold the resident's Eliquis for two doses and resume the resident's Eliquis on the evening of 4/5/24 and should have relayed that information to the day licensed nurse in change of shift report. -Normally the licensed nurse on duty at the time a resident returns from hospital was responsible for reviewing all paperwork from the hospital, then notifying the resident's physician, obtaining any needed orders and writing those orders on the MAR, then writing that information on the 24-hour report that is used to report pertinent information to the oncoming licensed nurse at shift change. -He/she received no information regarding the resident's Eliquis in shift report and he/she also had not had any time to review the resident's 4/4/24 emergency room information. -He/she had now read the resident's 4/4/24 emergency room record and saw that his/her Eliquis was to have been held for two doses and then resumed for the evening on 4/5/24. -He/she also spoke with CMT A who had told her he/she had given the resident his/her 4/5/24 morning dose of Eliquis but had not signed that his/her medications had been given. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/11/24 at 10:58 A.M. the ADON said there should have been weekly licensed nurse skin assessments and weekly licensed nurse wound documentation for the resident fully documenting the measurements description of all wound and skin conditions. During an interview on 4/11/24 at 12:45 P.M. the DON said: -He/she was not employed at the facility prior to the resident's bilateral above the knee amputations. -The DON started his/her employment at the facility in late February 2024; in late March 2024, he/she discovered that the wound nurse had not been doing his/her job, including that he/she had not been completing weekly licensed nurse skin assessments and had not been assessing and documenting on resident wounds week; shortly thereafter the wound nurse's employment was terminated, and the Assistant Director of Nursing (ADON) left his/her position. -Weekly licensed nurse skin assessments had not been completed for the resident or for any of the other residents at the facility since February 1, 2024. -As of April 2024, the new ADON was now ensuring weekly skin assessments were completed for all residents and that weekly wound documentation was completed on all resident wounds. -At the time the resident was admitted to the facility on [DATE], his/her skin assessment should have included a complete description and measurements of scabs on his/her left heel, and any other scabs or alterations in his/her skin on any part of his body, including both of his/her legs and feet; the edema in his/her left leg should have been described accurately. -On 1/5/24 the resident's physician should have been notified of the resident's scabs on his/her left heel and edema in his/her left leg; treatments should have been put in place; the resident's skin and wounds should have been assessed and documented weekly with notification to the resident's physician of any changes in the resident's skin/edema. -The previous shower aide also was no longer employed at the facility and there was a new shower aide as of April 1, 2024. -Shower aides were to fill out a shower sheets following each shower and were to mark briefly identify any abnormal skin issue skin areas, whether new or not. -If there was a new open area or increased drainage or other concern, the shower aide was to take the shower sheet to the charge nurse right then and say what he/she saw; the charge nurse was to then go and assess the resident, document what he/she saw, including measurements and full description and then call the physician for orders. -The shower aide was to give all shower sheets to the charge nurse during the shift and the charge nurse was to review and sign the sheets prior to end of his/her shift and forward the shower sheet to the DON for the DON's review; the DON/ADON then was to ensure physician's had been notified and treatments were in place for residents' skin conditions. MO00234138

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265404	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maywood Terrace Living Center	10300 East Truman Rd Independence, MO 64052

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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 weekly 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) assessments were completed, ensure hand hygiene (washing/sanitizing hands) during wound treatment and correct application of a wound product for one sampled resident (Resident #1), out of four sampled residents. The facility census was 49 residents. Review of the facility Prevention of Pressure Injuries policy revised April 2020 showed: -Assess the resident on admission (within eight hours) for existing pressure injury risk factors. -Repeat the risk assessment weekly and upon any changes in condition. -Use standardized pressure injury screening tool to determine and document risk factors. -Supplement the use of a risk assessment tool with assessment of additional risk factors. -Conduct a comprehensive skin assessment upon or soon after admission, with each risk assessment, as indicated according to the resident's risk factors. Review of the facility Handwashing/hand Hygiene policy revised October 2023 showed: -Hand hygiene is indicated: --immediately before touching a resident. --before performing an aseptic (practices and procedures that helps protect residents from germs) tasks. --after contact with blood, body fluids, or contaminated surfaces. --after touching a resident. --after touching the resident's environment. --before moving from work on a soiled body site to a clean body site on the same resident; and --immediately after glove removal. -Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. -Wash hands with soap and water: --when hands are visibly soiled. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The use of gloves does not replace hand washing/hygiene. 1. Review of Resident #1's Face Sheet showed: -He/she was admitted to the facility on [DATE]. -He/she had diagnoses of partial paralysis on his/her left side. Review of the Resident's Admission Nursing Evaluation dated 1/5/24 showed he/she had no skin breakdown on his/her buttocks, or hips. Review of the resident's Nurse's Progress Notes dated 1/5/24 showed no mention of his/her skin. Review of the resident's Daily Skilled Nurse's Note dated 1/5/24 showed no assessment of his/her skin. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 1/12/24 showed: -He/she had mild cognitive impairment. -He/she had no pressure ulcers. Review of the resident's Nursing Progress Note dated 2/27/24 showed the resident was sent to hospital for evaluation. Review of the resident's Nursing Progress Note dated 3/10/24 showed: -He/she arrived back at the facility on or around 5:00 P.M. -Wounds on coccyx (tailbone area) noted. -In addition, see Admission Skin Assessment in chart. Review of the resident's care plan dated 3/10/24 showed he/she was at high risk for pressure ulcers related to limited mobility, incontinence, poor circulation, history of stroke with left sided weakness and peripheral vascular disease (PVD - inadequate flow of blood to the legs and arms). Review of the resident's undated Admission Nursing Evaluation showed he/she had an area marked on his/her skin map on on his/her sacral (area above the tailbone) with a line drawn to an illegible written word. Record review of the resident's medical record showed no further licensed nurse assessment of the resident's sacral wound. Review of the resident's physician's progress note dated 4/3/24 showed his/her coccyx wound was improving and had 100% slough (dead tissue, usually cream or yellow that occurs in full thickness skin loss). (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 Nursing Progress Note dated 4/5/24 showed: -Wound care consultant was at facility, resident assessed. -New orders received. Observation and interview on 4/5/24 at 11:10 A.M. showed: -The resident was alert, laying on his/her LAL (LAL-a mattress that provides airflow to help keep skin dry as well as to relieve pressure with alternating air cells that expand and contract to shift pressure mattress. -Licensed Practical Nurse (LPN A) said the resident recently returned from the hospital with open areas. -The resident had new orders for his/her wound care from the consulting wound company that he/she had not yet put in the resident's chart. Observation on 4/5/24 at 11:55 A.M. showed: -With gloved hand LPN A removed a dressing from the resident's coccyx and cleansed a slough covered full thickness pressure ulcer. -Then without first washing removing his/her gloves and washing/sanitizing his/her hands, he/she applied Santyl to the resident's inner dressing with his/her gloved hand, placed the inner dressing on the resident's wound bed and then applied an outer dressing. During an interview on 4/11/24 at 10:26 A.M. regarding the resident's treatment on 4/5/24, LPN A said: -He/she may not have washed/sanitized his/her hands each time it was indicated but he/she did not specifically remember if that happened. -It was his/her normal practice to wash his/her hands before treatments, after cleansing a wound, after applying a treatment, between wounds and when finished with treatments. -He/she normally did apply Santyl to the wound bed with an applicator but had not done so during the resident's treatment on 4/5/24. During an interview on 4/11/24 at 10:58 A.M. the ADON/Wound Nurse said: -Santyl should be applied nickel thick to the wound bed with an applicator. -Hand hygiene should be done before treatments, after removing dressings, after cleansing wounds, after and between treatments. During an interview on 4/11/24 at 2:45 P.M. the Director of Nursing (DON) said: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The DON started his/her employment at the facility in late February 2024; in late March 2024, he/she discovered that the wound nurse had not been doing his/her job, including that he/she had not been documenting resident wounds weekly; shortly thereafter the wound nurse's employment was terminated, and the Assistant Director of Nursing (ADON) left his/her position. -As of April 2024, the new ADON was ensuring that weekly wound documentation was completed on all resident wounds. -He/she expected licensed nurses to maintain hand hygiene at all times, including during treatments. MO00234138

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 09895 Based on observation, interview and record review, the facility failed to ensure correct catheter (a hollow, partially flexible tube inserted into the bladder to drain urine) care for one sampled resident (Resident #1) out of four sampled residents. The facility census was 49 residents. Review of the facility Catheter Care, Urinary revised August 2022 showed: -Wash and dry hands thoroughly. -Put on gloves. -With non-dominant hand separate the labia (the folds of skin around the vaginal opening) of the female resident or retract the foreskin (skin that covers the head of the penis) of the uncircumcised (having intact foreskin) male resident; maintain the position of this hand throughout the procedure. -For a male resident: --Use a washcloth with warm water and soap (or clean bathing wipe) to cleanse around the meatus (the opening where urine leaves the body). --Cleanse the body of the glans (the head/tip of the penis) using circular strokes from the meatus outward. --Change the position of the washcloth (or bathing wipe) with each cleansing stroke. --With a clean washcloth (or wipe), rinse using the above technique. --Return the foreskin to its normal position. -Use a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward (away from the body). 1. Review of the Resident #1's admission Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 1/12/24 showed: -He/she had mild cognitive impairment. -He/she had occasional urinary and bowel incontinence. -He/she had no pressure ulcers and did not have a urinary catheter. Review of the resident's Nursing Progress Note dated 3/10/24 showed: -He/she arrived back at the facility on or around 5:00 P.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wounds on coccyx (tailbone area) noted. Review of the resident's care plan dated 3/11/24 showed: -He/she needed assistance to complete activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting). -He/she was at high risk for pressure ulcers and his/her risk factors included his/her incontinence. Record review of the resident's March 2024 Physician's Orders Sheet (POS) showed to place a urinary catheter for wound healing, dated 3/22/24. Observation on 4/5/24 at 11:10 A.M. showed: -Without first washing/sanitizing his/her hands, Certified Nursing Assistant (CNA) A applied barrier cream to the resident's abdominal folds, inner thighs and then without first removing his/her gloves and washing/sanitizing his/her hands, he/she cleansed the shaft of the resident's penis with a cleansing wipe. -Without retracting the resident's foreskin, he/she cleansed the head of the resident's penis with a cleansing wipe. -He/she then wiped the resident's catheter outward about two inches. During an interview on 4/5/24 at 3:20 P.M. CNA A said: -He/she usually did a better with washing his/her hands, he/she was thinking about the next resident he/she was going to provide care. -He/she should have washed or sanitized his/her hands more. -He/she should have pulled back the resident's skin before he/she cleansed around the opening where the catheter came out and he/she should have wiped the catheter down at least four inches. During an interview on 4/11/24 at 10:26 A.M. Licensed Practical Nurse (LPN A) said: -He/she was in the resident's room with CNA A when the resident's catheter care was completed on 4/5/24 and noticed some things. - CNA A needed to have washed/sanitized his/her hands and change his/her gloves more. -CNA A should have pulled back the resident's foreskin and should have wiped further down the resident's catheter. -He/she did talk to CNA A the afternoon of 4/5/24 regarding how to complete catheter care. During an interview on 4/11/24 at 2:45 P.M. the Director of Nursing (DON) said: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected the CNAs to practice good hand hygiene during catheter care. -He/she expected the CNAs to retract the foreskin before cleansing a male's penis. -He/she expected the CNAs to cleanse catheters four inches away from the resident's body. MO00234138

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09895 Based on observation, interview and record review, the facility failed to ensure side rails (also known as bed rails - devices, usually metal attached to the bed frame and extending along the side of the mattress and extend upward above the level of the mattress) were not used unless the resident's assessment indicated side rails were safe for the resident, out of four sampled residents. The facility census was 49 residents. A side rail policy was requested and not received. Review of U.S. Food and Drug Administration Safety Concerns About Adult Portable Bed Rails dated 2/27/23 showed: -Deaths and serious injuries can happen when using bed. -Even when adult portable bed rails are properly designed to reduce the risk of entrapment or falls, are compatible with the bed and mattress, and are used appropriately, they can present a hazard to certain individuals, particularly to people with physical limitations or altered mental status, such as dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses) or delirium (altered state of consciousness, consisting of confusion, distractibility, disorientation, and disordered thinking). 1. Review of Resident #2's annual Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) dated 1/6/23 showed: -He/she was admitted to the facility on [DATE]. -He/she received hospice (specialized services provided by an contracted company that focuses on relieving symptoms for terminally ill residents). -He/she had no bed rails. Review of the resident's care plan dated 4/3/24 showed: -He/she had limited mobility and needed staff to reposition him/her. -He/she needed assistance to complete activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting). Record review of the resident's April 2024 Physician's Orders Sheet (POS) showed no order for side rails on his/her bed. Observation on 4/5/24 at 12:24 P.M. showed the resident: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was sleeping in his/her bed on a low air loss mattress (LAL - a mattress that provides airflow to help keep skin dry as well as to relieve pressure with alternating air cells that expand and contract to shift pressure) with side rails on both sides of his/her bed that extended from the head of his/her bed to halfway to the foot of his/her bed. -Certified Nurses Assistant (CNA) A fully positioned the resident during his/her personal care, including turning him/her from side to side. -The resident opened his/her eyes briefly but did not attempt to turn or position himself/herself and did not reach out for the side rails. During an interview on 4/5/24 at 3:20 P.M. CNA A said: -He/she had been off work and returned today and saw that the resident now had side rails. -The resident was not able to position himself/herself in bed and could not use side rails for positioning and had not been able to do so for a long time. During an interview on 4/5/24 at 3:40 P.M. Licensed Practical Nurse (LPN) A said: -He/she was surprised to see the resident had side rails because he/she did not have side rails a week or two ago. -The resident would not be able to use side rails for positioning/turning himself/herself in bed. During an interview on 4/5/24 at 3:50 P.M., the Administrator said: -The resident had not had side rails on his/her bed until a few days prior when Hospice switched out his/her bed. -The resident would not be able to use side rails for positioning/turning himself/herself in bed. -The facility normally did not have any side rails on resident beds and would not put side rails on a resident's bed without the licensed nurses or MDS/Care Plan Coordinator first assessing the resident and determining the side rails would assist a resident with independent or assisted movement in bed, reviewing the risks/benefits with the resident or the resident's representative and getting signed consent for side rails. -He/she planned to have the resident's side rails removed that afternoon. During an interview on 4/11/24 at 12:45 P.M. the Director of Nursing (DON) said: -The side rails had been placed on the resident's bed by the Hospice company. -The licensed nurses are in each resident's room daily and should have told his/her or the facility Administrator that there were side rails on the resident's bed and the side rails would then have been removed immediately. (continued on next page)

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