STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265477	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to ensure residents only self-administer their medication once assessed by an interdisciplinary team and if clinically indicated when staff failed to observe one resident (Resident #28) take his/her medications, who had not been assessed for self-administration. The facility census was 98. Review of the facility's policy titled Self Administration of Medications, dated 12/2017, showed the following information: -If a resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team (IDT) of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. The resident should be re-assessed quarterly; -If the resident demonstrated the ability to safely self-administer medications, a further assessment of the safety of the bedside medication storage was conducted; -Bedside medication storage was permitted only when it did not present a risk to confused residents who wandered into rooms. When there was a safety concern with bedside medication storage, the medications would be stored in a central medication cart and the resident may request each dose. 1. Review of Resident #28's face sheet showed the following information: -admitted [DATE]; -Diagnoses include anxiety, extrapyramidal and movement disorder (a group of conditions that affect the body's voluntary and involuntary movements), pain, and intellectual disabilities. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 11/13/24, showed the following information: -Resident had moderate cognitive impairment; (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident received antipsychotic (a class of drugs used to treat mental health conditions characterized by psychosis), antianxiety (a class of drugs used to treat anxiety), antidepressant (a class of drugs used to treat depression), diuretic (medications that increase urine output by promoting the excretion of water and electrolytes from the body through the kidneys), opioid (a class of drugs used to treat moderate to severe pain), and hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood) medications. Observation on 01/30/25, at 10:37 A.M., showed the resident sat on the side of his/her bed. There were three empty medication cups on his/her bedside table. One of those medication cups had a pink colored, circular tablet (appeared to be a Tums - calcium carbonate, an antacid) inside of it. There were two additional circular tablets, one green and one orange, laying directly on the resident's bedside table. Observation on 02/05/25, at 10:09 A.M., showed the resident's room door open and two circular tablets, one pink and one orange, laying on the resident's bedside table. Observation on 02/06/25, at 10:29 A.M., showed the residents' room door open and two circular tablets, one pink and one orange, laying on the resident's bedside table. Review of the resident's care plan, with a target date of 04/16/25, showed staff did not care plan the resident self-administered medication or the ability to keep medications at bedside. Review of the resident's January 2025 Physician Order Sheet (POS) showed the resident did not have an order to self-administer medication or keep medications at bedside. During an interview on 01/30/25, at 10:54 A.M., Resident #205 said staff administered his/her medication, but at times they leave the medication on the resident's bedside table for him/her to take at his/her discretion. During an interview on 01/30/25, at 12:51 P.M., Resident # 83 said there was one staff member that watched him/her take his/her medication. The rest of the staff left his/her medications on the bedside table for him/her to take at his/her discretion. During an interview on 01/30/25, at 1:08 P.M., Laundry Aide H said the following: -He/she has found loose medications in residents' rooms; -There is no particular resident and it's sporadic; -He/she collected the loose medications and took them to the charge nurse; -He/she had found loose medications in Resident #28's soiled clothing prior to washing them. During an interview on 01/30/25, at 12:11 A.M., Certified Nursing Assistant (CNA) B said the following: -If he/she saw loose medications in any resident room, he/she would remove them from the room and report it to the charge nurse and/or Director of Nursing (DON); (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was not acceptable for residents to have medications in their rooms without a physician's order. During an interview on 02/11/25, at 10:54 A.M., CNA I said loose medications should be gathered and reported to the charge nurse immediately. The charge nurse will then take it from there as far as policy and procedure goes. During an interview on 01/30/25, at 12:40 A.M., Certified Medication Technician (CMT) E said the following: -Staff must always stay with the residents when administering mediation; -He/she had seen loose medications in resident rooms on several occasions; -He/she was not aware of any current residents that self-administered medications. During an interview on 01/30/25, at 12:26 P.M., Licensed Practical Nurse (LPN) C said the following: -He/she expected staff to watch residents take their medication; -Medications should never be left at bedside; -When staff finds loose medications, they bring the medication to him/her and he/she destroyed them and notified the DON. -He/she was not aware of any current residents that self-administer medications. During an interview on 02/11/25, at 11:20 A.M., LPN D said the following: -If medications were to be found in resident rooms, the staff member who found the medication should immediately turn it into the DON and provide education to the staff member who is passing medication that day; -Staff should stay with residents when administering medication; -He/she was not aware of any current residents that self-administered medications; -If a resident was able to self-administer medications an assessment would be completed. During an interview on 02/13/25, at 9:13 A.M., the DON said the following: -If medications were found in resident rooms, those medications need to be identified; -The staff member who found the medication needed to report it to the charge nurse and the charge nurse would then have to contact the physician; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medications should not be left at bedside. No residents in the facility have an order for medications at bedside with the exception of creams; -Staff should stay with residents when administering medication; -Self-administer assessments were completed on admission and quarterly; -There were no current residents who self-administered medications. During an interview on 02/13/25, at 1:00 P.M., the Administrator said the following: -Loose medications should not be found a resident's room; -If loose medications are found a resident's room, the medication should be identified and the physician should be notified immediately; -Staff should stay with residents when administering medication; -Self-administer assessments were completed on admission and quarterly; -There were no current residents who self-administered medications

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 36974 Based on observation and interview, the facility failed to ensure the prior survey results were kept current and complete in a readily accessible, public location for residents, family members, and residents' legal representatives. The facility census was 98 at the time of survey. 1. Observation on 02/04/25, at 10:50 A.M., showed the following; -A maroon binder located in a wall pocket close to the television/day area near the junction of 100, 200, and 300 halls. -The binder contained the most recent survey results for 05/02/24. -The binder did not contain the other survey results from the previous three years including the results of the last recertification survey completed on 02/03/23. During interviews on 02/05/25, starting at 10:00 A.M., during the resident council group meeting, the residents said they did not know where any survey results were available at the facility. None of the residents were aware they could look at previous survey results. During an interview on 02/05/25, at 2:10 P.M., Certified Nurse Aide (CNA) I said the survey results should be at the nurses' desk, but he/she did not know the exact location of the survey results book. Observation and interview on 02/06/25, at 8:50 A.M., showed Registered Nurse (RN) A was at the at the nurses' station on 300 hall. RN A said he/she didn't know where the survey results were, but anyone could ask for them at the front desk. RN A looked around the nurses' station, but was unable to find any survey results. Observation and interview on 02/06/25, at 9:07 A.M., showed Licensed Practical Nurse (LPN) D was at the nurses' station on 400 hall. LPN D said the survey results were probably at the nurses' stations, or up front. He/she could not specify where up front was and said it was some place close to the Administrator's office. LPN D looked around the nurse station, but was unable to find any kind of survey results. During observation and interview on 02/06/25, at 11:41 A.M., LPN G said the survey results were close to the TV area (at the junction of 100, 200, and 300 halls). The Administrator puts in results after the surveys. He/she didn't know if they were available anywhere else in the facility. He/she then looked around the nurse station on 600 hall, and was unable to find any survey results. During an interview on 02/06/25, at 11:50 A.M., the Director of Nursing (DON) said she thought the past survey results were located at the nurses' station. The results were also in a binder close to the junction of 100, 200, and 300 halls. The survey results book should be labeled and easily accessible to family, visitors, or residents. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 02/06/25, at 12:50 P.M., the Administrator said the annual survey results were in a binder close to the junction of 100, 200, and 300 halls. The binder should have all results of complaints, through the last annual survey (completed in February 2023). The Administrator said it was his responsibility to make sue the binder was up to date with the most recent results of complaints and surveys. He said he didn't know the results from the previous annual survey were not in the binder.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 28865 Based on interview and record review, the facility failed to provide the resident or resident representative with a Notice of Medicare Provider Non-Coverage (NOMNC-form CMS-10123) when all covered Medicare services were ending for two residents (Resident #62 and #98) and failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN - form CMS-10055) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for one resident (Resident #98) who remained in the facility after discharge from Medicare Part A services. The facility census was 98. Review of the Centers for Medicare and Medicaid Services Survey and Certification memo (S&C-09-20), dated 01/09/09, showed the following information: -The Notice of Medicare Provider Non-Coverage (NOMNC, form CMS-10123) is issued when all covered Medicare services end for coverage reasons; -If the Skilled Nursing Facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNFs responsibility to provide notice to the resident can be fulfilled by the use of either the SNFABN (form CMS-10055) or one of the five uniform denial letters; -The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them him/herself or through other insurance they may have; -If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met is obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. Issuing the NOMNC to a beneficiary only conveys notice to the beneficiary of his/her right to an expedited review of a service termination; -The SNF provider is required to notify the beneficiary of the decision to terminate covered services no later than two days before the proposed end of services. Review showed the facility did not provide a policy regarding Notice of Medicare Provider Non-Coverage (NOMNC-form CMS-10123) or Skilled Nursing Facility Advance Beneficiary Notices (SNFABN - form CMS-10055). 1. Review of Resident #62's Skilled Nursing Facility Beneficiary Protection Notification Review showed the following: -Medicare Part A skilled services episode start date of 08/29/24; -Services ended on 11/24/24; (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Last covered day of Medicare Part A service was 11/24/24; -Facility staff did not provide the resident or his/her legal representative the NOMNC CMS-10123. 2. Review of Resident #98's Skilled Nursing Facility Beneficiary Protection Notification Review showed the following: -Medicare Part A skilled services episode start date of 06/12/24; -Services ended on 08/15/24; -Last covered day of Medicare Part A service was 08/14/24; -Facility staff provided a SNFABN CMS-10055 blank form with writing on the form someone had notified the guardian. There were no dates or signature that it had been received by the resident or guardian or who the guardian was; -NOMNC CMS-10123 was provided with no date and no signature from the resident or the representative. 3. During an interview on 02/06/25, at 2:20 P.M., the Social Service Designee (SSD) said the following: -She recently started and had not completed any of these notices. -She was just learning how to do the NOMNC and ABN notices. -The notices should have been provided as required. During an interview on 02/06/25, at 3:30 P.M., the Administrator said the beneficiary notifications should be provided to the residents or responsible party as required. The Administrator was not aware that these notices were not completed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review the facility failed to coordinate with the appropriate state-designated authority to ensure that individuals with a mental disorder, intellectual disability, or related condition receive care and services in the most integrated setting appropriate to their needs, when the facility failed to obtain and maintain a copy of a level II Pre-Admission Screening and Resident Review (PASRR) for one resident (Resident #61). The facility census was 98. Review showed the facility did not provide a policy regarding PASRR requirements. 1. Review of Resident #61's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included anoxic brain damage (occurs when the brain is deprived of oxygen for an extended period of time, leading to damage),cognitive communication deficit, anxiety, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder), and major depressive disorder. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 01/15/25, showed the resident was cognitively intact. Review of the resident's care plan, dated 09/08/24, showed the following information: -Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears; -Assist and encourage the resident to set realistic goals; -Encourage participation; -Monitor and document the resident's response to problems; -Provide opportunities for the resident and family to participate in his/her care; -When conflict arises, remove the resident to a calm and safe environment; -Observe for signs of mania, and document and report mood patterns. Review of the resident's Electronic Medical Record (EMR) on 02/06/25, at 1:07 P.M., showed the following: -Level I PASRR completed on 11/23/24; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Level II PASRR indicated and due by 12/07/24; -Level II PASRR not found in the resident's EMR. During an interview on 02/13/25, at 1:15 P.M., the Social Services Director said he/she was unable to locate the resident's level II PASRR. He/she was sure it had been completed by the prior Social Services Director. During an interview on 02/13/25, at 9:15 A.M., the Director of Nursing (DON) said the following: -The PASRR's are usually completed by the admissions nurse however the admissions nurse no longer worked at the facility; -PASRR's should be completed prior to admission to the facility and the facility should have them in the resident's EMR. During an interview on 02/13/25, at 1:00 P.M., the Administrator said the following: -All resident's have to have a completed Level I prior to entering the facility; -If level II's are indicated, they should be completed, and the facility should have them in the resident's EMR. 40769

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice when the facility failed to obtain an order for, care plan, and monitor the use of a brace for one resident (Resident #12). Facility had a census of 98. 1. Review of Resident #12's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included cerebral infarction (stroke that occurs when the blood supply to part of the brain is blocked or reduced), hemiplegia (paralysis or weakness on one side of the body) of the left side, foot drop, and left ankle contracture. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/02/24, showed the following: -Cognitively intact; -Required set up and clean up assistance with personal and oral hygiene; -Dependent with dressing, transfers, toileting, showers, and mobility; -Used wheelchair for mobility. Review of the resident's care plan, revised on 12/20/24, showed the following: -Required maximum assistance for transfers, toileting, and dressing; -At risk for falls related to gait and balance problems; -Staff should ensure resident shoes were on and secured. Resident wore an ankle foot orthotic (AFO - brace that supports the ankle and foot). -Staff did not care plan further regarding the AFO brace care and use. Review of resident's January 2025 Physician Order Sheet (POS) showed no orders for the application or monitoring of an assistive device to left lower extremity. Review of the resident's January 2025 physical therapy notes showed staff did not document regarding the AFO brace use. Review of the resident's January 2025 nursing progress notes showed staff did not document regarding the AFO brace use. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's February 2025 POS showed no orders for the application or monitoring of an assistive device to left lower extremity. Review of the resident's February 2025 physical therapy notes showed staff did not document regarding the AFO brace use. Review of the resident's February 2025 nursing progress notes showed staff did not document regarding the AFO brace use. Observation and interview on 02/06/25, at 11:37 A.M., showed the resident sat in a wheelchair with a brace on the left lower extremity. The resident said he/she wore the brace for therapy. The brace allowed him/her to walk due to a leg and foot that had turned in from a previous stroke. Observation of the resident on 02/10/25, at 11:42 A.M., showed resident sat in wheelchair with a brace applied to his/her left leg. During an interview on 02/06/25, at 2:25 P.M., the Certified Occupational Therapist Assistant/Licensed (COTA/L) L said the resident came to the facility with an AFO brace. The nurse is responsible for entering any therapy orders during the interdisciplinary team meeting. The brace should have an order and be included in the care plan. During an interview on 02/06/25, at 2:30 P.M., Physical Therapy Assistant (PTA) M said the following: -The resident had an AFO brace that he/she came to the facility with years ago; -The resident wore the brace to hold his/her leg in correct position and provides stability; -Staff know to apply the brace as the resident had the brace for years and staff are familiar with him/her; -Brace should be worn when out of bed; -Any staff can apply the brace before the resident is out of bed; -He/she would assume there would be an order for an AFO brace; -He/she does not have access to resident care plans but an AFO brace should be included. During an interview on 02/07/25, at 11:45 A.M., Certified Nurse Assistant (CNA) I said the following: -Therapy advises staff about any assistive devices and provides training; -Therapy sometimes places a sign on the wall or the resident can let staff know about the need for a brace to be applied; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she applies the resident # 12's hand brace (resident not observed wearing a hand brace or had no order to use one); -Resident's leg brace should be applied when out of bed and removed when in bed; -CNA's are responsible for applying and removing assistive devices. During an interview on 02/11/25, at 9:23 A.M., CNA K said the following: -CNAs know to apply or remove a resident brace based upon visually seeing the resident in a brace; -The resident was to wear a brace when out of bed; -The resident had a brace when he/she started working at the facility; -He/she would ask the nurse if there was a question regarding an assistive device; -He/she could ask therapy to show how to apply a brace if needed; -He/she did not know where a care plan was, but the facility should have some information that allows staff to know about resident care. During an interview on 02/11/25, at 9:40 A.M., Registered Nurse (RN) J said the following: -Any resident with an assistive device should have the information listed on the Treatment Administration Record (TAR) or Medication Administration Record (MAR); -The resident's skin should be monitored if they have a brace on; -There should be an order for residents who use a brace; -The resident did not have an order for a brace or to monitor the brace; -The resident did not have an order for the brace so it is unknown when it should be applied or removed; -An assistive device such as a brace should be included in the care plan. During an interview on 02/11/25, at 11:50 A.M., Licensed Practical Nurse (LPN) G said the following: -A brace should have an order, be included on the care plan, and have an order for monitoring of brace; -Therapy was responsible for applying and removing braces; -Therapy was who would recommend a brace and would also be responsible for putting in an order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said the following: -He/she is responsible for care plans; -He/she would think that the use of an orthotic device would be on the care plan. During an interview on 02/11/25, at 2:50 P.M., the Assistant Director of Nursing (ADON) said the following: -Any splint or brace should have an order and be included in the care plan; -Skin should be assessed if a resident wears a brace. During an interview on 02/13/25, at 11:15 A.M., the Director of Nursing (DON) said the following: -Any brace needs to have an order and be included in the care plan; -Staff should monitor skin under a brace routinely; -Nursing staff is responsible for applying and monitoring a brace; -The resident has always had a brace; -The brace should be applied in the morning and removed at bedtime. During an interview on 02/13/25, at 1:05 P.M., the Administrator said that there should be an order for brace use and monitoring.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to initiate a discharge summary for an anticipated discharge (a discharge that is planned and not due to the resident's death and/or emergency) for one resident (Resident #102). The facility census was 98. Review of the facility's policy titled Discharge Plan/Summary Voluntary, dated 11/01/18, showed the following information: -A physician order must be obtained; -If the resident is discharged home, the resident's community based physician is sent a copy of the residents Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), discharge summary (final summary of the resident's status which includes the residents most recent comprehensive assessment), physician order sheet (POS), progress notes, the resident's face sheet (brief look at resident information), advance directives, contact information for physicians, and any special precautions; -Social work should meet with the person accepting responsibility for the resident. Referrals needed should be made to home health, or others based upon the needs of the resident; -Therapy may complete a home assessment to ensure a safe discharge and arrange any assistive equipment needed for home care; -Nursing should meet with the person responsible for the resident at home and provide instruction to that person as appropriate regarding medications and treatment to be continued at home. Referral should be ensured for home care as needed; -The nursing portion of the discharge summary should identify continuing nursing needs, specify level of nursing care needed, verify resident understanding of orders including all medication prescribed by physicians, details nursing plan of care, special problems, and teaching steps and level of progress and further teaching needs as appropriate; -Food and nutrition services should identify the resident's nutritional needs; -Social services should identify the resident's personal, financial, and social needs in relation to medical and psychological problems; -Therapy should identify resident problems based on evaluations and outline a treatment plan; -Activities should identify the resident's recreational needs; -A copy of the summary is given to the resident/family and the original is stored in the resident's medical record; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There should be documentation in the nurses' notes regarding resident status at the time of discharge. 1. Review of the Resident #101's face sheet, showed the following information: -admitted [DATE]; -Diagnoses included paraplegia (paralysis that affects all or part of the truck, legs, and pelvic organs), obesity, spina bifida (a birth defect in which a developing baby's spinal cord fails to develop properly), and lymphedema (swelling most often in the arm or leg, caused by lymphatic system blockage). Review of the resident's discharge MDS, dated [DATE], showed anticipated discharge to home and reconciled medication list provided to the resident. Review of the resident's care plan, with a target date of 01/08/25, showed staff did not care plan related to discharge planning. Review of the resident's progress note, dated 10/01/24, showed the IDT (Interdisciplinary Team) met to review the resident's current skilled care stay. The resident's goal was to return to prior level of functional independence at home/assisted living/skilled nursing facility. The resident actively participated with therapy and required daily nursing care. It was determined by IDT that it was reasonable and necessary that the resident remains on Skilled Care Services currently. IDT to continue to monitor the resident's daily skilled care needs. (Staff did not document any further IDT progress notes.) Review of the resident's progress note, dated 12/20/24, showed the resident's Nurse Practitioner (NP) noted the resident was seen at the request of nursing staff for pulmonary embolism (PE - a condition in which one or more arteries in the lungs become blocked by a blood clot) history and generalized weakness. The resident continued skilled services for weakness, wounds, and required therapy for strengthening. The resident denied any cough, trouble breathing, or wheezing. The resident denied any nausea, vomiting, or abdominal pain. The resident denied chest pain or irregular heartbeat. The resident reported a good appetite and was sleeping well. The resident was planning to discharge home this week with home health and have wounds managed by an outside wound clinic. Review of the resident's December 2024 POS showed the resident may discharge home on 12/20/24 with home health and wound care management through an outside wound clinic. Review of the resident's record on 02/13/25, at 2:20 P.M., showed the following: -Staff did not complete the discharge summary dated 12/20/24; -Staff did not document progress notes related to the resident's discharge. During an interview on 02/11/24, at 11:20 A.M., Licensed Practical Nurse (LPN) D said discharges should be documented in the progress notes and discharge summaries should be completed. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/24, at 9:15 A.M., the Director of Nursing said discharges should be documented in the progress notes and discharge summaries should be completed. During an interview on 02/13/24, at 1:00 P.M., the Administrator said discharges should be documented in the progress notes and discharge summaries should be completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to provide good grooming and personal hygiene for residents who were unable to carry out activities of daily living (ADL- basic care tasks that are essential for maintaining independence and daily life) for themselves when the facility failed to document bathing attempts for one resident (Resident #205), who was dependent on staff for bathing. The facility census was 98. Review of the facility's policy ADL Care Bathing, dated 07/21/22, showed the following information: -Nursing staff will assist in bathing residents to promote cleanliness and dignity; -The charge nurse will be made aware of residents who refuse bathing. 1. Review of Resident #205's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included acquired absence of right and left below the knee, diabetes, anxiety, high blood pressure, and syncope and collapse (temporary loss of consciousness with a quick recovery). Review of the resident's admission Minimum Data Set (a federally mandated assessment tool filled out by facility staff), dated 01/22/25, showed the following information: -Moderate cognitive impairment; -Dependent on staff for personal hygiene, bathing, and toileting. Review of the resident's care plan, dated 01/31/25, showed the following information: -The resident had a self care deficit; -Staff to observe/document and report any changes, potential for improvement, reasons for self-care deficit, expected course, and declines in function. -Staff did not care plan related to the resident need for assistance from staff for bathing or any history of refusal of cares. Observation and interview on 02/06/25, at 10:22 A.M., showed the resident lay in bed on his/her back. The resident's hair appeared to be unbrushed and had an oily look to it. The resident was dressed in a hospital gown that had brown staining around the collar of the gown. The resident said he/she was hoping to receive a shower that day. He/she had only been offered one shower since admission on 01/16/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/07/25, at 8:59 A.M., showed the resident lay in bed on his/her back. The resident's hair appeared to be unbrushed and had an oily look to it. The resident was dressed in a hospital gown that had brown staining around the collar of the gown. The resident said that a staff member had came into his/her room yesterday and explained they would be unable to provide his/her shower due to staffing. Review of the facility provided shower sheets showed staff documented the resident had one shower sheet completed on 01/22/25. Staff did not have shower sheets since 01/22/25 that indicated the resident had been offered a shower since that date. Review of the resident's Electronic Medical Record (EMR) showed the resident had a bathing task assigned. There were no specifications for his/her shower days and/or times. Review of the resident's progress notes, dated 01/16/25 to 02/07/23, showed staff did not document any shower refusal from the resident. During an interview on 02/11/25, at 10:54 A.M., Certified Nursing Assistant (CNA) I said the following: -All aides, on all shifts should provide bathing to the residents; -Refusals should be documented on the shower sheet by the aide offering the shower; -The resident does say he/she does not get offered showers, but he/she often refuses to get up out of bed; -In the cases of the resident refusing, that should be documented, and a bed bath should be offered. During an interview on 02/11/25, at 11:20 A.M., Licensed Practical Nurse (LPN) G said the following: -Showers should be completed according to the resident's preference, regarding which days and times; -Refusals should be documented on the shower sheet, by the aide offering the shower. Those forms are then turned into the charge nurse; -The resident had not complained to him/her about not being offered showers; -He/she had heard the resident refused to get out of bed; -The resident had been showered more than once, but there was a lack in documentation. During an interview on 02/13/25, at 9:15 A.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents should be offered two showers a week and this should be on the resident's preferred schedule; -If the resident had a preference, that should be documented and care planned; -If the resident frequently refused to bathe, that should be documented and care planned; -The resident has refused his/her showers; -When the resident refuses, staff should continue to fill out a shower sheet, indicating the resident refused, and have the resident sign that sheet before turning it into the charge nurse. During an interview on 02/13/25, at 1:00 P.M., the Administrator said the following: -Residents should receive two showers a week; -If the resident refuses, that should be documented and care planned.

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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** 40769 Based on observation, record review, and interview, the facility failed to provide care per physician's orders and professional standards of practice for all residents when staff failed to document complete and thorough assessments, provide care per physician's orders, and to care plan treatment of a burn for one resident (Resident #2). The facility census was 98. Review of the facility's policy titled, Accident and Incident Documentation and Investigation, revised 04/26/23, showed the following: -The licensed nurse at the time of an incident is responsible for documenting the incident in the resident's medical record; -The licensed nurse shall document the incident and notify the supervisor and Director of Nursing (DON) for follow through as needed; -The licensed nurse may complete a nurses' note and update the resident's care plan as needed; -The nurse's notes may contain clear objective facts of what occurred; an evaluation of the resident's condition at the time of the accident/incident; description of the resident; vital signs; other physical characteristics apparent as a result of the accident/incident; any treatment provided; notification or attempts to notify the resident's physician, family, and/or legal representative, or any other health care professional or individuals involved with the resident's care; and the charge nurse's signature, date, and time of the documentation. Review of a facility policy titled Wound Management, dated 11/15/22, showed the following: -The facility will provide evidence-based treatments in accordance with current standards of practice and physician orders; -Wound treatment will be provided in accordance with physician's order; -Charge nurse will notify the physician in the absence of treatment orders; -Treatments will be documented on the Treatment Administration Record (TAR); -The effectiveness of treatments will be monitored though ongoing evaluation of the wound. Review of a facility policy titled Comprehensive Person-Centered Care Plan, dated 10/23/19, showed the following: -Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care; -The interdisciplinary team, along with the resident and/or resident representative, will identify resident problems, needs, strengths, life history, preferences, and goals; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-For each problem, need, or strength a resident centered measurable goal is developed; -Staff approaches are to be developed for each problem, need, and strength. Assigned disciplines will be identified to carry out the intervention; -The comprehensive person-centered care plan can be reviewed and/or revised at quarterly intervals; -Upon a change in condition the care plan will be updated if applicable: -The care plan is updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included burn of unspecific degree of left thigh, subsequent encounter, epilepsy (a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), and unspecified open wound, left hip, burn of first degree (a minor injury that affects only the top layer of skin) of left lower leg. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/24, showed the following: -The resident was cognitively intact; -The resident required supervision or touching assistance with meals; -The resident can use a manual wheelchair to wheel 50 feet with two turns with supervision or touching assistance. Review of the resident's current care plan showed the following: -On 08/19/24, staff care planned the resident will remain free from injury related to seizure activity through the review date; -On 09/30/24, staff care planned the resident continued to have seizures, however, they are noted to be becoming further apart and vary; -On 09/30/24, staff care planned to not leave the resident alone during a seizure. Protect him/her from injury. If he/she is out of bed, help to the floor to prevent injury and remove or loosen tight clothing. Do not attempt to restrain the resident during a seizure as it could make convulsions more severe, protect onlookers, draw a curtain etc; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 09/30/24, staff care planned seizure documentation should include location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity; -On 09/30/24, staff care planned to give seizure medication as ordered; -On 08/23/23, staff care planned the resident has an activities of daily living (ADL) self care performance deficit due to impaired cognition and staff to assist with ADLs. Staff updated the care plan on 09/30/24 with resident is able to eat without assistance. Review of an incident report dated 12/29/24, at 4:30 P.M., showed the following: -The resident was in the dining room having a cup of coffee before dinner when it spilled in his/her lap causing burns to develop to the anterior (front of the body) and posterior (back of the body) aspects of the left thigh. The resident believed as he/she reached to place the coffee cup on the dining table, he/she experienced a mild seizure which caused him/her to spill the hot liquid from his/her cup; -Staff removed resident from the dining room, assessed for injury, and notified physician. Assistant Director of Nursing (ADON) present and notified. Staff contacted the wound doctor and a treatment order was received, noted, and completed. Staff assessed resident for pain and the ADON initiated new pain management orders; -No injuries were observed at the time of the incident; -The resident was alert and level of pain was a seven; -The resident was oriented to person, place, and situation; -Anterior and posterior left thigh were red, hot to the touch, and painful; -No injuries observed post incident. During an interview on 02/13/25. at 11:36 A.M., the Director of Nursing (DON) said he/she added an incident report regarding the burn on 02/07/25, at 11:13 A.M., after speaking with a Department of Health and Senior Services (DHSS) staff and realizing there was not one. Staff should have completed it on 12/19/24 after the incident. Review of the resident's December 2024 Physician's Order Sheet (POS) showed an order, dated 12/19/24, to cover blistered area of the right thigh with a thin layer of Silvadene (topical treatment to prevent and treat wound infections in second and third degree burns) and cover with telfa (non-adherent dressing) BID (two times a day) for superficial burn from spilled coffee. Review of the resident's medical record showed staff did not document a full assessment of the resident's wound on 12/19/24. Review of the resident's care plan showed staff did not update the care plan with the burn or ordered treatment from 12/19/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's December 2025 Treatment Administration Record (TAR) showed the following: -An order, dated 12/19/24, to cover blistered area of the right thigh with a thin layer of Silvadene and cover with telfa BID for superficial burn from spilled coffee; -On 12/19/24, staff coded treatment as HD (HD - hold see nurses notes); -On 12/21/24 staff did not document completion of the morning treatment; -On 12/22/24 staff did not document completion of the treatment. Review of the resident's nurses' notes, dated 12/19/24 to 12/22/24, showed staff did not document why the ordered treatments were not completed. Review of the resident's physician note, dated 12/23/24, showed the resident was seen at the request of nursing staff for a coffee burn to his/her left leg. The resident believed he/she had a seizure causing him/her to spill his/her coffee onto his/her leg. He/she reported being amnestic (experiencing or relating to a partial or total loss of memory) prior to spilling coffee. He/she had superficial burns along with two partial thickness burns. The wound physician will be asked to examine and give recommendations for treatment. Review of the resident's nurse's note, dated 12/23/24, at 8:33 A.M., showed Registered Nurse (RN) A noted the resident was sent to the hospital for treatment of a burn received from spilling coffee on 12/19/24. The wound worsened since the incident. Staff notified the physician and guardian of the transfer. Review of the resident's Skilled Nursing Facility/Nursing Facility (SNF/NF) to hospital transfer form dated 12/23/24, at 9:00 A.M., showed the reason for transfer was burn to the thigh on 12/19/24 and need for wound evaluation and management. Review of the resident's hospital records, dated 12/23/24, showed the following: -The resident said he/she spilled hot coffee on his/her leg around five days ago; -He/she was concerned that he/she may have had a seizure which caused the spill; -The burn was located on the lateral left hip; -Initially the leg was only red, but it has since worsened and developed blisters; -The facility assessed the burn a few days ago after the incident and applied bandages; -The burn was discussed with the on-call trauma surgeon. The burn was debrided and the wound was dressed with an antibiotic ointment placed on the wound. The resident was referred to the burn clinic and discharged back to the facility; -Diagnosis of burn involving less than 10% of body surface-left thigh; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Order to change dressing daily and apply triple antibiotic ointment and sterile gauze. Review of the resident's wound physician's note, dated 12/23/24. showed the following: -Resident presented with wounds to his/her left proximal (situated near the center of the body) anterior(near the front of the body) thigh and left posterior (near back of the body) thigh; -The facility physician requested a thorough wound care assessment and evaluation performed; -Burn wound of the left proximal, anterior thigh full thickness, wound size 8.3 centimeter (cm) x 5.2 cm x .2 cm with 20% slough (soft yellow or white material that builds up on the surface of a wound) and 80% granulation tissue (new, pink or red soft tissue that forms in the healing process of wounds); -Surgical excisional debridement (removing non-viable tissue) procedure, removal of necrotic tissue to establish the margins of viable tissue; -Burn wound of the left, posterior and lateral (away from the middle of the body) thigh with undetermined thickness 28.5 cm x 36.2 cm with depth not being measurable with fluid filled blister. Open ulceration area of 928.53 squared cm; -The resident was requiring an increased level of care and was being sent to the hospital. The resident has 18% second degree burn (an injury that damages the outer layer of skin (epidermis) and part of the underlying layer (dermis)) on his/her thigh area. Review of the resident's December 2024 POS showed the following: -An order, dated 12/24/24, for Silvadene external cream 1%, apply to left thigh two times a day for burn cleanse with normal saline, cover with telfa; -An order, dated 12/24/24, for left thigh at left posterior thigh to cleanse with the wound cleanser, pat dry, and apply triple antibiotic cream to area. Review of the resident's December 2024 TAR showed staff did not complete the order for Silvadene the evening of 12/25/24 and 12/26/24. Staff entered a code of HD. Review of the resident's nurses' notes, dated 12/25/24 and 12/26/24, showed staff did not document why the Silvadene order was not completed. Review of the resident's hospital records showed the following: -On 12/27/24, the resident presented to the burn unit office for status post burn from hot coffee; -The resident is an epileptic and thinks he/she may have had a seizure. The resident does now have burn cellulitis (a bacterial infection of the skin), thick eschar (dead or devitalized tissue), and a fairly deep burn. Diagnosis of deep partial thickness burn of thigh, cellulitis, burn any degree involving less than 10 percent body surface; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 01/07/25, preoperative diagnosis of full thickness burn (third-degree - involve all of the layers of skin and sometimes the fat and muscle tissue under the skin) of the left proximal thigh measuring 19 cm x 13 cm. Postoperative diagnosis of full thickness burn (third-degree) of the left proximal thigh measuring 19 cm x 13 cm. Patient had developed burn cellulitis. He/she was admitted to the hospital and the cellulitis was treated. He/she had been receiving local wound care, but the wound failed to heal. Given these findings we discussed the optic of proceeding with operative intervention. A graft was applied over the burn wound, cut to size, secured with skin staples. -On 01/13/25, resident returned to the facility. Review of the resident's nurse's notes, dated 01/13/25, at 5:07 P.M., showed the resident was readmitted to the facility from the hospital for a burn of the left outer thigh. The resident had a dressing around his/her left thigh. On 01/07/25, he/she had a skin graft to burn on left outer thigh from a donor site on the left inner thigh. It was reported to be healing well. The dressing is intact and will be changed tomorrow. Review of the resident's care plan showed the staff did not update the care plan to reflect the burn or new treatments upon the resident's return from the hospital. Review of the resident's January 2025 POS showed an order, dated 01/14/25, for Bacitracin (prevents infection in cuts and burns) zinc external ointment 500 unit/gram, apply to affected area topically two times a day for wound care. Review of the resident's physician note, dated 01/15/25, showed the resident was seen for readmission to the facility after recent hospitalization for 2nd and 3rd degree burns to the left thigh. The resident underwent a skin graft and has a donor site on the anterior left thigh with silver dressing in place to be removed by surgeon. Review of the resident's January 2025 TAR showed staff did not complete the Bacitracin treatment on 01/15/25 and 01/18/25 evening treatments. The staff entered a code of HD. Review the resident's nurses' notes, dated 01/15/25 and 01/18/25, showed staff did not document whey the Bacitracin treatment was not completed. Review of the resident January 2025 POS showed an order, dated 01/16/25, for calcium alginate-honey 4 x 5, apply four each to affected area for three days every day shift, every three days for wound care. Review of the resident's January 2024 TAR showed staff did not complete the calcium alginate wound treatment on 01/16/25 and 01/19/25. Staff entered a code of HD. Review of the resident's nurses' notes, dated 01/16/25 and 01/19/25, showed staff did not document the reason the wound treatment was not completed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident had a moderate cognitive impairment; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Resident had second or third degree burns; -Resident had a surgical wound. Review of the resident's January 2025 POS showed the following: -An order, dated 01/19/25, for Bacitracin zinc external ointment 500 unit/gram, apply to affected area topically weekly seven days for wound care, cover with xeroform (petroleum-impregnates gauze dressing used to cover wounds) gauze and abdominal pad as needed; -An order, dated 01/21/25, for donor site, to wash wound bases with wound cleanser, apply a thin layer Bacitracin and xeroform, secure with gauze, and gentle compression as needed, one time a day for burn left thigh; -An order, dated 01/21/24, for graft site, for dry dressing daily until scab is formed, one time a day. Review of the resident's January 2025 TAR showed the following: -On 01/25/25, staff did not document completion of the 01/21/25 order to donor site or graft site orders; -On 01/26/25 staff did not complete the Bacitracin wound treatment (order 01/19/25) and entered a code of HD; -On 01/26/25 and 01/27/25, staff did not complete the wound treatment to the donor cite and coded with a HD; -On 01/27/25, staff did not complete the graft site order and coded as HD. Review of the resident's nurses' notes, dated 01/25/25 to 01/27/25, showed the staff did not document why the wound treatments were not completed. Review of the resident's medical record, 01/13/25 to 02/06/25, showed staff did not document a full assessment of the wound. Review of the resident's current care plan showed staff updated the care plan on 02/07/25, with the following: -The resident has a burn and donor site to his/her left thigh; -The resident will remain free from complications related to wound healing and infection; -Encourage good nutrition and hydration in order to promote healthier skin; -Follow wound care as ordered by provider; -Monitor/document location, size and treatment of the wound; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Offer resident lids with hot liquids, resident does remove lids his/herself; -Use caution during transfers and bed mobility. During an interview on 02/05/25, at 11:12 A.M., the resident said the following: -He/she got a burn on his/her left thigh in December 2024 after spilling hot coffee on him/herself. He/She thinks he/she had a seizure which caused the spill; -The staff treated the burn and he/she was sent to the hospital a few days after. It was a pretty bad burn and was painful; -He/she had to have a skin graft; -It was a third degree burn. Observations on 02/05/25, at 11:12 A.M., showed the resident lifted up his/her clothing to show a large scarred reddish pink area with a few scabs that appeared to be closed on her left thigh spanning from just above his/her knee cap to close to his/her abdomen. A dressing was covering a small portion of the top of the healing burn. There was a rectangular smaller area that was reddish but also appeared closed on his/her lower leg. The resident said the smaller area on the lower leg was from the skin graft. During an interview on 02/05/25, at 11:20 A.M., Certified Nurse Aide (CNA) I said the following: -On 12/19/24, he/she went to change the resident around 7:00 P.M. and saw that the resident's left thigh appeared to be covered with a burn and there was a large blister; -He/she told the nurse; -He/she believed the burn was being cared for and the resident was sent to the hospital sometime after that. During an interview on 02/05/25, at 12:36 P.M., CNA K said the following: -He/she was aware the resident burned his/her thigh from hot coffee; -He/she did not remember who assisted the resident; -The resident was sent to the hospital and then returned a day later, but was sent a second time and stayed. He/she believed the burn was being treated. During an interview on 02/7/25, at 12:14 P.M., Licensed Practical Nurse (LPN) G said the following: -The resident spilled coffee on him/herself. The resident was sent to the hospital at one point and had to get skin grafts. He/she did not do any of the treatments or assessments until after he/she returned from the hospital; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He/she was not aware that treatments had not been completed; -The resident's burn should have been assessed and documented in a nurse's note. The nurse should also document communication with the physician. During an interview on 02/06/25, at 10:25 A.M., RN A said the following: -The resident spilled coffee on him/herself on 12/19/24 around 5:00 P.M.; -He/she was informed by a CNA who was pushing the resident back to her room in a wheelchair. He/she believed the resident got the coffee herself and then spilled it after having a seizure; -He/she assessed the resident's burn and it was originally just a reddish, pink area that was warmer to the touch than the outlying skin. The redness was from just above the knee to his/her abdomen/groin and it wrapped around to the back of the thigh. There was about an inch strip of skin that was shriveled and wrinkled with loose skin on the back of the thigh. He/she did not measure it. He/she sent a picture of the burn to the resident's physician, and he/she provided orders for treatment of the burn and pain medication; -He/she put in the orders for wound care and completed the wound care and left the facility. He/she did not remember what documentation he/she completed; -The resident's physician requested that the wound physician see the resident's burn on 12/23/24 due to the burn being significantly worse. The burn was found to be completely covered in a blister; -The wound physician assessed and debrided the burn and then recommended the resident go to the hospital. The resident was sent to the emergency room and was sent back to the facility the same day with a follow-up scheduled with the burn center for 12/26/24; -He/she did notify the wound physician that he/she had returned, and he/she gave new orders for treatment. The treatment was being completed as far as he/she knew; -He/she did not recall making any nurses' notes, incident reports, events or documenting any assessments regarding the burn; -The nurse should documented assessments and a nurse's note in the chart. The nurse should document any changes in condition and communication with the physician in a nurses note; -The resident went to his/her appointment on 12/26/24 and was sent to the hospital burn unit where he/she stayed for a few weeks and had to have a skin graft; -He/she believed the new orders from the hospital were completed as ordered and as far as he/she knew the burn was improving; -He/she is not sure if anything was added to the care plan. During an interview on 02/06/25, at 3:23 P.M., the ADON said the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He/she saw the resident's burn on either Saturday or Sunday (12/21/24 or 12/22/24); -He/she believed he/she assessed the burn on the front of the thigh. He/she thought he/she made a nurse's note; -The burn covered most of the outer thigh and was blistered. It progressively was getting worse; -He/she did not look at the back of the leg/thigh; -He contacted the physician, but could not recall what instructions were given if any; -He/she used nursing judgement and chose not to complete the wound treatment as ordered or any treatment because he/she was worried it might stick to the blister and cause it to pop; -The burn should have been measured and any observations documented; -The resident ended up going to the hospital and getting a skin graft for the burn. During an interview on 02/07/25, at 3:33 P.M., the resident's physician said the following: -The resident spilled coffee on him/herself. The resident said he/she had a seizure, but he/she did not think the resident had a seizure due to the resident not having any seizure's recently and they are well controlled; -He/she believed the burns were only partial thickness and not full thickness initially; -The burn was at least 5 cm x 10 cm. The burn initially was just redness, but burns can continue to decline for 4 to 5 days; -He/she was made aware that the burn was declining and he/she had the wound physician look at the burn on 12/23/24; -The resident was sent to the hospital and then came back and went back to the hospital due to continued decline; -The facility staff should document assessments and change in condition in the chart; -Wound treatments should be completed as ordered and if not there should be a documented reason why given. During interviews on 02/05/25, at 1:57 P.M., and on 02/13/25, at 11:36 A.M., the DON said the following: -The resident was in the dining room, around dinner time and had a mug with a handle. The resident wheeled him/herself in front of the table and either had a seizure or fell asleep. He/she spilled coffee on him/herself; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-He/she believed this occurred on 12/19/24 based on an order for pain medication and wound care for the burn placed on that date; -He/she was unable to find any nurses notes, assessments, or an incident/event report regarding the burn or incident from 12/19/24 until 12/23/24; -The nurse should have completed an assessment of the burn, including measurements and a description of what it looked like; -RN A did look at the wound and it was reported to the DON and it was just a red area that was warmer than the surrounding area to the touch; -He/she saw the wound on 12/20/24 and had redness that went from just below the mid-thigh to the groin and then back behind the leg. There was a blister approximately the size of a hot dog bun. He/she did not look at the back of the leg; -On 12/23/24, the burn was more extensive and the resident was assessed by the wound physician and sent to the hospital; -RN A should have documented an assessment and communication with physician in the computer. He/she should have completed an incident report. During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said the following: -He/she responsible for care plans; -Burns and wounds should be on the care plan with the appropriate interventions; -Wounds should be treated per the physicians orders. During an interview on 02/06/25, at 2:45 P.M., the Administrator said the following: -He/she was informed that the resident had spilled coffee on him/herself when he/she fell asleep or had a seizure; -The resident was assessed by nursing staff after the incident. -Wound care should be completed as ordered. New wounds should be assessed by the nurse. 50185 36974

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to provide wound prevention and treatment per standards of practice when staff failed to complete a full assessment and obtain treatment orders timely upon discovery of a wound, failed to follow physician orders for interventions, completion of wound treatments and labs, and failed to care plan interventions for one resident (Resident #95) who developed facility acquired pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). The resident developed infection and was referred to a surgeon for possible amputation of the right lower leg. The facility census was 98. The Administrator was notified on 02/07/25, at 4:59 P.M., of an Immediate Jeopardy (IJ) which began on 12/05/24. The IJ was removed on 02/07/25, as confirmed by surveyor onsite verification. Review of a facility policy titled Wound Management, dated 11/15/22, showed the following: -The facility will provide evidence-based treatments in accordance with current standards of practice and physician orders; -Wound treatment will be provided in accordance with physician's order; -Charge nurse will notify the physician in the absence of treatment orders; -Wound characteristics and documentation will included location of the wound; pressure injury and stage; size (shape, depth, tunneling (passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound), and/or undermining (the destruction of tissue or ulceration extending under the skin edges); volume and exudate (drainage) characteristics; pain evaluation; presence of infection; condition of the wound bed and wound edges; condition of the peri wound (skin surrounding wound); and resident preference and goals. -Treatments will be documented on the Treatment Administration Record (TAR); -The effectiveness of treatments will be monitored through ongoing evaluation of the wound. Review of a facility policy titled Comprehensive Person-Centered Care Plan, dated 10/23/19, showed the following: -Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care; -The interdisciplinary team (IDT), along with the resident and/or resident representative, will identify resident problems, needs, strengths, life history, preferences, and goals; -For each problem, need, or strength a resident centered measurable goal is developed; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff approaches are to be developed for each problem, need, and strength. Assigned disciplines will be identified to carry out the intervention; -The comprehensive person-centered care plan can be reviewed and/or revised at quarterly intervals; -Upon a change in condition the care plan will be updated if applicable: -The care plan is updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence. 1. Review of Resident #95's face sheet (document that gives resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included encephalopathy (brain disease that alters brain function and structure), cerebral infarction (when blood flow to the brain is blocked leading to brain tissue death), non-pressure ulcer of the right foot with fat layer exposed (skin breakdown or open sore that develops due to a cause other than pressure), and type two diabetes mellitus (the body has trouble controlling blood sugar and using it for energy). Review of the resident's current care plan showed on 09/05/24, staff care planned following: -Resident had potential impairment to skin integrity related to deconditioning and incontinence; -Staff to follow facility protocols for treatment of injury; -Staff to educate resident/family/caregivers of causative factors and measures to prevent skin injury and encourage good nutrition and hydration in order to promote healthier skin. Review of the resident's skin assessment, dated 09/12/24, showed resident had no wounds and a rash to the groin area. Review of the resident's record, dated 09/13/24 to 10/18/24, showed staff did not document completion of skin assessments. Review of the resident's skin assessment, dated 10/19/24, showed the following: -An unstageable pressure ulcer to the right heel, measuring 5 centimeters (cm) by 3 cm; -Drainage noted when staff assisted resident to get dressed; -Bordered gauze dressing applied and heel offloaded; -Staff notified the Director of Nursing (DON), physician, and family. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the resident's medical record, dated 10/19/24 and 10/21/24, showed no wound orders in place for the unstageable pressure ulcer on right heel. Review of the resident's physician progress note, dated 10/21/24, showed the nurse practitioner evaluated the resident due to staff report of a right heel wound. Resident found to have a stage 3 full thickness wound with eschar (dead tissue that forms over healthy skin). New orders included to cleanse with house wound cleanser, apply calcium alginate (absorbent wound dressings made from seaweed (alginate)) to wound and cover with bordered gauze and change daily, wound care consult, and Tylenol (pain reliever) 325 milligrams (mg) two tablets every six hours. Review of the resident's October 2024 Physician Order Sheet (POS) showed an order, dated 10/22/24, to cleanse with house wound cleanser, apply calcium alginate to wound and cover with bordered gauze and change daily. (The order did not specify the location of the wound.) Review of the resident's initial wound evaluation from the wound care provider, dated 10/24/24, showed the following: -Stage 3 full thickness pressure wound of the right heel; -Wound size 4.0 cm by 1.8 cm with depth not measurable; -Depth not measurable due to nonviable tissue and necrosis (death of body tissue); -Wound had moderate amount of serous (clear, watery fluid that leaks from a wound); -Wound had 80% necrotic (dead or non-viable tissue) and 20% slough (dead, yellow or white tissue that covers wound). Review of the resident's care plan showed staff did not update the care plan regarding the right heel wound. Review of the resident's October 2024 POS showed a new order, dated 10/26/24, was received to cleanse the right heel with house wound cleanser, apply calcium alginate to wound and cover with bordered gauze and change daily. Review of the resident's wound evaluation and management summary from the wound care provider, dated 10/31/24, showed the following: -Resident had wounds on the right posterior (back of body) heel and right plantar (sole of foot) heel; -Full thickness pressure wound of the right posterior heel measured 2.9 cm by 1 cm by 0.1 cm with moderate serous drainage; -Right posterior heel was improved; -Wound covered in 25% slough and 75% granulation tissue (soft, pink-red tissue that forms as wound heals). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Unstageable deep tissue injury (DTI) of the right plantar heel measured 1.7 cm by 1.8 cm by non-measurable depth with no drainage. Review of the resident's care plan showed staff did not update the care plan regarding the two identified wounds. Review of the resident's nursing progress notes, dated 10/19/24 to 10/31/24, showed staff did not document related to the resident's unstageable pressure ulcer or right heel stage 3. Review of resident's November 2024 POS showed the following: -An order, dated 11/01/24, for stage 3 right posterior heel to cleanse with house wound cleanser, apply calcium alginate to wound and cover with bordered gauze and change daily; -An order, dated 11/01/24, for unstageable DTI to right heel to cleanse with facility choice wound cleanser and apply bordered gauze daily until healed. Review of resident's November 2024 TAR showed the following: -Staff did not document completion of the wound treatment to stage 3 right posterior heel 11/01/24 and 11/02/24. -Staff did not document completion of the wound treatment to the unstageable right heel wound on 11/01/24 and 11/02/24. Review of the resident's wound evaluation and management summary from the wound care provider, dated 11/06/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel measured 2.5 cm by 1.0 cm by 0.1 cm and was improved; -Wound had moderate serous drainage with 25% slough and 75% granulation tissue in wound bed; -Unstageable DTI to right heel measured 1.5 cm by 1.8 cm by 0.1 cm with light serous drainage was improved. Review of resident's November TAR showed the following: -Staff did not document completion of the the wound treatment to the stage 3 right posterior heel on 11/07/25. -Staff did not document completion of the wound treatment to the unstageable right heel on 11/07/24. Review of resident's November 2024 POS showed the following orders -An new order, dated 11/08/24, for stage 3 right heel to cleanse with normal saline, apply Santyl (medication used to remove damaged skin) to wound and cover with bordered gauze and change daily; (continued on next page)

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Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-An new order, dated 11/08/24, for unstageable right heel to cleanse wound with normal saline, apply small amount of Santyl to wound and cover with bordered gauze daily and as needed. Review of the resident's care plan showed staff did not update the care plan with the wounds or change in treatment. Review of resident's November 2024 TAR showed the following: -Staff did not document completion of the wound treatment to the stage 3 right posterior heel on 11/08/24 and 11/10/24. -Staff did not document completion of the wound treatment to unstageable right heel on 11/08/24 and 11/10/24. Review of the resident's wound evaluation and management summary from a wound care provider, dated 11/13/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel measured 2.4 cm by 0.9 cm by 0.1 cm and was improved. Wound had light serous drainage with 20% slough and 80% granulation tissue in wound bed; -Unstageable DTI to right heel measured 0.9 cm by 1.4 cm by 0.1 cm with light serous drainage. Wound bed with 25% slough and 50% granulation tissue and not at goal. Review of resident's November 2024 POS showed the following orders: -An new order, dated 11/15/24, for stage 3 right heel to cleanse with normal saline, apply small amount of Santyl to wound and cover with bordered gauze daily and as needed; -An new order, dated 11/15/24, for unstageable right heel to cleanse with normal saline, apply small amount of Santyl to wound bed, cover with bordered gauze daily and as needed. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/06/24, showed the following: -Cognitively intact; -Resident had impairment to lower extremities; -Required partial to moderate assistance with dressing, showers, hygiene, bed mobility, and transfers; -At risk for development of pressure ulcers; -Had one stage 3 (full thickness tissue loss, fat may be visible, but bone, tendon, or muscle is not exposed) pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Had one unstageable (full thickness pressure injury in which the base is obscured by eschar (dead tissue that forms over healthy skin) or slough (dead, yellow or white tissue that covers wound)) pressure ulcer due to a non-removable dressing or device that was present on entry to facility; -Pressure reducing device for chair and bed. Review of the resident's care plan showed staff did not update the care plan with the wounds or change in treatment. Review of the resident's November 2024 TAR showed the following: -Staff did not document completion of wound treatment to stage 3 right posterior heel on 11/14/24, 11/16/24, and 11/17/24. -Staff did not document completion of wound treatment to unstageable right heel on 11/14/24, 11/16/24, and 11/17/24. Review of the resident's wound evaluation and management summary from a wound care provider, dated 11/20/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel measured 2.2 cm by 0.8 cm by 0.1 cm and was improved; -Wound had moderate serous drainage with 25% slough and 75% granulation tissue in wound bed; -Unstageable DTI to right heel measured 0.5 cm by 0.5 cm by 0.1 cm with light serous drainage; -Wound bed with 25% slough, 25% necrotic tissue and 50% granulation tissue and not at goal. Review of the resident's care plan showed on 11/20/24 staff updated the care plan with the following: -Resident had a stage 4 (full thickness skin loss that exposes muscle, bone, and other tissue) pressure wound to the right heel. -Administer vitamins and minerals per order; -Off load affected area as resident allows; -Provide nutrition and hydration per current orders; -Provide treatment per current order. Review of the resident's weekly wound observation, dated 11/21/24, showed the following: -Pressure ulcers to right posterior heel and right plantar heel acquired on 10/30/24; -Stage 3 to right heel is improved and measured 2.2 cm by 0.8 cm by 0.1 cm; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Stage 3 right heel had moderate serous drainage with epithelial tissue and slough visible; -DTI to right planter heel is now a stage 3 pressure ulcer measuring 0.5 cm by 0.5 cm by 0.1 cm; -Right plantar heel has serous drainage and wound bed is covered in 25% slough, 25% necrotic tissue, and granulation tissue. Review of resident's November 2024 TAR showed the following: -Staff did not document completion of wound treatment to stage 3 right posterior heel on 11/22/24 and 11/23/24. -Staff did not document completion of wound treatment to the unstageable right heel on 11/22/24 and 11/23/24. Review of the resident's wound evaluation and management summary from a wound care provider, dated 11/26/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel measured 2.5 cm by 1.2 cm by 0.1 cm and was not at goal. Wound had moderate serous drainage with 25% viable tissue and 75% granulation tissue in wound bed; -Unstageable DTI to right heel measured 0.7 cm by 0.8 cm by 0.1 cm with light serous drainage. Wound bed with 5% slough, 75% necrotic tissue and 20% granulation tissue and not at goal. Review of resident's November 2024 TAR showed the following: -Staff did not document completion of wound treatment to stage 3 right posterior heel was on 11/27/24. -Staff did not document completion of wound treatment to unstageable right heel on 11/27/24. Review of resident's November 2024 POS showed the following orders: -An new order, dated 11/28/24, for stage 3 right heel to cleanse with wound cleanser and apply Medi honey (dressing that removes necrotic tissue and aids in healing) to wound bed, cover with bordered gauze daily and as needed; -An new order, dated 11/28/24, for unstageable right heel, cleanse with wound cleanser, skin prep with wound area, apply Medi honey to wound bed, cover with bordered gauze dressing daily and as needed. Review of a resident's weekly wound observation, dated 11/28/24, showed the following: -Pressure ulcers to right posterior heel and right plantar heel acquired on 10/30/24; -Stage 3 to right heel is improved and measured 2.5 cm by 1.2 cm by 0.1 cm; (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Stage 3 right heel had moderate serous drainage with 25% slough visible; -DTI to right plantar heel is now a stage 3 pressure ulcer measuring 0.7 cm by 0.8 cm by 0.1 cm; -Right plantar heel had light serous drainage and wound bed was covered in 5% slough and granulation tissue. Review of resident's December 2024 TAR showed the following: -Staff did not document completion of the wound treatment to the stage 3 right posterior heel on 12/01/24. -Staff did not document completion of the wound treatment to unstageable right heel on 12/01/24. Review of the resident's wound evaluation and management summary from a wound care provider, dated 12/05/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel was now unstageable due to necrosis and measured 2.4 cm by 1.4 cm by 0.2 cm and was exacerbated (worse) due to infection. Wound had moderate purulent (thick, yellowish fluid containing pus) drainage with 25% slough, 10% necrotic, and 40% granulation tissue in wound bed. -Unstageable DTI to right plantar heel was now a stage 3 and measured 1.5 cm by 1.0 cm by 0.1 cm with moderate serous drainage. Wound bed with 100% granulation tissue and not at goal. -The provider recommended the following tests white blood cell (WBC - measures amount of blood cells to detect infections); erythrocyte sedimentation rate (ESR - blood test to check for inflammation), C-reactive protein (CRP - test to check for inflammation); deep swab wound culture on right posterior heel (test used to diagnose a suspected deep wound infection), and hemoglobin A1C (HBA1C - measures average blood sugar over the past couple months). Review of the resident's December 2024 POS showed the following: -A new order, dated 12/05/24, for unstageable right heel to cleanse wound with Dakin's (solution used to prevent and treat skin and tissue infections) and half normal saline, cut to size sterile Dakin's moistened gauze and apply to wound bed, cover with bordered gauze twice daily and as needed; -A new order, dated 12/06/24, for stage 3 right heel to cleanse wound with normal saline, apply calcium alginate with silver (cut to size) to wound bed, cover with bordered gauze daily and as needed. Review of the resident's care plan showed staff did not update the care plan to reflect the new treatment interventions. Review of the resident's December 2024 POS showed staff did not place labs on the resident's order sheet of completion. Review of the resident's nurses' notes, dated 12/05/24, showed staff did not document why the labs orders were not placed on the POS. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident's December 2024 TAR showed the following: -Staff did not document wound treatment to the stage 3 right posterior heel on 12/05/24, 12/06/24, 12/10/24, and 12/11/24. -Staff did not document wound treatment to unstageable right heel on 12/05/24 and 12/11/24. Staff documented completion of wound treatment once daily (instead of the twice daily as ordered) on 12/06/24, 12/09/24, and 12/10/24. Review of the resident's wound evaluation and management summary from a wound care provider, dated 12/12/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel was now unstageable due to necrosis and measured 3 cm by 3.5 cm by unmeasurable depth and was not at goal. Wound intact with purplish discoloration with no drainage; -Unstageable DTI to right plantar heel was now a stage 3 and measured 1.6 cm by 1.2 cm by 0.3 cm with moderate serosanguinous (fluid containing blood and serum (liquid part of blood) drainage. Wound bed with 80% granulation tissue and 20% slough and not at goal; -The following tests recommended on 12/05/24 visit still pending including WBC, ESR, C-Reactive Protein, Deep swab wound culture on right posterior heel, and HBA1C. Review of the resident's December 2024 POS showed labs were not placed on the resident's order sheet of completion. Review of the resident's nurses' notes, dated 12/12/24, showed staff did not document why the labs orders were not placed on the POS. Review of resident's December 2024 TAR showed the following: -Staff did not document completion of the wound treatment to the stage 3 right posterior heel on 12/12/24. -Staff document completion of the unstageable wound once (instead of the order twice daily) on 12/12/24. Review of the resident's nursing progress note, dated 12/17/24, showed resident noted with increased pain with treatment. Physician called and new order for Ultram (pain medication) 50 milligrams (mg) four times daily ordered. Review of December 2024 POS showed an order, dated 12/18/24, for an air mattress, pressure relief. Review of the resident's care plan showed staff did not update the care plan with the new intervention. Review of the resident's wound evaluation and management summary from the wound care provider, dated 12/19/24, showed the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Unstageable pressure ulcer of the right posterior heel was now stage 3 and measured 3.5 cm by 3 cm by 0. 1 cm and exacerbated due to infection and resident noncompliance with wound care. Wound bed 50% necrotic, 30% slough, and 20% granulation with moderate serosanguinous drainage; -Stage 3 to right plantar heel measured 2 cm by 1.4 cm by 0.2 cm with moderate serosanguinous drainage. Wound bed with 100% granulation tissue and improved; -The following tests still pending WBC, ESR, CRP, deep swab wound culture on right posterior heel, and HBA1C. Review of the resident's medical record showed staff did not document why the labs were not completed. Review of resident's December 2024 TAR showed the following: -Staff did not document completion of the wound treatment to stage 3 right posterior heel on 12/20/24, 12/21/24, and 12/22/24. -Staff did document completion of the unstageable heel once daily (instead of the ordered twice daily) on 12/20/24 and 12/21/24. Staff did not complete a treatment to the unstageable heel on 12/22/24. Review of a the resident's wound evaluation and management summary from the wound care provider, dated 12/23/24, showed the following: -Stage 3 pressure ulcer of the right posterior heel measured 4.1 cm by 3.9 cm by 0.1 cm and not at goal;. Wound bed 50% necrotic, 30% slough, and 20% granulation with moderate serosanguinous drainage; -Stage 3 to right plantar heel measured 1 cm by 1.5 cm by 0.2 cm. Wound bed with 100% granulation tissue and improved; -The following tests still pending WBC, ESR, CRP, deep swab wound culture on right posterior heel, and HBA1C. -Wound care physician discussed offloading, obtaining lab results, and further management with resident and facility wound nurse. Review of resident's December 2024 POS showed the following: -A new order, dated 12/24/24, for stage 3 right heel to cleanse wound with Dakin's and half normal saline, cut to size sterile Dakin's moistened gauze, and apply to wound bed, cover with bordered gauze twice daily and as needed. Record review of the resident's care plan showed staff did not address the new treatment/intervention on the care plan. Review of resident's December TAR showed the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A new order, dated 12/24/24, for wound care to stage 3 pressure wound of the right plantar heel, to cleanse wound with Dakin's and half normal saline, cut to size sterile Dakin's moistened gauze, and apply to wound bed, cover with bordered gauze twice daily and as needed every day shift for wound care. (The POS showed the order to be completed twice daily.) Review of resident's December 2024 TAR showed staff documented completing the treatment to the unstageable heel once on 12/25/24 and 12/29/24. Review of the resident's record showed the resident was discharged to the hospital on 12/29/24 for seizures. Review of the resident's hospital facility to facility discharge paperwork, dated 01/10/25, showed a diagnosis of acute osteomyelitis (bone infection) of the right ankle and foot. New order to paint right heel with betadine (antiseptic solution), cover with ABD pad and wrap with kerlix (gauze bandage) daily. Facility to make appointment with the vascular surgeon for follow up in 3 to 4 weeks. Review of the resident's admission note, dated 01/10/25, showed resident returned from hospital for suspected seizure activity and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). The right heel has eschar present with 1.3 cm by 0.5 cm open area, betadine applied to eschar and calcium alginate applied to open area after cleaning with normal saline. Review of the resident's January 2025 POS showed an order, dated 01/11/25, to paint right heel with betadine and cover with ABD pad and wrap with kerlix daily. Review of the resident's physician progress note, dated 01/13/25, showed resident seen due to readmission from hospital. Resident reported pain in right heel with odor and drainage noted on exam. Cellulitis (bacterial infection of the skin and underlying tissues. It typically causes redness, swelling, pain, and warmth in the affected area) of right heel and will order clindamycin (antibiotic) 300 mg twice daily for 10 days. Review of the resident's January 2025 POS showed an order, dated 01/11/25, to paint right heel with betadine and cover with ABD pad and wrap with kerlix daily. -An order, dated 01/13/25, for clindamycin capsule 300 mg twice daily for right heel cellulitis for 10 days. Review of the resident's wound evaluation and management summary from a wound care provider, dated 01/16/25, showed the following: -Right posterior heel wound resolved; -Pressure wound to right heel measured 7 cm by 9 cm by 0.2 cm with moderate serosanguinous drainage. Wound bed is 40% necrotic, 30% slough, 30% granulation tissue. Exacerbated due to infection. -Physician discussed starting antibiotic for wet gangrene (condition where tissue dies due to lack of blood flow and bacterial infection); (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The following tests recommended on 12/05/24 visit were still pending: WBC, ESR, CRP, deep swab wound culture on right posterior heel, and HBA1C. Review of the resident's medical record showed staff did not address the need for the ordered labs or why they were not completed. Review of the resident's care plan showed staff did not update the care plan upon readmission to the facility. Review of the resident's nurse practitioner progress note, dated 01/17/25, showed right heel eschar present with two areas that have now joined, 2 cm by 2 cm, open area distally with foul odor. Resident currently taking clindamycin. Obtain right foot x-ray for concern of osteomyelitis. Review of the resident's January 2025 POS showed an order, dated 01/17/25, for a right foot x-ray. Review of the resident's nurse progress note, dated 01/17/25, showed x-ray results reviewed and no acute findings noted. Review of radiology report, dated 01/17/25, showed foot suspicious for acute osteomyelitis and cellulitis. Review of the resident's skin/wound note, dated 01/20/25, showed the following: -Stage 3 pressure wound of the right posterior heel in resolved. -Stage 3 pressure wound of the right heel measured 7.0 cm by 9.0 cm by 0.2 cm with moderate serosanguinous drainage. Wound progress exacerbated due to infection. Surgical debridement done to remove infected and necrotic tissue. No treatment changes this visit. -Pending labs of CRP, deep wound culture on pressure wound of heel, ESR, WBC, and HBA1C. Review of the resident's medical record showed staff did not address the need for the ordered labs or why they were not completed. Review of resident's January 2025 TAR showed staff did not document completion of the wound treatment to right heel on 01/20/24. Review of the resident's physician's progress note, dated 01/20/25, showed resident seen due to right heel and osteomyelitis noted on x-ray. Patient requested to go to emergency room for evaluation and treatment of osteomyelitis and wound. Review of the nurse's progress note dated 01/21/25, at 12:28 P.M., showed results from x-ray noted and per physician send resident to emergency room for follow up (the day after physician noted the order to transfer). Review of the resident's nurse progress note dated 01/21/25, at 6:18 P.M., showed the resident returned from hospital. Staff did not document any new diagnoses or orders. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's physician progress note, dated 01/22/25, showed resident returned from the emergency room with decision to make regarding amputation of right leg or palliative care. On exam resident stated, I want to see a surgeon, I would rather lose my leg then my life. Treatment plan indicated patient to consult with vascular surgeon and continue cipro 50 mg (antibiotic) twice daily until evaluation for osteomyelitis. Review of the resident's January 2025 POS showed the following: -An order, dated 01/22/25, for ciprofloxacin tablet 500 mg, one tablet twice daily for infection with no end date. Review of resident's January 2025 TAR showed the following: -Staff did not document completion of the wound treatment to right heel on 01/22/25; -An order dated 01/27/25, for a vascular surgeon consult documented as completed on 01/27/25. Review of resident progress notes showed staff did not document an appointment made with vascular surgeon. Review of the resident's January 2025 POS showed the following: -An order, dated 01/23/25, to cleanse right heel with Dakins and normal saline, apply Dakin's gauze to area, cover with ABD pad and kerlix three times weekly. Review of the resident's wound evaluation and management summary from a wound care provider, dated 01/23/25, showed the following: -Pressure wound to right heel measured 5.6 cm by 6.8 cm by 0.3 cm with moderate serosanguinous drainage. Wound bed is 60% necrotic, 20% slough, 20% granulation tissue. Exacerbated due to infection. -The tests recommended on 12/05/24 visit still pending ESR and CRP. Review of the resident's medical record showed staff did not document regarding the need for the labs or why they were not completed. Review of resident's January 2025 TAR showed staff did not document completion of the wound treatment to right heel on 01/24/25. Review of the resident's January 2025 POS showed the following: -A new order, dated 01/25/25, to cleanse right heel with Dakin's, apply calcium alginate with silver and cover with ABD pad and kerlix, skin prep peri wound. Review of the resident's wound evaluation and management summary from a wound care provider, dated 01/30/25, showed the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Pressure wound to right heel measured 5 cm by 7 cm by 0.3 cm with moderate serosanguinous drainage. Wound bed is 60% necrotic, 20% slough, 20% granulation tissue. -The tests recommended on 12/5/24 visit still pending ESR and CRP. Review of the resident's medical record showed staff did not document regarding the need for the labs or why they were not completed. Review of resident's January 2025 TAR showed staff did not document completion of the wound treatment to right heel on 01/31/25. Observation and interview on 02/05/25, at 10:01 A.M. showed the resident resting in bed on a regular mattress (not an air mattress as ordered on 12/18/24). Resident reported he/she was unsure how long he/she had the wound on right heel, but staff clean it and change the bandage on it. The wound was not improving and he/she was seeing a vascular physician about amputation. He/she was on antibiotics due to an infection to the right foot, but was unsure how long. Resident reported pain to the right foot and that he/she was currently receiving pain medication to help. During an interview on 02/07/25, at 11:27 A.M., the wound care physician said the following: -The wound care company had been seeing the resident for right heel pressure wound for 93 days; -The right heel was non purulent (not containing or producing pus) and did not have an infection on initial consult; -The resident had two wounds that merged into one during treatment; -The wound was currently malodorous (unpleasant-smelling) and had bone exposed; -He/she was unsure when osteomyelitis started, but spoke with the nurse practitioner about starting antibiotics related to wet gangrene and osteomyelitis; -If wound treatments are missed it can cause a wound to deteriorate; -The resident's wound would get worse due to heavy exudate that could cause maceration (softening of the skin) and infection; -Missing wound treatments could have contributed to infection or osteomyelitis. Observation of the resident's wound to right heel on 02/07/25, at 12:04 P.M., s[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on record review and interview, the facility failed to keep an environment free from accident hazards when staff did not complete and document a timely investigation or assessment into the cause of a coffee spill that resulted in a burn and did not update the resident's care plan timely regarding new interventions to prevent future burns for one resident (Resident #2). The facility census was 98. Review of the facility's policy titled, Accident and Incident Documentation and Investigation, revised 04/26/23, showed the following: -Accidents and/or Incidents involving residents will be investigated and documented on an Incident Report in the electronic health record (EHR). An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of Incidents; -The licensed nurse assigned at the time of the resident care accident/incident was responsible for conducting an investigation of the circumstances surrounding the accident/incident, and for notifying the supervisor, Director of Nursing (DON), and/or the Administrator as appropriate; -The licensed nurse at the time of the incident was responsible for initiating/completing the Incident Report and ensuring that all items had been completed as applicable to the accident/incident;. -The licensed nurse at the time of the incident was responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth in the incident report. -The licensed nurse shall document the incident and notify the supervisor and DON for follow through as needed; -The licensed nurse may complete a nurses' note and update the resident's care plan as needed; -The nurses' notes may contain clear objective facts of what occurred; an evaluation of the resident's condition at the time of the accident/incident; description of the resident; vital signs; other physical characteristics apparent as a result of the accident/incident; any treatment provided; notification or attempts to notify the resident's physician, family, and/or legal representative, or any other health care professional or individuals involved with the resident's care; and the charge nurse's signature, date, & time of the documentation; -Accidents/incidents will be reviewed as part of the quality assurance program; -The Incident Report will be completed in the Electronic Medical Record (EMR); -In the event the computer is down paper copies of an Incident Report will be available. (continued on next page)

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	265477	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review showed the facility did not provide a policy regarding monitoring of hot water for coffee. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included burn of unspecific degree of left thigh, muscle weakness, abnormalities of gait and mobility, unsteadiness on feet, cognitive communication deficit, unspecified dementia (a decline in mental abilities, including memory, thinking, and reasoning, severe enough to interfere with daily life, and is caused by damage to or changes in the brain), epilepsy (a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness) , and unspecified open wound, left hip, burn of first degree (a minor injury that affects only the top layer of skin) of left lower leg. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/24, showed the following: -The resident was cognitively intact; -The resident required supervision or touching assistance with meals; -The resident could use a manual wheelchair to wheel 50 feet with two turns with supervision or touching assistance. Review of the resident's current care plan showed the following : -On 01/14/19, staff revised the care plan to reflect the resident had a seizure disorder; -On 08/19/24, staff care planned the resident would remain free from injury related to seizure activity through the review date; -On 09/30/24, staff care planned the resident continued to have seizures, however, they were noted to be further apart although they could vary; -On 09/30/24, staff care planned to not leave the resident alone during a seizure. Protect him/her from injury. If he/she was out of bed, help to the floor to prevent injury and remove or loosen tight clothing. Do not attempt to restrain the resident during a seizure as it could make convulsions more severe, protect onlookers, draw a curtain etc; -On 09/30/24,staff care planned seizure documentation should include location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling) duration, level of consciousness, any incontinence, and sleeping or dazed post-ictal state, after seizure activity; -On 09/30/24, staff care planned to give seizure medication as ordered; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/23/23, staff care planned the resident had an activities of daily living (ADL) self care performance deficit due to impaired cognition and staff to assist with ADLs. Staff updated the care plan on 09/30/24, to reflect resident was able to eat without assistance. Review of the facility's Incident Report, for date 12/19/24 at 4:30 P.M., showed the following: -The resident was in the dining room having a cup of coffee before dinner when it spilled in his/her lap causing burns to develop to the anterior (front of the body) and posterior (back of the body) aspects of the left thigh. The resident believed he/she reached to place the coffee cup on the dining table and he/she experienced a mild seizure which caused him/her to spill the hot liquid from his/her cup; -Staff removed the resident from the dining room, assessed for injury, and notified the physician. The Assistant Director of Nursing (ADON) was present and notified. Staff contacted the wound doctor and a treatment order was received, noted, and completed and resident assessed for pain. The ADON initiated new pain management orders; -The resident was alert and level of pain was a seven; -The resident was oriented to person, place, and situation; -Anterior and posterior left thigh red hot to the touch and painful. -Staff did not document new interventions to prevent future burn injury. During an interview on 02/13/25, at 11:36 A.M., the DON said he/she added an incident report regarding the burn on 02/07/25, at 11:13 A.M., after speaking with Department of Health and Senior Services (DHSS) staff and realized there was not one. Staff should have completed the Incident report on 12/19/24 after the incident. Review of the resident's December 2024 Physician's Order Sheet (POS) showed an order, dated 12/19/24, to cover blistered area of the right thigh with a thin layer of Silvadene (topical treatment to prevent and treat wound infections in second and third degree burns) and cover with telfa (non-adherent dressing) BID (two times a day) for superficial burn from spilled coffee. Review of the resident's physician note, dated 12/23/24, showed the resident was seen at the request of nursing staff for a coffee burn to his/her left leg. The resident believed he/she had a seizure causing him/her to spill his/her coffee onto his/her leg. He/she reported being amnestic (experiencing or relating to a partial or total loss of memory) prior to spilling coffee. He/she had superficial burns along with two partial thickness burns. The wound physician will be asked to examine and give recommendations for treatment. Record review of the resident's medical record showed staff did not document completion of a timely investigation or what immediate interventions were put in place to prevent future burns. Review of the resident's current care plan showed the following: -On 02/07/25, the resident has a burn and donor site to his/her left thigh; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 02/07/25, the resident will remain free from complications related to wound healing and infection; -On 02/07/25, encourage good nutrition and hydration in order to promote healthier skin; -On 02/0725, follow wound care as ordered by provider; -On 02/07/25, monitor/document location, size and treatment of the wound; -On 02/07/25, offer resident lids with hot liquids, resident does remove lids herself; -On 02/07/25, use caution during transfers and bed mobility. (Staff did not update the care plan with new interventions to prevent future burns prior to 02/07/25.) During an interview on 02/05/25, at 11:12 A.M., the resident said the following: -He/she got a burn on his/her left thigh in December 2024 after spilling hot coffee on him/herself. He/She thought he/she had a seizure which caused the spill; -He/she often got coffee for her/himself and had not been told not to. During an interview on 02/05/25, at 11:20 A.M., CNA I said the resident was generally pretty safe with the coffee and he/she did not believe it was usually hot enough to burn someone. During an interview on 02/05/25, at 12:36 P.M., CNA K said the residents help themselves to the coffee in the dining room. He/she thought the residents were supposed to ask for help, but they do not; -They do have lids for the resident's coffee mug. During an interview on 02/05/25, at 1:49 P.M., the Dietary Manager said the following: -The resident spilled coffee on him/herself causing a burn. He/she believed the resident fell asleep; -There is in a coffee dispenser in the dining room that dietary staff fill up in the dining room. The residents can get coffee themselves; -They ordered lids for the resident to use on his/her coffee mug. During an interview on 02/07/25, at 11:59 A.M., the Registered Dietician (RD) said the residents that are ambulatory or more mobile get coffee for themselves from the dispenser in the dining room. During an interview on 02/7/25, at 12:14 P.M., Licensed Practical Nurse (LPN) G said the following: -The residents like to get their own coffee from the dispenser in the dining room; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would check the care plan to see what new interventions have been implemented. He/she was not sure if the resident is using lids. During an interview on 02/6/25, at 10:25 A.M., Registered Nurse (RN) A said the following: -The resident spilled coffee on him/herself on 12/19/24 around 5:00 P.M.; -He/she was informed by a CNA who was pushing the resident back to her room in a wheelchair. He/she believed the resident got the coffee him/herself and then spilled it after having a seizure; -He/she was not aware of any education being completed regarding the incident. A staff member did test the coffee temperature, but he/she is not aware of any other interventions implemented for the resident to prevent future burns; -He/she was not sure if anything was added to the care plan. During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said the following: -He/she was responsible for care plans; -Burns and wounds should be on the care plan with the appropriate interventions; -He/she would think there would be interventions added if the resident had an incident/accident and burned themselves; -A resident should have an incident report and nurse's note if there is an accident such as a burn. During an interview on 02/07/25, at 3:33 P.M., the resident's physician said the following: -The resident spilled coffee on him/herself. The resident said he/she had a seizure, but he/she did not think the resident had a seizure due to the resident not having any seizures recently and they are well controlled; -He/she believed the resident was capable of handling hot liquids independently. During an interview on 02/05/25, at 1:57 P.M., the DON said the following: -The resident was in the dining room, around dinner time and had a mug with a handle. The resident wheeled him/herself in front of the table and either had a seizure of fell asleep. He/she spilled coffee on him/herself; -The staff are to put lids on hot drinks; -The residents should not be getting coffee for themselves. During an interview on 02/13/25, at 11:36 A.M., the DON said the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN A should have documented an assessment and communication with the physician in the computer. He/she should have completed an incident report; -Interventions to prevent future incidents should be added to the care plan. During an interview on 02/06/25, at 2:45 P.M. the Administrator said the following: -He/she was informed the resident had spilled coffee on him/herself when he/she fell asleep or had a seizure; -He/she thinks the resident had gotten the coffee him/herself out of the dispenser in the dining room; -He/she preferred the residents not get it themselves, but they do it all the time; -They are providing lids for the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to ensure catheters (a thin, flexible tube used to drain fluids, including urine, from the body) were only used when indicated and were maintained in a manner to prevent possible infection when staff failed to obtain an order with indication for use for an indwelling catheter, failed to obtain timely orders for catheter care, failed to complete the catheter care as ordered, and failed to care plan catheter use timely for one resident (Resident #95). The facility census was 98. Review of the facility policy titled, Catheter Care, dated 07/13/22, showed it was the the policy of the facility to maintain consistent and adequate hygiene standards for residents with an indwelling catheter to maintain function and prevention of infection or complications. 1. Review of Resident #95's face sheet (document that gives resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included encephalopathy (brain disease that alters brain function and structure), cerebral infarction (when blood flow to the brain is blocked leading to brain tissue death), and type two diabetes mellitus (the body has trouble controlling blood sugar and using it for energy). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/06/24, showed the following: -Cognitively intact; -Required partial to moderate assistance with dressing, showers, hygiene, bed mobility, and transfers; -Resident did not have an indwelling catheter; -Resident was frequently incontinent of bladder and bowel. Review of the resident's current care plan showed the following: -On 09/05/24, staff care planned the resident had potential impairment to skin integrity related to deconditioning and incontinence; -On 09/05/24, staff care planned the resident was dependent on one staff for showers, dressing, toileting, transfers, and showers; -On 09/05/24, staff care planned the resident was occasionally incontinent of bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, dated 12/29/24, showed the resident was unresponsive and had seizure activity while visiting family. Resident was sent to emergency room via emergency medical services for evaluation. Review of the resident's hospital discharge note, dated 01/10/25, showed the resident had a catheter placed on 12/29/24. The hospital did not state the indication for use. Review of the resident's nursing note, dated 01/10/25, showed the resident returned from the hospital and was incontinent of bladder with an indwelling Foley catheter in place. The hospital reported catheter placed due to urine retention. Staff did not document physician notification of the resident returning from the hospital with a catheter in place. Review of the resident's medical record showed no indication of urine retention prior to the hospitalization . Review of the resident's physician progress note, dated 01/13/25, showed the resident was seen for readmission to the facility after a recent hospitalization for seizure and sepsis. (The physician did not address the resident's catheter or reason for the catheter usage.) Review of resident's January 2025 Physician Order Sheet (POS) showed the following: -An order, dated 01/16/25, for catheter care every day and night shift; -An order, dated 01/16/25, to record the amount of output from catheter every shift, monitor for signs and symptoms of infection; (Staff did not obtain an order of the use of the catheter.) Review of resident's January 2025 Treatment Administration Record (TAR) showed the following: -Staff did not document providing catheter care as ordered on 01/23/25, 01/24/25, 01/30/25, and 01/31/25. -Staff did not document catheter output as ordered on one shift on 01/29/25 and 01/31/25. Observation and interview on 02/05/25, at 9:52 A.M., showed the resident had a Foley catheter with drainage bag in place. The resident said he/she had the catheter for a while, but did not know why he/she had it. The resident said he/she possibly returned from the hospital with it. Review of the resident's current care plan showed on 02/06/25, the staff updated the resident's care plan to reflect the resident had a Foley catheter. Review of the resident's February 2025 TAR, on 02/06/25, showed the following: -Staff did not document providing catheter care as ordered on 02/01/25; -Staff did not document catheter output as ordered on one shift on 02/04/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(The TAR did not reflect an order for use or when to change the catheter.) During an interview on 02/11/25, at 9:23 A.M., Certified Nurse Assistant (CNA) K said the following: -Catheter care should be done once per shift; -The resident returned from hospital with a catheter and he/she does not know why. During an interview on 02/11/25, at 11:50 A.M., Licensed Practical Nurse (LPN) G said the following: -Catheter care should be done every shift and as needed; -Catheters should have an order to include size of catheter and balloon; -Catheters should have an order to include diagnosis and be included on the care plan; -The resident had a catheter due to acute kidney injury and hydronephrosis (a condition where there is excess fluid in the kidney due to a backup of urine). During an interview on 02/11/25, at 9:40 A.M., Registered Nurse (RN) J said catheters should have an order, indication, and be included on the care plan. The resident does not have an order for a catheter, but does have one for catheter care and monitoring urine output. Review of the resident's February 2025 POS showed an order, dated 02/11/25, for catheter size 16, balloon 30, medical necessity, change every other month as needed. The order did not specify what the medical necessity was. During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said the following: -He/she was responsible for care plans; -If a resident had a catheter, it should be included in the care plan. It should also include any important information regarding the catheter; -Catheter care and changing of the catheter should be provided per physician orders. During an interview on 02/11/25, at 2:50 P.M., the Assistant Director of Nursing (ADON) said the following: -Indwelling catheters should have an order, indication, and should indicate how often catheter should be changed; -The resident returned from the hospital with a catheter due to a diagnosis of acute kidney injury and hydronephrosis; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should advise the physician that the resident returned from hospital and an order for the catheter and follow up care should be received. During an interview on 02/13/25, at 11:15 A.M., the Director of Nursing (DON) said the following: -Catheters should have an order and be included in the care plan; -Catheter care should be provided every shift; -The resident had urine retention in the hospital and the catheter remained in place until consultation with urologist; -Resident is still waiting for urology consult. During an interview on 02/13/25, at 1:05 P.M., the Administrator said catheters should have an order that included diagnosis. MO00248978 40769

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with standards of practice and residents' care plans when staff failed to ensure staff changed oxygen equipment per physician order for two residents (Resident #12 and #83) and failed to include the use of oxygen on the care plan for one resident (Resident #12). The facility had a census of 98. Review of the facility policy titled, Oxygen Administration, undated, showed the policy did not address care of oxygen concentrators, humidifiers, or oxygen tubing. 1. Review of the Resident #12's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included cerebral infarction (stroke that occurs when the blood supply to part of the brain is blocked or reduced), hemiplegia (paralysis or weakness on one side of the body) of the left side, foot drop, and left ankle contracture. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/14/24, showed the resident was cognitively intact and received continuous oxygen. Review of the resident's care plan, dated 08/30/23, showed the resident was at risk for impaired gas exchange and shortness of breath. Staff did not care plan related the resident's oxygen use. Review of resident current Physician Order Sheet (POS) showed the following orders: -An order, dated 09/20/24, for 1 to 6 liters (L) of oxygen via nasal cannula to maintain oxygen saturation above 92% every day and night shift for cough and congestion; -An order, dated 12/03/24, to change humidifier bottle on oxygen concentrator weekly and as needed at bedtime every Tuesday related to acute respiratory failure. The order was discontinued on 01/14/25. -An order, dated 01/14/25, to change humidifier bottle on oxygen concentrator weekly and as needed at bedtime every Sunday related to acute respiratory failure. (Staff did not obtain an order regarding oxygen tubing care.) Review of the resident's January 2025 Treatment Administration Record (TAR) showed the following: -On 01/07/25, staff did not document changing the resident's humidifier bottle; -On 01/14/25, staff did not document changing the resident's humidifier bottle; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 01/19/25, staff documented changing the resident's humidifier bottle; -On 01/26/25, staff documented changing the resident's humidifier bottle. Review of the resident's February 2025 showed the following: -On 02/02/25, staff documented changing the resident's humidifier bottle; -On 02/09/25, staff documented changing the resident's humidifier bottle. Observation on 02/05/25, at 11:00 A.M., showed the resident sat in his/her wheelchair with a portable oxygen tank attached to nasal cannula with no date on the tubing. The oxygen concentrator in room had no date on the nasal cannula tubing and the humidifier was dated 01/20. Observation on 02/10/25, at 10:02 A.M., showed the resident's nasal cannula tubing to concentrator was dated 02/10. The oxygen concentrator humidifier was dated 01/20. 2. Review of the Resident #83's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - lung disease causing restricted airflow and breathing problems), congestive heart failure (CHF - a chronic condition in which the heart does not pump blood as well as it should), and dyspnea (difficulty breathing). Review of the resident's care plan, dated 10/08/24, showed the following: -Resident had oxygen therapy related to CHF; -Staff to monitor for signs and symptoms of respiratory distress; -Resident had altered respiratory status and difficulty breathing. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact and on oxygen. Review of resident's current POS showed the following: -An order, dated 03/07/23, to change oxygen tubing every week, label and date, every night shift on Sunday; -An order, dated 03/14/23, for oxygen at 2 to 4 L via nasal cannulas needed to keep oxygen saturation above 90%. (Staff did not obtain an order regarding changing the humidifier on the oxygen concentrator.) Review of the resident's January 2025 TAR showed staff did not document changing the resident's oxygen tubing on 01/19/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Skilled Care Center	2401 West Grand Springfield, MO 65802

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/05/25, at 12:53 P.M., showed the resident sat in his/her room in a wheelchair with nasal cannula in place. The tubing to oxygen concentrator was not dated and the humidifier had a date of 01/24. Observation on 02/10/25, at 10:00 A.M., showed tubing to oxygen concentrator dated 02/10 and the humidifier had a date of 01/24. 3. During an interview on 02/10/25, at 11:45 A.M., Certified Nursing Assistant (CNA) I said CNAs make sure nasal cannulas are clean and notify the nurse if anything appears wrong. Oxygen tubing should be changed on Sunday night shift. During an interview on 02/11/25, at 9:23 A.M., CNA K said the following: -CNAs should make sure the concentrator is turned on and there is water in the humidifier; -Night shift is supposed to change and date the tubing and humidifier on Sunday. During an interview on 02/11/25, at 9:40 A.M., Registered Nurse (RN) J said oxygen tubing and humidifiers should be changed weekly. During an interview on 02/11/25, at 11:50 A.M., Licensed Practical Nurse (LPN) G said night shift nurses are responsible for changing oxygen tubing and humidifiers weekly. During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said he/she was responsible for care plans and the use of oxygen should be included on the care plan. During an interview on 02/11/25, at 2:50 P.M., the Assistant Director of Nursing (ADON) said oxygen tubing should be changed every Sunday on night shift. During an interview on 02/13/25, at 11:15 A.M., the Director of Nursing (DON) said oxygen tubing and humidifier changes should occur Sunday night shift. During an interview on 02/13/25, at 1:05 P.M., the Administrator said oxygen tubing and humidifiers should be changed and dated weekly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40769 Based on observation, interview, and record review, the facility failed to document an ongoing evaluation of bed rails and failed to complete regular inspections of the bed frame and side rails for risk of entrapment for one resident (Resident #2) whose side rails were loose. The facility failed to document identification and use of possible alternatives prior to use of side rails; failed to document assessing risk versus benefits of side rail use; failed to obtain informed consent for the use of side rails prior to installation; failed to care plan side rail use; and failed to complete initial and ongoing assessments to ensure the side rails were appropriate for use for two residents (Resident #12 and # 93). The facility census was 98. Review of the facility procedure titled, Restraints: Bed Rail Safety Check, undated, showed the following: -When using bed rails, close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. Entrapment may occur in flat or raised bed positions with the rails fully or partially raised; -The bars within the bed rails should be closely spaced to prevent a resident's head from passing through the openings and becoming entrapped; -The mattress to the bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering; -Mattresses may shrink overtime or after cleaning and causing space between the rails and the mattress; -Check for compression of the mattress's outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail; -Ensure the mattress is appropriately sized for the bed frame. Not all bed and mattresses are interchangeable; -The space between the bed rails and the mattress and the headboard and the mattress should be filled by the mattress or by the added firm inlay. This creates an interface with the bed rail that prevents an individual from falling between the mattress and the bed rails; -Latches securing bed rails should be stable so that the bed rails will not fall when shaken; -Maintenance and monitoring of the bed, mattresses, and accessories should be ongoing. Review of the facility procedure titled, Device Care Planning Process, undated, showed the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The use of any device requires a care plan; -Document a detailed history of the symptom for using the device; -Document ability to purposely remove the device and resident to perform activity of choosing; -Identify likely causes for using the device; -Monitor impact of device on resident and problems or risks for which it is used; -Document why continued use was needed despite complications; -Maintain ongoing monitoring for safety hazard; -Periodically (as least quarterly) reassess the resident for continued need for device and document in care plan. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included muscle weakness, abnormalities of gait and mobility, unsteadiness on feet, cognitive communication deficit, and unspecified dementia (a decline in mental abilities, including memory, thinking, and reasoning, severe enough to interfere with daily life, and is caused by damage to or changes in the brain). Review of the resident's current care plan showed the following: -On 03/06/20, staff care planned the resident had a grab bar in his/her bed to use for positioning as he/she needed. Staff are to encourage him/her to use this for bed mobility and positioning; -On 09/20/24, staff care planned staff will ensure adaptive equipment is provided, is present, and is functional. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/19/25, showed the resident had moderate cognitive impairment and required substantial/maximal assistance with transfers. Review of the resident's Restraints: Bed Rail Safety Check, dated 11/22/19, showed the following: -Use the bed rail safety check to determine if the resident's bed meets the safety measurement requirements suggested by the Food and Drug Administration (FDA); -For each side, go through every zone and measure according to the FDA's instructions found online on the FDA's website; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Measurements for quarter side rails on either side of the bed were documented and passed the assessment. Review of the resident's record showed staff did not document any completion of additional bed rail safety checks. Review of the resident's February 2025 Physicians Order Sheet (POS) showed an order, dated 02/25/22, for the resident may have half side rail/grab bar for positioning. Review of the resident's Assistive Device Consent Form, dated 09/30/24, showed the following: -The form addressed understanding of the use of the device and the potential risks and benefits of using the assistive device; -The name of the resident representative was typed in the signature box with no date given; -The staff completing and witnessing the form was typed in the signature box with no date given. Observation on 02/05/25, at 11:11 A.M., showed the following: -The resident's bed had quarter bed rails towards the head of each side of the bed; -The bed rails were loose with at least one inch of give when the bed rail was pushed down on the side towards the head of the bed or the end of the bed. The bed rail was able to turn side to side in a steering type motion one to two inches. -The resident told Certified Nurse Aide (CNA) I his/her bed rails were loose and CNA I shook the bed rails to show they were loose. During an interview on 02/05/25, at 11:11 A.M., the resident said the following: -He/she had bed rails for awhile. He/she used them to move around in bed and to get out of bed; -His/her bed rails have been loose on both sides for at least two weeks. They have been loose before and maintenance had to tighten them back up at least four times, but they just keep getting loose. It makes him/her scared to use them; -He/she told a nurse about it at least a week ago. During an interview on 02/05/25, at 11:14 A.M., CNA I said the following: -The resident used the bed rails to help him/her move around in the bed; -He/she believed the bed rails were maintained by maintenance staff; -He/she was aware the resident's bed rails were loose and reported it to Registered Nurse (RN) A about two weeks ago. The bed rails should not be loose. The resident was concerned for his/her safety; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Generally, the nurse lets maintenance know if bed rails need adjusted; -He/she thought maintenance staff had fixed the rails. During an interview on 02/05/25, at 10:25 A.M., RN A said he/she was not sure who was in charge of assessing the residents for bed rails. If a bed rail was loose or broken staff should let maintenance know. He/she was not aware of any loose bed rails. During an interview on 02/11/25, at 9:40 A.M., RN J said side rails should be checked daily and if loose, reported to the physician. During an interview and observation on 02/11/25, at 11:02 A.M., the Maintenance Director said the following: -He/she was not aware the resident's bed rail was currently loose; -He/she had to tighten the resident's bed rails periodically because they got loose; -The bed rails cannot be changed due to being the ones that work for that bed; -He/she does not monitor or have a maintenance schedule to check any of the residents' bed rails; -He installs the bed rails and use to measure for entrapment, but he/she stopped doing that when he/she got new maintenance staff that did not know how to do it; -He/she was not sure who is responsible for that; -He/she would fix the bed rail if the nursing staff made a request; -There was no request made for the resident's bed rail recently. During an interview on 02/11/25, at 2:50 P.M., the Assistant Director of Nursing (ADON) said he/she was not aware of any measurements done on side rails, but they should be checked daily. During an interview on 02/13/25, at 11:36 A.M., the Director of Nursing (DON) said maintenance staff should be checking and monitoring bed rails regularly to make sure they are not becoming a hazard. Staff should report any loose bed rails to maintenance. During an interview on 02/13/25, at 12:31 P.M., the Administrator said maintenance staff measure the bed/bed rails and check them regularly. 49585 2. Review of the Resident #12's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included cerebral infarction (stroke that occurs when the blood supply to part of the brain is blocked or reduced), hemiplegia (paralysis or weakness on one side of the body) of the left side, foot drop, and left ankle contracture. Review of the resident's current February 2025 POS showed an order, dated 11/21/22, for grab bars for mobility. Review of the resident's Safety Device Evaluation Tool, dated 11/13/24, showed staff indicated no safety device was present, used, or indicated. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent with transfers, and mobility. Observations on 02/04/25, at 1:52 P.M., on 02/06/25, at 10:19 A.M., and on 02/10/25, at 10:02 A.M., showed two half side rails at head of bed in upright position. Review of the resident's care plan, revised on 12/20/24, showed the following: -Required maximum assistance for transfers; -At risk for falls related to gait and balance problems; -Required two staff assist with bed mobility. -Staff did not care plan related to the use of side rails. Review of resident's current medical record showed staff did not document related to the use of possible alternatives prior to use of the side rails, assessing risk versus benefits of side rail use, an informed consent, or of an initial or ongoing assessment to ensure the side rails were appropriate and safe to use. During an interview on 02/06/25, at 2:25 P.M., the Licensed Certified Occupational Therapy Assistant (COTA/L) L said the resident had been assessed by physical therapy and side rails were recommended to assist with mobility and position change. 3. Review of the Resident #93's face sheet showed the following: -admitted [DATE]; -Diagnoses included Guillain-Barre syndrome (condition in which a person's immune system attacks the peripheral nerves) and muscle weakness. Review of the resident's annual MDS, dated [DATE], showed the resident was cognitively intact. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Safety Device Evaluation Tool, dated 10/09/24, showed no safety device was present, used, or indicated. Observation on 02/04/25, at 3:35 P.M., showed two U-shaped grab bars at head of bed in upright position. Review of the resident's care plan, revised on 09/04/24, showed the following: -Required one staff assistance for transfers and mobility; -Resident had a history of fall. -Staff did not care plan related to the use of side rails. Observation and interview on 02/05/25, at 1:07 P.M., showed the resident sat up to the edge of bed without the use of grab bars. Two U-shaped grab bars were in an upright position at the head of the bed with a bed controller hanging on the right-side bar. He/she said the side rails were used to hang the bed controller on. Observations on 02/06/25, at 11:47 A.M., and on 02/10/25, at 10:02 A.M., showed two U-shaped grab bars at head of bed in upright position. Review of the resident's February 2025 POS showed staff did not obtain an order for side rails. Review of resident's current medical record showed staff did not document related to the use of possible alternatives prior to use of the side rails, assessing risk versus benefits of side rail use, an informed consent, or of an initial or ongoing assessment to ensure the side rails were appropriate and safe to use. During an interview on 02/06/25 at 2:25 P.M., COTA/L L said the resident used side rails for weakness due to Guillain-Barre syndrome. 4. During an interview on 02/06/25, at 2:25 P.M., the COTA/L L said the following: -Therapy will request grab bars if it would benefit a resident with mobility or positioning; -Physical therapy will evaluate the resident to see if they would benefit from side rail usage; -There is no specific assessment related to side rail use that is filled out by physical therapy; -He/she discussed obtaining side rails for residents during the interdisciplinary plan meeting (IDT); -Maintenance was responsible for installing side rails; -Nursing will put an order for resident side rails in during the IDT meeting; -Maintenance will install the side rails after their use is placed in care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/10/25, at 11:15 A.M., the Maintenance Assistant said the following: -Nursing staff advised maintenance if a resident required side rails; -Side rails required an order, or the resident should request them for mobility help; -Maintenance installed side rails and nursing was responsible for them after that; -Nursing staff will notify maintenance if the resident needed side rails removed or a resident had a room change; -There were no safety checks needed as all the beds come with the exact bars to install the side rails. During an interview on 02/11/25, at 9:40 A.M., RN J said the following: -Maintenance staff install side rails after a physician order is obtained; -Facility should be measuring and assessing side rails; -Side rails should be included in the care plan and there should be a consent on file due to being a type of restraint. During an interview on 02/11/25, at 11:50 A.M., Licensed Practical Nurse (LPN) G said the following: -Side rails should have an informed consent; -Side rails should have an initial assessment and follow up to make sure they are not a restraint. During an interview on 02/13/25, at 12:38 P.M., the MDS Coordinator said the following: -Bed rails should be included on the resident's care plan. The resident should be assessed prior to getting the bed rails put on their bed; -He/she was not sure who completed the assessments. The residents should be reassessed regularly to ensure the side rails have not become a hazard or restraint. During an interview on 02/11/25, at 2:50 P.M., the ADON said side rails should have an order and a consent before use. During an interview on 02/13/25, at 9:05 A.M., the DON said the following: -Therapy evaluates residents for side rails based upon appropriate need for mobility; -Side rails required an order, a consent from the resident or responsible party, and then maintenance staff installed side rails; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintenance was responsible for assessment and evaluation of side rails; -Side rails should be included in the care plan. During an interview on 02/13/25, at 12:31 P.M., the Administrator said the following: -If residents need or want a bed rail, nursing staff and the MDS Coordinator should do a risk versus benefits assessment and it should be reassessed annually; -Maintenance staff measure the bed/bed rails and check them regularly; -There should be a completed consent form.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36974 Based on observation, interview, and record review, the facility failed to post the required nurse staffing in a prominent place readily accessible to residents and visitors on a daily basis. The facility census was 98. Review of facility policy Direct Care Staff Daily Report, updated 02/28/23, showed the following: -The facility will post direct care staffing hours daily, as required by federal/state agencies. -The posting will include actual hours worked and total hours worked. -The responsibility for the report falls on the Staffing Coordinator, nursing, nursing administration, Director of Nursing (DON), and the Administrator. 1. During interviews on 02/05/25, starting at 10:00 A.M., at the resident council group meeting, residents said the following: -Most residents said they did not know staffing levels were posted anywhere in the facility; -One resident confirmed the daily staffing sheet was located in a display area close to the television area (junction of 100, 200, and 300 halls). The same resident said the daily staffing sheet was often days or weeks behind, and sometimes not posted in the display area at all. Observation on 02/06/25, at 9:12 A.M., showed the facility daily staffing sheet posted was dated 02/05/25. Observation on 02/07/25, at 8:50 A.M., showed the facility daily staffing sheet posted was dated 02/05/25. Observation on 02/08/25, at 9:20 A.M., showed the facility daily staffing sheet posted was dated 02/05/25. Observation on 02/10/25, at 11:50 A.M., showed the frame where the facility daily staffing sheet had been posted was empty. No staffing sheet was observed at any other location in the facility. Observation on 02/11/25, at 10:30 A.M., showed the frame where the facility daily staffing sheet had been posted was empty. No staffing sheet was observed at any other location in the facility. During an interview on 02/13/25, at 12:45 P.M., the DON said the charge nurses sometimes post the daily staffing sheets. The Assistant Director of Nursing (ADON) had been overseeing the daily posting, but the current ADON was new, and they facility was without an ADON for a time before that. The DON said she didn't know the sheet was not posted and updated daily. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 02/13/25, at 1:10 P.M., the Administrator said the DON or the charge nurse of the day was responsible for posting the daily staffing sheet. He didn't know the sheet was not posted and updated daily. The only location in the building the daily staffing sheet was located in a display area close to the front television area.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on interview and record review, the facility failed to ensure all residents were free from significant medication errors. The facility failed to ensure physician orders were entered and/or reviewed by nurses, failed to document monitoring of medication side effects, and failed to follow physician orders to discontinue Xanax (a drug in a class of medications called benzodiazepines (class of medications that act as central nervous system (CNS) depressants) that works by decreasing abnormal excitement in the brain) for one resident (Resident #94) who suffered a hospitalization due to a benzodiazepine overdose. The facility staff failed to notify management and the physician of the medication error. The facility census was 98. Review of the facility's policy titled Physician Orders, dated 09/28/22, showed the following information: -Physician orders must be recorded in the medical record by the licensed nurse authorized to transcribe such orders; -Physician orders must be documented clearly in the medical record and must include date and time, name of practitioner providing the order, name and strength of the medication, quantity and duration, dosage and frequency, route of administration, indication, and stop date if indicated; -Discontinued orders will be marked as discontinued with the date and all new orders will be written in the appropriate area on the physician order sheet with the date the order was received; -Telephone/Verbal orders may only be received by a licensed nurse and are required to be signed by the ordering physician within 30 days; -Written/Faxed orders must be documented and entered into the medical record by a licensed nurse. Review of the facility's policy titled Psychotropic Management Guidelines, dated 07/26/23, showed the following information: -A licensed nurse will implement the physician order for the medication including an approved diagnosis or targeted behavior, a psychoactive medication consent and review, and standardized behavior tracking monitoring to identify targeted behaviors, documentation of episodes, and documentation of interventions and outcomes. -Care plans will be individualized. Review of the facility's policy titled Medication Administration-General Guidelines, dated 12/2017, showed the following information: -Medications are administered in accordance with written orders of the prescriber; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to administration of the medication or if necessary contacts the prescriber for clarification. This interaction with the pharmacy or prescriber and the resulting order should be documented in the nursing notes. 1. Review of the Resident #94's face sheet (brief look at resident information), showed the following information: -admitted [DATE]; -Diagnoses included Guillain-Barre syndrome (condition in which the immune system attacks the nerves), bi-polar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), low blood pressure, and restless legs syndrome. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 11/27/24, showed the following information: -Cognitively intact with no episodes of delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings); -Required substantial to maximum assistance from staff for mobility; -Received antipsychotic (drugs that treat psychotic disorders), antianxiety (drugs that treat anxiety disorders), antidepressant (drugs that treat depressive disorders), hypnotic (drugs that promote and induce sleep by depressing the CNS system), and opioid (a class of natural, semi-synthetic, and synthetic drugs that are used for treatment of pain) medications; -Antipsychotics received on a scheduled basis with no gradual dose reductions attempted. Review of the resident's care plan, initiated on 08/30/24, showed the following information: -The resident takes several Black Box Warning (the highest safety-related warnings that medications can have assigned by the Food and Drug Administration (FDA). These warnings are intended to bring the consumers attention to the major risk of the drugs, including potential risks of death, serious injury, and/or disability. The severe risk is associated with the mechanism of action and its undesired effects on the body. These warnings emphasize the need for careful monitoring.) medications and will not sustain any harm from the use of the medications; -The resident took antidepressant medications. Staff to monitor and document any side effects and effectiveness every shift; -The resident took antianxiety medications. Staff to monitor and document any side effects and effectiveness every shift. Review of the resident's Physician Order Sheet (POS), dated 01/01/25, showed the following medication orders: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 12/11/24, for Cymbalta capsule delayed release (antidepressant that belongs to a group of medicines called serotonin- norepinephrine reuptake inhibitor (SNRI)), 30 milligram (mg) tablet. Staff to give three capsules po (by mouth) daily at 7:00 A.M., for bipolar disorder; -An order, dated 07/28/24, for Effexor XR (antidepressant that belongs to a group of medicines called SNRI), 75 mg. Staff to give three capsules po at bedtime for depression; -An order, dated 10/28/24, for lorazepam (controlled substance that belongs to the benzodiazepine drug class) 0.5 mg. Staff to give 1 tablet po three times a day (tid) as needed for anxiety; -An order, dated 12/16/24, for amitriptyline (tricylic antidepressant that increases certain chemicals in the brain) 100 mg tablet. Staff to give two tablets po at bedtime for depression; -An order, dated 01/01/25, for amitriptyline 50 mg tablet. Staff to give one tablet po at bedtime for insomnia, give with 200 mg tablet to equal 250 mg dose; -An order, dated 12/18/24, for Seroquel (antipsychotic that balances dopamine and serotonin in the brain) 50 mg tablet. Staff to give two tablets po one time a day in the morning for bipolar disorder; -An order, dated 12/18/24, for Seroquel 50 mg tablet. Staff to give two tablets po in the afternoon for bipolar disorder; -An order, dated 10/04/24, for Lyrica (FDA approved as an antiepileptic drug that works by slowing down impulses to the brain) 50 mg capsule. Staff to give one capsule po after meals for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet); -An order, dated 08/26/24, for Norco (opioid pain medication that contains acetaminophen and hydrocodone) 5-325 mg tablet. Staff to give one tablet po four times a day (qid) at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M., for pain; -An order, dated 07/28/24, for Seroquel 300 mg tablet. Staff to give two tablets po at bedtime for panic disorder; -An order, dated 12/18/24, for Ambien (a controlled substance that belongs to the hypnotic drug class) 5 mg tablet. Staff to give one tablet po at bedtime for insomnia; (Staff did to obtain orders to monitor for adverse effects of antipsychotic, antidepressant, antianxiety or hypnotic medications. Cymbalta, Effexor ER, lorazepam, amitriptyline, Seroquel, and Norco carried black box warnings.) Review of the resident's nurse's note, dated 01/09/25, showed the medical records personnel documented the following: -The resident was seen on this day by the psychiatrist via telehealth visit; -New order received to start Xanax (controlled substance that belongs to the benzodiazepine drug class) 1 mg po q (every) six hours as needed; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-New order received to lower amitriptyline to 100 mg po at bedtime; -New order received to increase Seroquel to 600 mg po at bedtime; -New order received to discontinue Ativan (lorazepam) once Xanax starts. Review of the resident's January 2025 MAR and POS showed the following: -An order, dated 01/09/25, for Xanax 1 mg tablet. Staff to give one tablet po every six hours as needed for severe anxiety with first administration on 01/12/25; -An order, dated 01/09/25, to decreased previously ordered amitriptyline 100 mg tablet. Staff to give one tablet po at bedtime for depression; dated 01/09/25 -An order, dated 01/10/25, to discontinue lorazepam. -An order, dated 07/28/24, for Seroquel 300 mg tablet. Staff to give two tablets (600 mg) po at bed time for panic disorder continued. The prior order for 50 mg was discontinued. Review of the resident's nurses' notes, dated 01/10/25, showed a system generated, moderate drug interaction warning between lorazepam, Xanax, and Norco for coadministration may cause Central Nervous System (CNS, refers to the brain and spinal cord) depression especially in misuse/overdose situations. Staff did not document regarding contacting the prescribing physician for the triggered drug interaction. Review of the resident's nurse's note, dated 01/22/25, showed the resident's Nurse Practitioner ordered Depakote (anticonvulsant used to treat psychiatric disorders) 500 mg po in the morning. The system generated the following following drug interaction warning: -Coadministration with Seroquel may increase the risk for neutropenia (low white blood cell count) and leukopenia (low white blood cell count); -Coadministration with amitriptyline may cause plasma concentrations (agent becomes concentrated in the plasma) and toxic effects of amitriptyline. -Staff did not document regarding contacting the prescribing physician for the triggered drug interaction. Review of the resident's January 2025 MAR and POS showed the following: -An order, dated 01/22/25, for Depakote 500 mg tablet. Staff to give two tablets po each night; -An order, dated 01/23/25, changed Depakote 500 mg tablet, Staff to give one tablet po in the morning. Review of the resident nurse's note, dated 01/22/25, showed the medical records personnel noted the resident was seen by the psychiatrist via telehealth with several new orders. Staff noted see POS for orders and follow up in 4 to 6 weeks. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the Psychiatrist's POS, dated 01/23/25, showed the following new orders: -An order, dated 01/23/25, for Valium (controlled substance that belongs to the benzodiazepine drug class) 10 mg po qid. -An order, dated 01/23/25, for once Valium began, discontinue the as needed Xanax; -An order, dated 01/23/25, to discontinue Depakote; -An order, dated 01/23/25, to begin Lamictal (an antiepileptic medication) 25 mg po each night for two weeks, then increase to 50 mg po each night for two weeks, then increase to 100 mg po at night for three nights, then increase to 100 mg po every morning and each night; -An order, dated 01/23/25, to restart trazodone (antidepressant) 150 mg po at night; -Medication changes were phoned into the pharmacy and follow up in the next 4-6 weeks. Review of the residents January 2025 MAR showed the following information: -An order, dated 01/24/25, for Valium 10 mg po qid at 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8 P.M., administered as order with the first dose administered on 01/24/25, at 8:00 P.M.; -The order for Xanax was continued and administered on 01/24/25, at 1:56 A.M., 8:32 A.M., and 4:30 P.M., on 01/25/25, at 2:15 A.M., and on 01/26/25, at 4:12 A.M., and 12:19 P.M.; -The order for Depakote was discontinued on 01/23/25; -An order, dated 01/24/25, for Lamictal 25 mg po each night for two weeks, then increase to 50 mg po each night for two weeks, then increase to 100 mg po at night for three nights, then increase to 100 mg po every morning and each night; -An order, dated 01/24/25, for trazodone 150 mg po each night. (Staff did not obtain orders regarding monitoring of adverse effects of antipsychotic, antidepressant, antianxiety or hypnotic medications.) Review of the resident's nurse's note, dated 01/23/25, showed the following: -System generated warning for moderate to severe drug interactions with coadministration of Cymbalta, trazodone, Effexor, and amitriptyline, which could result in serotonin syndrome (potentially life-threatening condition that occurs when you take medications that affect serotonin levels) and toxicity may be increased. CNS depression may also occur; -System generated warning for coadministration of Norco, Xanax, and Valium that may cause additive CNS depression especially in misuse/overdose situations. -Staff did not document contacting the prescribing physician regarding the triggered drug interaction warnings. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the residents' nurses notes, dated 01/23/25 through 01/25/25, showed no entries regarding the resident's behavior and/or any care concerns. Review of the resident's nurse's note, dated 01/26/25, showed Licensed Practical Nurse (LPN) D noted he/she nurse sent resident to the hospital due to altered mental status. The resident was alert and oriented to self, slurred speech, and pupils slowly reactive. Resident had weak grips. Staff notified the Director of Nursing (DON) notified and the medical provider. Review of the resident's nurse's note, dated 01/26/25, showed the DON noted charge nurse called the DON and requested him/her to assess the resident as he/she wasn't acting like his/herself. The DON responded to the smoke area to see the resident up in the motorized wheelchair, fidgeting with his/her clothes, which were wet from him/her spilling his/her drink. The peripheral spontaneous movements he/she was experiencing previously have minimized significantly; however, the resident was having difficulty holding his/her head up and with fine motor movement. The resident could follow simple commands and completed a neurological assessment. The resident's pupils were dilated and he/she was not aware of the year and had slurred speech. The resident was taken to his/her room to lay down. The DON instructed the certified medication technician (CMT) to hold all narcotic medications. The DON attempted to call the psychiatrist as he/she had ordered valium recently with no answer. The DON attempted to call the primary care physician with no answer. The DON returned to bedside and provided sternal rubs to the resident alongside a cold washcloth. DON was unable to make out any words the resident attempted to communicate. The resident was unable to sit up. Staff called emergency medical services (EMS) for emergent response for altered mental status. The resident left the facility awake, but disoriented. Review of the resident's admitting hospital's documentation, dated 01/26/25, showed the following information: -At the time of the examination the resident was comatose and minimally responsive only to painful stimulus; -Diagnosis of benzodiazepine overdose, accidental (unintentional). Hospital staff to admit to inpatient, place in step-down for close monitoring. Once resident has recovered from acute ingestion, psychology referral in place to review and restart home medications once reconciled; -The resident required intubation with mechanic ventilation (a procedure that uses a breathing machine to help the patient breathe when they can't on their own) on admission; -The resident was extubated (breathing machine removed) on 01/29/25 and was adamant he/she did not intentionally overdose his/herself and the facility administered his/her medications. Review of the residents' nurses note, dated 01/31/25, showed the resident arrived back to the facility on this date, via ambulance. The resident was alert and oriented with fine motor skills intact. Review of the resident's nurses notes, dated 01/26/25 to 01/31/25, showed staff did not document regarding the medication errors of Xanax not being discontinued and coadministered with Valium. Staff did not document any notifications to the physician regarding the medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/30/25, at 12:11 P.M., Certified Nursing Assistant (CNA) B, said the following: -The resident started to complain about not feeling well and experiencing extra anxiety around the middle of January 2025; -The resident suffered from panic attacks at baseline; -The staff spoke to the resident's doctor about the increased anxiety and this CNA believed the doctor had made some medication changes; -He/she believed that two of those medications were Xanax and Valium; -After starting the medication the resident began getting increasingly confused and had to be sent out to the hospital; -Some of the symptoms the resident started to experience leading up to the hospitalization were jitteriness and slurring of the words; -The resident was alert and oriented to self, time, and place at baseline. By the time the resident needed to be sent to the hospital he/she was only alert to him/herself and could not communicate his/her needs. During an interview on 01/30/25, at 12:26 P.M., LPN C said the following: -If a resident exhibited a change of condition, he/she would document it in the progress notes, notify the physician and DON, and begin monitoring the resident; -He/she was not aware of who entered new medication orders into the electronic medical record. He/she was a new nurse and did not know if certain medications such as antipsychotics should be monitored for adverse effects; -Nurses do monitor for adverse effects of medications, they just aren't the ones who put the orders in. -All he/she knows in regard to the resident, he/she was alert and oriented at baseline, then had a change of condition, and was sent to the hospital. During an interview on 02/05/25, at 11:45 A.M., CMT F said he/she was not the resident's CMT, but did see the resident up at the nurses' station at one point between 01/24/25 and 01/26/25, and the resident was slurring his/her words and talking about how the doctor was not prescribing the right medication. During this time the resident was also running into walls with his/her electric wheelchair and had poor fine motor skills. During an interview on 01/30/25, at 12:40 P.M., CMT E said the following information: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Charge nurses enter physician orders into the electronic medical record. When new orders are put into the system, the system will alert that person putting the order in with any possible drug interactions; -If a drug interaction is triggered, the nurse should contact the physician and address the concerns, but physician's orders trump the interaction in most cases; -CMT's do not have drug side effect monitoring on their MAR's. CMT's only monitor for pain; -The resident had a lot of anxiety and the doctor increased his/her Valium to four times a day, plus his/her Norco four times a day, and Lyrica three times a day; -He/she thought the resident was receiving a lot of medication and believed it to be too much for the resident; -The resident was on the increased medication for two days prior to having to be sent to the hospital. During an interview on 01/30/25, at 1:16 P.M., LPN D, said the following information: -He/she was the nurse on duty the day the resident had to be sent to the hospital; -He/she was familiar with the resident and the resident appeared to be acting within normal limits for most of the day (01/26/25); -Later in the evening, the nurse took the resident out for a smoke break around 6:00 P.M. During the smoke break the resident was acting funny and was confused. He/she completed a neuro assessment and found the resident was not oriented and did not know where he/she was and was only oriented to his/herself. Previously the resident was alert and oriented to person, place, and time; -The nurse believed the resident had been administered an as needed dose of Xanax around 12:00 P.M. At that time the resident had an order for Xanax, but he/she was pretty sure the Xanax was discontinued after that; -After seeing the change in condition in the resident, the nurse contacted the DON who came and assessed the resident. After the DON assessed the resident, he/she told the LPN that the resident had some recent mediation changes and maybe that was why the resident was acting this way; -He/she did think it was a lot of medication to administer to the resident; -He/she was shocked at the amount of Valium the resident was ordered; -The CMTs did not bring any concerns to the nurse throughout the day; -Nurses put medication orders into the electronic medical record and the system does trigger for any interactions or contraindications at the time of the medication being entered; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-If he/she were the nurse whom entered the medication, he/she would have caught it and immediately called the physician. During interviews on 02/05/25, at 11:50 A.M., and on 02/11/25, at 11:20 A.M., LPN G said the following; -The resident was experiencing increased anxiety and had seen the psychiatrist and was prescribed new medication for it; -The medical records personnel rounds with the physician and entered new orders into the EMR. The charge nurses should sign off on those orders. He/she did not recall the medical records personnel bringing him/her any orders or interactions to sign off. -If a CMT were to make a medication error, they would report it to the charge nurse, the charge nurse would then go and assess the resident, notify the physician, and do an incident report. The physician would tell the staff to begin monitoring the resident for any adverse effects; -Antipsychotics, antianxiety, antidepressants, and hypnotics should be monitored for adverse side effect. The use of these should also be care planned. During an interview on 02/04/25, at 10:10 A.M., the resident said the following: -He/she came back to the facility on [DATE]; -He/she was experiencing a lot of anxiety, and he/she believed the doctors put him/her on too much medication which led him/her to being hospitalized ; -When he/she started taking the Valium, two days prior to being sent to the hospital, he/she was having trouble speaking. The medical records personal was aware of this and told the resident that he/she needed to speak with the psychiatrist again. He/she was also experiencing vomiting so much to the extent that he/she did not even eat the day he/she was hospitalized ; -He/she believed the amount of Valium he/she was prescribed and given was too much for his/her body to handle. During an interview on 02/04/25, at 11:44 A.M., the DON said the following information: -The resident was starting to experience some spontaneous movements of his/her extremities. The psychiatrist then seen the resident via telehealth and ordered Valium; -Before the ordering of Valium the resident was and had always been very anxious; -The resident started taking Valium on the night of 01/24/25; -He/she was not aware the Xanax was ordered to be discontinued so it was administered as well; -On Sunday, 01/26/25, the DON was called to the smoke break area by the charge nurse, LPN D, and upon assessment the resident was noted to have a hard time articulating words and following commands; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-The DON told the CMT on duty to hold all narcotics at this time and attempted to contact the physician and psychiatrist without success; -The DON and LPN D took the resident to his/her room and laid him/her down onto the bed. The resident immediately went into a sleep. The resident would respond to sternal rubs, but would not keep his/her eyes open; -Paperwork was gathered and the resident was sent to the hospital for altered mental status; -Charge nurses are the only staff members to enter physician orders into the electronic medical record (EMR); -The medical records personal was a CMT and he/she was the one who entered the Valium order, as he/she was the one who rounded with the psychiatrist; -Two Black Box Warnings did trigger with the entering of Valium and the DON would have expected that to be addressed by the person entering the order. During an interview on 02/04/25, at 12:49 P.M., the Medical Records Personal/CMT said the following information: -The policy and procedure for entering orders is that the physician's nurse enters it into the EMR, then one of the facility staff nurses confirm the order; -He/She was not able to enter physician orders at this time. He/she used to be able to, but that was taken away about a week ago, around 01/28/25. He/she was not sure why he/she was not able to enter physician orders anymore; -When he/she was able to enter orders, he/she would do so, and any drug interactions or warnings that populated were the charge nurse's responsibility to double check and follow up on; -There were warnings and interactions when she entered the Valium order, but the charge nurse should have followed up on those; -The nurses were able to see that order and alerts within the system and should have followed up; -He/she did feel that the resident was on an excessive amount of medication. During interviews on 02/04/25, at 1:45 P.M., and on 02/05/25, at 1:25 P.M., the resident's physician said the following information: -He was aware of the new orders by the psychiatrist, and tries not to interfere with psychiatry; -All drugs have interactions and/or warnings and those interactions should be monitored for; -Coadministering Valium and Xanax is not a great idea; -He was not notified of the medication error; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Staff should always monitor for any adverse effects related to medication. During interviews on 02/04/25, at 5:01 P.M., and 02/05/25, at 2:38 P.M., the resident's psychiatrist said the following: -The medical records personnel rounds with him/her and he/she explained the orders to him/her, as well as faxing them to the facility and the pharmacy; -Anytime a resident was on these types of medications, staff should be monitored for adverse effects; -No staff member expressed any concerns to him/her, regarding the medication. He/she did expect to be notified of any concerns. -He/she was not aware that Xanax had not been discontinued and/or was administered with the Valium. Coadministering the two would not do the resident any favors; -No one notified him of the medication error; -Administering two benzodiazepines could lead to increased sedation and is not a good practice. During an interview on 02/13/25, at 9:15 A.M., the DON said the following; -If a medication error was made, the charge nurse should be notified immediately; -The charge nurse would notify the physician, family, and monitor the resident for any adverse side effects. -Antipsychotics, antianxiety, antidepressants, and hypnotics should be monitored for adverse side effects, and the use of these should be care planned; -He/she assumed the Valium is what led the resident to overdose and wished the documentation in the residents chart were better; -The medical records personnel use to be able to input physician orders. He/she no longer had that ability as of 01/28/25. This was a decision that came from corporate, no other reasoning; -He/she was not aware there was an order to discontinue the Xanax, nor of the medication error that occurred six times. During an interview on 02/13/25, at 1:00 P.M., the Administrator said the following: -Physician orders should be followed; -He expected medication errors to be addressed, notifications to be made, and follow up of the residents adverse effects; (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Antipsychotics, antianxiety, antidepressants, and hypnotics should be monitored for adverse side effects, and the use of these should be care planned. MO00248656

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on interview and record review, the facility failed to maintain records that were complete for all residents, when staff failed to document how a burn occurred, and assessment of the burn for five days, and failed to document regarding the reason for a follow-up hospitalization for one resident (Resident #2). The facility census was 98. Review of the facility's policy titled, Accident and Incident Documentation and Investigation, revised 04/26/23, showed the following: -Accidents and/or Incidents involving residents will be investigated and documented on an Incident Report in the electronic health record (EHR); -The licensed nurse at the time of the incident was responsible for initiating/completing the Incident report; -The licensed nurse at the time of the incident was responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth in the incident report. -The licensed nurse shall document the incident and notify the supervisor and Director of Nursing for follow through as needed; The licensed nurse may complete a nurses' note and update the resident care plan as needed; -The nurse's notes may contain clear objective facts of what occurred; an evaluation of the resident's condition at the time of the accident/incident; any treatment provided; notification or attempts to notify the resident's physician, family, and/or legal representative, or any other health care professional or individuals involved with the resident's care; and the charge nurse's signature, date, and time of the documentation. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included a burn of unspecific degree of the left thigh and a burn of first degree (affects the epidermis, or outer layer of skin) of the left lower leg. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/24, showed the resident was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's December 2024 Treatment Administration Record (TAR) showed an order, dated 12/19/24, to cover a blistered area of the right thigh with a thin layer of Silvadene (topical treatment to prevent and treat wound infections in second and third degree burns) and cover with telfa (non-adherent dressing) two times a day (BID) for a superficial burn from spilled coffee. Review of the resident's physician note, dated 12/23/24, showed the resident was seen at the request of nursing staff for a coffee burn to his/her left leg. The resident believed he/she had a seizure causing him/her to spill his/her coffee onto his/her leg. He/she had superficial burns along with two partial thickness burns. The wound physician will be asked to examine and give recommendations for treatment. Review of the resident's nurses' note dated 12/23/24, at 8:33 A.M., showed Registered Nurse (RN) A noted the resident was sent to the hospital for treatment of a burn received from spilling coffee on 12/19/24. The wound had worsened since the incident. Staff notified the physician and guardian of the transfer. Review of the resident's Skilled Nursing Facility (SNF)/Nursing Facility (NF) to hospital transfer form, dated 12/23/24, at 9:00 A.M., showed the reason for transfer was a burn to the thigh on 12/19/24, and for wound evaluations and management. Review of the resident's medical record showed staff did not document nursing notes between 12/19/24 (time of the burn) and 12/23/24 (time resident was sent to the hospital) regarding the accidental burn and did not document an investigation into the cause of the accidental burn. Review of the resident's hospital records, dated 12/23/24, showed the following: -The resident came to the emergency room with a chief complaint of a burn; -The resident said he/she spilled hot coffee on his/her leg around five days ago; -Initially the leg was only red, but it had since worsened and developed blisters; -The facility assessed the burn a few days ago after the incident and applied bandages; -The burn was discussed with the on-call trauma surgeon. The burn was debrided and the wound was dressed with an antibiotic ointment placed on the wound. The resident was referred to the burn clinic and discharged back to the facility. Review of the resident's hospital records showed on dated 12/27/24 the resident presented to the burn unit office for status post burn from hot coffee and on 01/13/25 the resident returned to the facility. Review of the resident's records showed staff did not document regarding the resident's discharge to the hospital on 12/27/24. Review of the resident's current care plan showed on 02/07/25, staff updated the care plan with the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident had a burn and donor site to his/her left thigh; -Follow wound care as ordered by the provider; -Monitor/document location, size, and treatment of the wound; -Offer resident lids on cups containing hot liquids, however the resident does remove the lids herself. During an interview on 02/07/25, at 12:14 P.M., Licensed Practical Nurse (LPN) G said the following: -The resident spilled coffee on him/herself. The resident was sent to the hospital at one point and had to get skin grafts; -The resident's burn should have been assessed and documented in a nurse's note. The nurse should also document communication with the physician. During an interview on 02/06/25, at 10:25 A.M., Registered Nurse (RN) A said the following: -The resident spilled coffee on him/herself on 12/19/24, around 5:00 P.M.; -He/she assessed the resident's burn and it was originally just a reddish, pink area that was warmer to the touch than the outlying skin. The redness was from just above the knee to her abdomen/groin and it wrapped around to the back of the thigh. There was about an inch strip of skin that was shriveled and wrinkled with loose skin on the back of the thigh. He/she did not measure it. He/she sent a picture of the burn to the resident's physician, and he/she provided orders for treatment of the burn and pain medication; -He/she put in the orders for wound care and completed the wound care and left the facility. He/she did not remember what documentation he/she completed; -He/she did not work again until 12/23/24; -He/she did not recall making any nurses notes, incident reports, events or documenting any assessments regarding the burn; -The nurse should document assessments and a nurses note in the chart. The nurse should document any changes in condition and communication with the physician in a nurses note. During an interview on 02/06/25, at 3:23 P.M., the Assistant Director of Nursing (ADON) said the burn should have been measured and any observations documented. During an interview on 02/05/25, at 1:57 P.M., the Director of Nursing (DON) said he/she believed the burn occurred on 12/19/24 based on an order for pain medication and wound care for the burn placed on that date. He/she was unable to find any nurses notes, assessments, or an incident/event report regarding the burn or incident from 12/19/24 until 12/23/24. The nurse should have completed an assessment of the burn, including measurements and a description of what it looked like. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/07/25, at 3:33 P.M., the resident's physician said the resident spilled coffee on him/herself. The facility staff should document assessments and change in condition in the chart. 49585

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 28865 Based on record review and interview, the facility failed to have the required minimum of six staff members attend the Quality Assessment Committee (QAA) meetings. The facility census was 98. Review of the facility's Quality Assurance Process Improvement (QAPI) policy showed the following: -QAPI takes a systematic comprehensive and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving. -Responsibility of the interdisciplinary team to meet at a minimum of quarterly and as needed; -Best practice is to meet monthly; -The QAPI members shall include representatives from all departments in the interdisciplinary teams; -This also includes seeking input from residents, residents representatives, and frontline care staff. 1. Review of the facility's QAA minutes log showed the following QAA meetings held in 2024: -On 01/17/24, the Administrator, the Director of Nursing (DON), the Infection Preventionist (IP), and the Medical Director attended the QAA meeting; -On 02/14/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 03/13/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 04/10/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 05/08/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 06/12/24, the Administrator, DON, and IP attended the QAA meeting; -On 07/10/24, the Administrator, DON, and IP attended the QAA meeting; -On 08/14/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 09/11/24, the Administrator, DON , IP, and the Medical Director attended the QAA meeting; -On 10/16/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting; -On 11/13/24, the Administrator, DON, IP, and the Medical Director attended the QAA meeting. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/11/24, at 3:30 P.M., the Administrator said the following: -The QAA members include the Administrator, the DON, MDS Coordinator, the Medical Director at least quarterly, and most department heads; -He was not aware there was a required number of staff who must attend the QAA meetings.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40769 Based on observation, record review, and interview, the facility failed to have a working call light system for all residents when the call light was not working properly in one resident room, affecting two residents (Resident #34 and #91). The facility census was 98. Review of the facility's policy titled, Resident Call System, revised 10/20/22, showed the following: -The facility call system relay calls directly to a centralized work area from the resident's bedside, toilet, and bathing area. The call system is accessible to a resident lying on the floor as required by state/federal guidelines; -During rounds nursing and the Interdisciplinary Team (IDT) members will ensure resident call systems are within reach of residents; -In the event the resident call system is down, call bells will be utilized until power is restored; -The Maintenance Director will complete routine call system inspections. 1. Review of the current resident room roster showed Resident #34 and Resident #91 shared a room. 2. Review of Resident #34's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included polyneuropathy (a condition that affects multiple peripheral nerves, causing damage and dysfunction), Type 2 diabetes mellitus, muscle weakness, unsteadiness on feet, repeated falls, bipolar disorder (mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function), major depressive disorder, and schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder). Review of the resident's annual Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/13/24, showed the following information: -Resident had moderate cognitive impairment; -Resident required supervision with transfers and toileting. During an interview on 02/08/25, at 10:02 A.M., the resident said the call light had not been working for at least a few weeks. It just constantly goes off. The staff gave him/her a bell to use. 2. Review of Resident #91's face sheet showed the following: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - is a group of lung diseases that cause airflow obstruction and breathing difficulties), muscle weakness, unsteadiness on feet, and aphasia (a disorder that affects how one communicates). Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Resident had moderate cognitive impairment; -Resident required supervision with transfers and toileting. During an interview on 02/13/24, at 9:58 A.M., the resident said the following: -The call light had been messed up for a while, at least two weeks now; -The light on the outside of the door just goes off all of the time; -The staff gave him/her a bell to ring if he/he needed help. 3. Observation on 02/08/25, at 9:25 A.M., showed Resident #34's and Resident #91's call light indicator above the door was continually blinking. Observation on 02/08/25, at 10:05 A.M., showed the following: -Certified Nurse Aide (CNA) O entered the residents' room and pushed the button on the wall to turn off the call light and it continued to blink above the outside of the door; -CNA O then pushed each resident's call light and the light above the door continued to blink. Observation on 02/11/25, at 11:02 A.M., showed the following: -The call light alert system at the nurses' station did not show that the residents' room call light was activated; -The room light above the door was lit up and blinking. 4. During an interview on 02/08/25, at 10:05 A.M., CNA O said the following: -Resident #34's and Resident #91's call light was not working properly and would not go off when it was pressed due to it just continually going off; -The staff can press the button to make the call light stop going off, but it doesn't work for the residents' room; -He/she believed it has been this way since December 2024, on and off; -If the residents needed something they generally just yell; (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The residents were given bells to use; -He/she thought maintenance was aware that it was not working; -The nurse generally put in a work order if the call light was not working properly; -The bathroom call light was working as far as he/she knew. During an interview on 02/13/25, at 9:53 A.M., CNA K said the following: -The call lights for the residents' room had not been working properly for at least a few months; -He/she thought maintenance knew about it. During an interview on 02/13/25, at 10:56 A.M., CNA P said the following: -He/she was aware that the call light for the residents' room had not been working correctly for a while. He/she was not sure exactly how long; -He/she believed it was reported to maintenance. During an interview on 02/11/25, at 11:24 A.M., Registered Nurse (RN) J said the following: -He/she was not aware if there were any call lights not working properly; -He/she didn't really pay any attention to the call lights or if they are going off or not; -If a call light was not working properly maintenance should be informed. During an interview on 02/08/25, at 10:15 A.M., the Assistant Director of Nursing (ADON) said the following: -The call light had not been working properly in the residents' room since December 2024; -If the call lights were not working and it should be reported to maintenance if nursing is unable to get it working; -He/she believed it was reported to maintenance. During an interview on 02/13/25, at 11:44 A.M., the Director of Nursing (DON) said the following: -He/she was aware that the call lights for the residents' room was not working correctly and the residents were given hand bells; -He/she believed that maintenance was aware. During an interview on 02/11/25, at 11:02 A.M., the Maintenance Supervisor said the following: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was not aware of any call lights not operating correctly; -He/she was not aware the residents' room call light was continually going off or he/she would have addressed it; -The staff did not put in a work order for maintenance to come fix it; -The call lights should alert at the nurses' station if they are pressed. The call light for this room was not alarming at the nurses' station. During interviews on 02/08/25, 10:18 A.M., and on 02/13/25, at 12:31 P.M., the Administrator said the following: -He/she thought the call light had been repaired in January; -The residents had been given bells in the mean time; -He/she was not aware that maintenance did now know it was currently not working correctly.