STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265522	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Health Care & Rehabilitation Center	1450 Ashley Road Boonville, MO 65233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48982 Based on observation, interview, and record review, facility staff failed to provide necessary treatment and services, consistent with professional standards of practice to prevent the development of pressure injuries and promote healing when staff failed to complete weekly wound assessments for one resident (Resident #1) of three sampled residents and failed to notify the physician when the resident's pressure injury worsened. The facility census was 45. 1. Review of the National Pressure Injury Advisory Panel's, Staging Definitions, dated 2016, showed Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Review of the facility's policy titled Wound and Skin Protocols, undated, showed: -It will be the responsibility of the Director of Nursing (DON) to ensure the wound care protocols are instituted and followed for all resident's needing wound treatment and have orders for protocol; -The DON will be responsible for reviewing weekly wound report and monitoring progress/decline of any wound and assuring compliance; -A complete wound assessment documentation will be done weekly on all pressure injuries until healed. A complete wound assessment and documentation will be done weekly on all pressure injuries until healed, the criteria to be included: -Site/location; -Stage; -Size: length, width, and depth measured in centimeters (cm); -Appearance of the wound bed; (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Undermining/tunneling: if present measure the depth of the area in cm and describe in relation to the face of a clock what position it is in; -Surrounding skin: describe the condition of the surrounding skin; -Drainage/exudate: describe the amount, color, consistency, and odor. 2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/28/24 showed staff assessed the resident as: -admitted to the facility on [DATE]; -Did not resist care; -Required maximum assistance of staff for bathing, and dressing; -Dependent on staff for toileting, and hygiene; -Incontinent of bowel and bladder; -At risk for pressure injuries; -Did not have a pressure injury; -Diagnosis of Parkinson's disease (a disorder that effects your nervous system), Coronary Artery Disease, Diabetes (a condition that effects your heart), and Dementia (inability to remember, think or make decisions); -Did not contain a cognition level assessment. Review of the resident's care plan, dated 03/21/24, showed staff assessed the resident with cognitive loss due to dementia. Review showed the resident required moderate to extensive assistance for toileting, bathing, dressing, and hygiene. Review of the resident's Physician's Order Sheet (POS), dated May 2024 showed physician orders to follow facility wound care protocol. Reviewed showed it did not contain an order for a treatment to the resident's coccyx wound. Review of the resident's Treatment Administration Record (TAR), dated May 2024 showed staff are directed to clean and cover the small open area on the resident's coccyx daily and as needed until healed. Review of the resident's weekly skin assessment, dated 05/29/24, showed staff documented the resident with an open area to his/her coccyx. The weekly skin assessment did not contain a complete wound assessment. Review of the resident's weekly skin assessments, dated June 2024, showed staff documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-06/05/24 open area to coccyx; -06/12/24 open area, but did not contain where; -06/19/24 wound to coccyx; -06/26/24 two open wounds to coccyx. Review of the resident's weekly skin assessment for June 2024 did not contain a complete wound assessment. Review of the resident's hospital wound consult note, dated 06/13/24, showed hospital staff assessed the resident wound as follows: -Right lower coccyx stage 3 pressure injury 2 centimeters (cm) x 1 cm x 0.3 cm with 90 percent slough (moist, stringy tissue over the wound); -Unstageable (full thickness tissue loss covered with slough) coccyx pressure injury 3 cm x 2 cm, wound bed soft dry eschar, no drainage; -Resident not able to reposition himself/herself; -Order for pressure relieving cushion in the wheelchair, air mattress for the bed, and Mepilex dressing to coccyx area. Review of the resident TAR, dated 06/01/2024 to 06/14/2024, showed the TAR did not contain treatment orders for the residents coccyx wound. Review of the resident's POS, dated June 14, 2023, showed the resident physician order directed staff to check air pressure mattress and pressure reducing cushion twice a day, to soak gauze in Vashe (solution used to treat wounds) for seven to nine minutes, clean the coccyx wound bed with Vashe soaked gauze and pat dry, apply a nickel size thick layer of Triad (a cream used to treat wounds), cover wound with mepilex (dressing used to cover wounds) and change ever Monday, Wednesday, Friday, and as needed. Review of the resident's TAR, dated June 14, 2024, showed staff were directed to soak gauze in Vashe for seven to nine minutes, clean the coccyx wound bed with Vashe soaked gauze and pat dry, apply nickel size thick layer of Triad, cover wound with mepilex, and change every Monday, Wednesday, Friday and as needed. Review showed air Mattress and pressure reducing wheelchair cushion check twice a day. Observation on 07/01/24 at 1:20 P.M., showed an open wound approximately the size of a quarter on the resident's coccyx and an open wound approximately the size of a quarter on the resident's left inner gluteal area. Observation showed the wound on the left inner gluteal area had slough (yellow or white matter in the wound bed) in the wound bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/01/24 at 9:30 A.M., Registered Nurse (RN) A said the resident had a small reddened-purple area on his/her coccyx and staff were attempting to have the resident seen by the facility wound care consultant. RN A said the resident had eye surgery on 06/13/24 before the wound care consultant could see the resident. RN A said the hospital had the wound care team consult while having eye surgery and the wound was debrided. RN A said the wound care consultants come to the facility on ce a week. RN A said all wound documentation for the facility is completed by the wound consultant. During an interview on 07/01/24 at 1:45 P.M., RN A said he/she attempted to contact the resident's physician to advise him/her of the wound decline but has not had any response and he/she did not document the attempts. RN A said he/she does not know why measurements were not documented for the resident's wounds. RN A said without proper measurements and wound descriptions staff will not know if the wound has improved or declined. RN A said if something is not documented then it was not done. During an interview on 07/01/24 at 1:45 P.M., Licensed Practical Nurse (LPN) B said if staff do not document something that means it was not done. LPN B said he/she did not know why the resident's skin assessments did not contain measurements or descriptions of the wounds. LPN B said measurements and description of the wound is important so staff can tell if a wound is declining. LPN B said he/she did not contact the physician. During an interview on 07/01/24 at 3:05 P.M., the administrator said the charge nurse is responsible for completing the weekly skin assessments and the DON oversees them. The administrator said he/she was not aware the staff were not completing weekly measurements on wounds per the facility protocol. The administrator said the charge nurse is responsible for calling a resident's physician to obtain new orders or treatments. The administrator said the charge nurse is responsible to document the new orders and transcribe them to the POS, MAR, and TAR. The administrator said if something is not documented then it is not done, and staff must document what they complete. The administrator said measurements, and correct orders are important to ensure a resident gets the proper wound care. During an interview on 07/17/24 at 2:00 P.M., physician C said he/she was aware the resident had a wound on his/her buttock, but he/she has not seen the wound and does not know if the wound would be avoidable or not. He/She said he/she is not sure if the wound consultant had seen the wound or not as the resident is currently in the hospital. The resident's physician said he/she was notified of the resident having a would a couple of weeks ago but does not know the exact date. The resident's physician said he/she made monthly rounds the first part of June 2024 and did not make notation of a wound then, so he/she believes he/she was notified after that. He/She said he/she would expect staff to contact him/her within a couple of days of finding the wound to get treatment orders if a new wound, or if a wound got worse. He/She said he/she would change the treatment orders if a wound was deteriorating with the current orders. He/She said he/she expects staff to assess any wounds when they do treatments and document the wound measurements, the etiology, any drainage, and color of the drainage. He/She said he/she expects staff to assess wounds at least weekly and if not assessed over a period of time the resident could get more wounds or deterioration of the wound. MO00237546