STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care for pressure ulcers per standards of practice when staff failed to follow-up regarding an intervention of an appropriately sized bed and when staff failed to follow-up with the physician in a timely manner regarding a wound culture for one resident (Resident #1) and when facility staff failed to utilize appropriate hand hygiene prior to and during pressure ulcer wound care for one resident (Resident #2). The facility census was 83. 1. Review of the facility policy titled, “Pressure Ulcer/Wound Assessment and Treatment”, revised June 2025, showed: -Nursing personnel will continually strive to maintain the skin integrity, tone, turgor, and circulation to prevent skin breakdown, injury, and infection; -Purpose to provide a consistent effective method or treatment for pressure ulcers/wounds; -Initiate the appropriate prevention intervention; -Positioning techniques: Use positioning devices (pillows, heel protectors, overlay air mattress) to raise a pressure off the support surface. Avoid utilizing donut-type devices; Establish a repositioning plan according to individual resident needs, care goals, tissue tolerance, and response to treatment. Avoid positioning on pressure ulcer/wound, when possible, to facilitate protection of uninvolved areas. Avoid positioning immobile individuals directly on their trochanters, bony prominences, or existing wounds. Use positioning devices to prevent direct contact between bony prominences. Maintain head of bed the lowest degree of elevation tolerated by the resident’s condition and limit the amount of time the head of bed is elevated more than 30 degrees. -Patient support systems: Protective padding, alternating pressure mattress, gel pads, low air loss therapy, air mattress overlay. Review of Resident #1’s face sheet showed the following: -admission date of 01/10/24; -Primary diagnosis of lumbar spine epidural abscess (a collection of pus that formed in the space between the spinal cord and the bones of the spine.) Review of the resident’s current care plan showed the following: (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 - Minimal harm or potential for actual harm Residents Affected - Few	-Resident had a history of peripheral vascular disease (PVD-a condition where the arteries and veins become narrowed or blocked resulting in reduced blood flow to and from the legs) and diabetes; -Resident has a history of skin break down; -Resident has had a right metatarsal great toe amputation due to a wound, resulting in greater high risk for skin integrity; -Interventions for pressure ulcer, start 01/18/24, Braden scale as needed, dietitian to evaluate resident nutrition as needed, keep nails trimmed and filed, encourage not to scratch as needed, keep skin clean and dry, use lotion on dry skin as needed, offer supplemental nutrition, if indicated, pressure relieving devices to bed (air mattress), provide peri-care after each incontinent episode, use caution during transfers and bed mobility to prevent shearing, and weekly and as needed skin monitoring; -Skin risk assessment scale every 90 days, starting on 01/10/24; -Skin assessment every 7 days, starting on 01/28/24; -Protective skin barrier at bedside, starting 05/30/24; -Resident has had a right metatarsal (mid foot bone) great toe amputation due to a wound resulting in a greater high risk for skin integrity. Review of the resident’s wound assessment dated [DATE], showed: -Wound location: Right great toe; -Present on Admit or Acquired: Acquired; -Wound type: Pressure injury; -Wound Staging: Stage 2; -Wound length: 0.4 centimeter (cm); -Wound width: 0.3 cm; -Wound appearance: Beefy red, pink, and shiny; -Wound surrounding tissue appearance: Bright red; -Surrounding tissue appearance: Cool; -Wound drainage description: Sanguineous (containing blood); -Wound drainage amount: Scant; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound drainage odor: No odor; -Wound details/comments: Resident acquired this pressure ulcer due to continuously sliding down in bed and his/her right great toe had contracture (stiffening and shortening of the muscles, tendons, ligaments) noted and pressed against the foot board. Sanguineous drainage was noted on the gauze, scant amount. Interventions and prevention measures have taken place as in a foam wedge placed between the mattress and foot board and heel/foot protectors are in place. Review of the resident’s nurse note dated 03/12/25, at 11:33 A.M., showed the wound nurse documented the following: -Right great toe wound open; -The resident states when he/she was getting up with assistance, he/she bumped his/her toe, and it started to bleed. The resident’s right great toe is open superficially. Review of the resident’s quarterly Minimum Data Sheet (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 4/04/25, showed the following: -Moderate cognitive impairment; -Did not reject care; -Required substantial/maximal assistance with upper body dressing, rolling left and right; -Dependent on staff for assistance with toileting hygiene, lower body dressing, putting on and taking off footwear, and transfers; -Functional limitation in range of motion to bilateral lower extremities; -Diagnoses of type 2 diabetes mellitus with polyneuropathy (impacts nerve function in multiple areas of the body, often characterized by numbness, pain, and muscle weakness, primarily in the distal arms and legs); -Mobility device manual wheelchair; -Presence of one stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer); -Pressure reducing device for chair and bed; -Application of dressings to feet. Review of the resident’s wound assessment dated [DATE], at 10:05 A.M., showed: -Wound location: Right great toe; -Present on Admit or Acquired: Acquired; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound type: Pressure injury; -Wound Staging: Stage 3 (full-thickness loss of skin); -Wound length: 0.9 centimeter (cm); -Wound width: 1.1 cm; -Wound Depth: 0.1 cm; -Presence of pain: No; -Wound appearance: Bleeding and reddened; -Wound surrounding tissue appearance: Granulated Pink; -Surrounding tissue appearance: Cool; -Wound drainage description: Sanguineous; -Wound drainage amount: Moderate; -Wound drainage odor: No odor; -Wound details/comments: Wound update and change from a stage 2 to a stage 3 pressure injury. Impeded wound healing with transfers. Review of the communication between the nurse and nurse practitioner (NP) showed the following: -On 04/09/25, at 12:51 P.M., the nurse wrote recommendation to get a wound culture on the resident’s right great toe wound related to stalled wound healing. Wound is slightly larger in size, there is edema (fluid retention/swelling) and erythema (redness of the skin) to the right great toe surrounding the wound. -On 04/09/25, at 1:54 P.M., the NP wrote please culture the drainage, if possible. Review of the communication between the nurse and nurse practitioner showed the following: -On 04/10/25, at 1:57 P.M., the nurse wrote resident was a sit to stand transfer (a mechanical transfer device that assists staff in lifting the resident to a standing position for transfers) and because of the location of the wound on the right great toe, the wound is being impeded. Recommendation for wound healing to use a Hoyer (a mechanical sling lift used to raise/transfer residents) to transfer the resident as he/she has in the past; -On 04/10/25, at 2:07 P.M., the NP wrote okay to use the Hoyer lift for skin protection, wound healing at this point. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Braden Scale (tool for predicting pressure ulcer risk completed by facility staff), dated 04/10/25, showed the following: -Sensory perception = Slightly limited; -Skin = Constantly moist; -Activity = Chairfast; -Mobility = Very limited; -Nutrition = Adequate; -Friction and shear = Potential problem; -Skin Risk = High risk. Review of the resident’s nurse note dated 04/10/25, at 10:54 A.M., showed the wound nurse documented the following: -Right great toe update: Wound to right great toe has worsened with size and moderate amount of serosanguineous drainage noted. The great toe is swollen and red. Recommendation to get a wound culture to rule out infection relating to the worsen appearance, size, swelling, and erythema noted. The physician noted to get a culture via messages. Obtained the culture on 4/10/25 at 10:48 A.M. and sent over to the laboratory. Review of the resident’s nurse note dated 04/10/25, at 1:43 P.M., showed the wound nurse documented the following: -Skin Team review; -Reason for review: Pressure ulcer; -Location: right great toe; -Measurements: See wound assessment; -Preventative measures: Continue all preventative measures set in place; -Current treatment: Silver alginate; -Progress: Wound has declined in healing with an increase in drainage and swelling to the toe; -Rehab: OT lymph massage; -Notes: Wound culture obtained today and pending results; -Team recommendations: To use Hoyer for transfers to assist in wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident’s nurse note dated 04/10/25, at 4:42 P.M., showed a nurse documented the following: -Resident complaining that he/she was “freezing to death.” The resident’s vital signs were stable and no fever at this time. -The resident was actively shivering, blankets applied. Staff notified the NP and the infection/sepsis tool completed. A urinalysis was ordered per the NP. Staff will continue to monitor. Review of the resident’s nurse note dated 04/10/25, at 9:31 P.M., showed a nurse documented UA obtained and taken to lab. Review of the resident’s laboratory report for wound culture of right great toe, showed the following: -Collected on 04/10/25 at 10:49 A.M.; -Received on 04/10/25 at 10:59 A.M.; -Preliminary results: 04/11/25 at 11:29 A.M., showed coagulase positive staphylococcus, sensitivity to follow. Record review of the resident’s nurse note, dated 4/11/25 at 5:34 A.M., showed a nurse documented the resident continued with chills. Review of the communication with the nurse and NP showed the following: -On 04/11/25, at 1:57 P.M., the nurse wrote: Please see wound culture results; -The NP did not reply. Review showed nurses did not document any further nurse notes between 04/11/25, at 1:57 P.M., and on 04/12/25, at 12:47 P.M., regarding the wound culture or follow-up with the NP. Review of the communication with the nurse and NP showed the following: -On 04/12/25, at 12:47 P.M., the nurse wrote: Notified of this day. -The NP did not reply. Review of the resident’s laboratory report for wound culture of right great toe showed the following: -Final results: 04/12/25 at 2:02 P.M., showed Methicillin Resistant Staph Aureus (MRSA - a bacteria that is resistant to several antibiotics). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident’s physician order showed an order dated 04/12/25, at 2:07 P.M., for ceftriaxone (a broad spectrum anti-infective medication) 1000 milligrams (mg) mixed with 1% lidocaine (used to treat pain) 2.1 ml, give intramuscular injection one time daily for diagnosis of MRSA infection of wound. Review of the resident’s pharmacy consultation note dated 04/12/25, at 7:00 P.M., showed the following: -Nursing infection screening completed on 04/10/25 at 4:38 P.M.; -Reason: Lumbar spine epidural abscess; -Overall symptoms: Mental status change not/applicable (N/A), functional decline N/A, vital signs N/A, and general illness N/A; -UTI Symptoms: Infection screening, new or marked increase in frequency, urinary pain/frequency; -Overall criteria met: Yes -Origin of infection: Infection acquired while at the facility? Yes; -Urinary tract infection: Appropriate empiric therapy ordered: Yes -Antibiotic medications ordered. Antibiotic ordered: Ceftriaxone; -Lab ordered: Urinalysis, urine culture. -On 04/10/25 UA showed: Clear, yellow urine with no protein, glucose, ketones, or nitrites, trace of blood, no bacteria, few white blood cells. Comment culture not indicated. -On 04/10/25, at 10:48 A.M. right great toe culture final showed MRSA. Review of the resident’s intervention documentation report showed staff did not document completion of a daily dressing change to the resident’s right great toe on 04/12/25. Review of the resident’s physician order dated 04/13/25, at 8:33 A.M., showed an order for doxycycline (an antiinfective medication) 1000 mg every 12 hours for diagnosis of MRSA infection of wound. Review of a communication form showed: -On 04/13/25, at 1:14 P.M., the nurse wrote: Orders were placed for Vibramycin (antibiotic) that started today. Upon inspecting his/her wound, it is exceptionally worse. The entire foot is now red, swollen and continues to enlarge. The wound is actively pouring blood of it. On call physician was contacted and gave approval to send the resident to the emergency room (ER) for further evaluation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident’s nurse note, dated 04/13/25 at 1:17 P.M., showed a nurse documented upon inspection of the resident’s great toe wound, it was noted that the entire foot was now inflamed, red, and had excessive amount of blood coming from the wound. The nurse contacted the on-call physician who gave orders to send the resident to the emergency room. Family notified. Called report to the emergency room nurse and called the ambulance for transport. Review of the resident’s nurse note, dated 04/13/25 at 1:53 P.M., showed a nurse documented the following: -This nurse went in to do the resident’s wound care on his/her right toe. This nurse was alarmed when observing the blood-soaked bandage. Bandage removed and wound cleansed. Wound had a large amount of blood discharge. Cleansed again and pressure applied. Bleeding subsided and wound cleansed again. This nurse went to get a second opinion from the nurse manager. Both in agreement that the on-call needed to be contacted to send the resident to the emergency room for evaluation. Resident’s toe had considerable swelling, redness, and warmth that extended down into his/her foot. Resident’s family contacted and in agreement with the resident’s plan of care. Vital signs were stable at the time of transfer. During an interview on 07/01/25, at 3:00 P.M., Certified Nurse Assistant (CNA) A said the following: -The wound nurse told staff the resident’s right great toe pressure ulcer was caused from the resident being transferred using a sit to stand lift and due to the resident’s bed foot board; -The resident slid down in the bed; -The resident needed a longer bed; -He/she and other aides told the wound nurse, the charge nurses, and maintenance several times about the resident’s need for a longer bed; -Maintenance said the facility did not have any longer beds, because the resident was on a bariatric air mattress; -The resident required assistance to moved up in the bed and reposition; -The CNA said the resident slid down in the bed for approximately 2 months prior to going out to the hospital for a toe amputation. During an interview on 07/01/25, at 3:14 P.M., CNA B said the following: -He/she kept a pillow at the foot of the resident’s bed; -The resident developed a sore on his/her toe due to not wearing proper footwear while in the sit to stand and the resident slid down in bed; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was not able to pull him/herself up in bed; staff needed to assist the resident in moving up in the bed; -He/she did not ask nursing for a longer bed for the resident, he/she was not aware the resident wanted a longer bed. Observation and interview of the resident on 07/01/25, at 10:50 A.M., showed the following: -The resident currently had a bariatric air mattress with no foot board; -The resident said he/she was too tall for his/her last bed, and he/she would slide down in the bed, and his/her toes would push against the foot board; -The resident said he/she told nursing staff, the wound nurse on multiple occasions that he/she needed a different bed, but they kept saying they did not have a different bed; -The resident said as a result of his/her toes pushing against the foot board, he/she developed a sore on the top of his/her right great toe, which became infected; -He/she talked to maintenance about his/her bed and maintenance said the facility did not have a longer bed at that time; -The facility tried to place pressure relieving boots on him/her, but they would slide sideways, and his/her feet would once again be pressing on the foot board. During an interview on 07/01/25, at 11:38 A.M., CNA C said the following: -The resident asked for a bed extender or padding for his/her toe; -The CNA said the resident thought his/her toe against the foot of the bed caused his/her toe ulcer, but the aide did not know for sure what caused the ulcer. During an interview on 07/01/25, at 12:30 P.M., CNA E said the following: -The resident’s bed was too short for him/her; -Staff tried to place pillows at the foot of his/her bed; -Staff tried to use pressure relief boots on the resident, but the Velcro straps would get caught on his/her bedding and the boots would twist, exposing the resident’s feet; -Staff tried different interventions, but these interventions did not matter, the resident always ended up with his/her feet against the foot board of the bed; -He/she was not aware foot boards would come off some of the beds; -He/she addressed with the nurses that the resident’s feet touched the foot board; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident’s heel protectors did not cover the resident’s toes; -The resident continued to slide down in bed, despite the staff’s best efforts; -He/she talked with the Administrator, the DON and OT about the issue; -The resident’s foot board wound not come off and the bed was the longest bed we could get; -Initially he/she did not realize the resident’s foot board was causing the pressure ulcer, but eventually it was obvious the foot board was putting pressure on the top of the resident’s toes because the resident’s feet were against the foot of the bed; -In March 2025, the wound showed signs of healing; -On 04/10/25, the wound worsened with increased redness and swelling; -He/she asked for and received from the NP, orders for a wound culture of the resident’s right great toe ulcer; -He/she obtained the wound culture on 04/10/25; -On 04/11/25, the wound culture showed staph infection; -On 04/12/25, the final wound culture showed MRSA infection; -The nurse should contact the physician as soon as they received the wound culture results; -The wound treatment was not initialed as completed on 04/11/25, and he/she was unsure if the nurse completed the treatment that day or not; -The wound nurse did not see the resident’s wound again after 04/10/25. During interviews on 07/02/25, at 4:45 P.M., and on 07/07/25, at 10:15 A.M., the DON said the following; -The resident had a tendency to slide down in the bed and was prone to pressure ulcers; -The resident was on an air mattress because he/she was unable to reposition him/herself; -The resident required the help of staff with repositioning in bed; -Prior to the resident’s right great toe amputation, the DON and the wound nurse both talked with maintenance about the resident's need for a bed modification, such as an extender for the bed or a longer bed; -Maintenance said the resident was already in the biggest bed that the facility could obtain; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265545	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Memorial Healthcare Facility	1218 West Locust Bolivar, MO 65613

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/10/25, the resident was shivering, the nurse notified the NP, and the NP gave orders for a urinalysis; -On 04/11/25, the nurse received the initial wound culture results and should have called the physician or on-call physician immediately to notify of the results instead of sending a message through the message portal; -On 04/12/25, the NP asked for a pharmacy consult and the pharmacist recommended antibiotic; -The facility began administration of ceftriaxone (Rocephin) IM 1000mg to the resident daily on 04/12/25 and began administration of doxycycline on 04/13/25; -The DON was unsure if the nurses completed the treatment on 04/12/25 or not, but they did not document completion of the treatment, and the nurse should sign when completed; -The facility sent the resident to the hospital 04/13/25 and the resident returned to the facility on [DATE] after amputation of his/her right great toe. 2. Review of the facility policy titled, “Standard Precautions, IP0-05”, revised October 2024, showed: -Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered; -Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents; -Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings; -Hand hygiene includes both hand washing with soap and water and use of alcohol-based products that do not require the use of water; -During delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces; -Indications for hand hygiene from Centers of Disease Control and Prevention (CDC) include prior to entering a patient’s room or care area; when exiting a patient’s room or care area; before direct contact with patients; before inserting invasive devices that do not require a surgical procedure; after contact with a patient’s intact skin; after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings; after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; before putting on gloves; and after removing gloves; (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	-Gloves are used to prevent contamination of hands when anticipating direct contact with blood or body fluids, mucous membranes, non-intact skin and other potentially infectious material, or handling, or touching visibly or potentially contaminated patient care equipment and environmental surfaces; -During patient care, transmission of infectious organisms can be reduced by adhering to the principles of working from “clean” to “dirty,” and confining or limiting contamination to surfaces that are directly needed for patient care; -It may be necessary to change gloves during care of a single patient to prevent cross contamination; -It will be necessary to change gloves if during the interaction you touch nonsterile objects such as computer keyboards, trash can, etc.; -Gloves are to be discarded immediately after removal and not reused. Review of the facility policy titled, “Hand Hygiene, IP02-07,” revised April 2025, showed: -Hand hygiene is the single-most effective method of reducing the transmission of microorganisms in a healthcare setting; -The term “hand hygiene” replaces “hand washing” to reflect the acceptance of waterless hand cleaning agents such as alcohol-based hand rubs (ABHR); -Gloves are not a substitute for hand hygiene; -Remove gloves prior to performing hand hygiene. Do not perform hand hygiene on gloves; -Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients; -Change gloves during patient care if moving from a contaminated body site to a different body site of the same patient; -Perform hand hygiene between glove changes; -Perform hand hygiene and change gloves if you suspect your gloves have been contaminated. Review of Resident #2’s face sheet showed: -admission date of 11/04/21; -Diagnoses included osteomyelitis (infection in a bone) of vertebra (back bones of the spine), sacral (bone at the bottom of the spine), and sacrococcygeal (bones at the bottom of the spine) region, chronic (long-term) decubitus ulcers (damage to the skin caused by constant pressure. Review of the resident’s MDS, dated [DATE], showed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -Dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, moving from sit to lying; -Always incontinent of bowel; -Had an indwelling urinary catheter; -At risk of developing pressure ulcers; -Had one stage four pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) that was present upon admission/reentry. Review of the resident’s physician order, dated 05/23/25, showed an order to cleanse the wound bed with wound cleanser, pat dry, apply skin prep to the wound edges and surrounding intact skin, dampen Drawtex (dressing for a wound bed) and apply Drawtex to wound bed only, then cover and apply sacral mepilex (absorbent foam dressing) to secure. Change dressing daily. Review of the resident’s wound assessment documentation, dated 06/11/25 at 1:00 P.M. showed: -Wound location number one: Left buttocks; -Present on Admit or Acquired: Admit; -Wound type: Pressure injury; -Wound Staging: Deep tissue injury; -Wound length: 2 centimeter (cm); -Wound width: 1.6 cm; -Wound Depth: 0.1 cm; -Wound appearance: Granulation, pink, and reddened; -Wound surrounding tissue appearance: Pink; -Surrounding tissue temperature: Cool; -Wound drainage description: Serous; -Wound drainage amount: Scant; -Wound drainage odor: No odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound location number two: Left sacrum; -Present on Admit or Acquired: Acquired; -Wound type: Pressure injury; -Wound Staging: Stage four; -Wound length: 2.3 centimeter (cm); -Wound width: 3.2 cm; -Wound Depth: 0.2 cm; -Presence of pain: No; -Wound appearance: Bleeding, granulation, pink, and reddened; -Wound surrounding tissue appearance: Pink; -Surrounding tissue temperature: Cool; -Wound drainage description: Sanguineous; -Wound drainage amount: Small; -Wound drainage odor: No odor. -Wound details/comments: Hypergranulated tissue has decreased, silver nitrate was ordered within the past week as daily for two days. Review of the resident’s care plan, last reviewed on 06/27/25, showed the following: -Resident has a risk for skin breakdown with a long history of skin problems due to his/her mobility status and disease process; -He/she has a diagnosis and history of diabetes mellitus, cellulitis, and stage four decubitus ulcers on his/her sacrum and c

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care to all residents with a urinary catheter (a sterile tube inserted into the bladder to drain urine) in a manner that prevented possible infection when staff failed to follow proper infection controls practices, including proper handwashing, during wound and catheter care for one resident (Resident #2) with a history of urinary tract infections (UTIs). The facility census was 83.Review of the facility policy titled, Standard Precautions, IP0-05, revised October 2024, showed the following:-Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered;-Hand hygiene is the single most important practice to reduce the transmission of infectious agents in healthcare settings;-Hand hygiene includes both hand washing with soap and water and use of alcohol-based products that do not require the use of water;-During delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces;-Indications for hand hygiene from Centers for Disease Control and Prevention (CDC) include prior to entering a patient's room or care area; when exiting a patient's room or care area; before direct contact with patients; before inserting invasive devices that do not require a surgical procedure; after contact with a patient's intact skin; after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings; after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; before putting on gloves; and after removing gloves;-Gloves are used to prevent contamination of hands when anticipating direct contact with blood or body fluids, mucous membranes, non-intact skin and other potentially infectious material, or handling, or touching visibly or potentially contaminated patient care equipment and environmental surfaces;-It may be necessary to change gloves during care of a single patient to prevent cross contamination;-It will be necessary to change gloves if during the interaction you touch nonsterile objects such as computer keyboards, trash can, etc. Review of the facility policy titled, Urinary Catheterization, NUR08-13,. revised March 2024, showed the following:-The policy is to provide guidance for the placement of urinary catheters, maintenance techniques, and to assist in the prevention of catheter-associated urinary tract infections (CAUTI);-For maintenance, standard precautions should be used. Use gloves when manipulating the catheter site and drainage system and practice hand hygiene before and after;-A sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems;-If there are breaks in aseptic technique, disconnection of tubing, or leakage from the bag, or if the catheter becomes contaminated, the catheter should be replaced;-Meatal care (hygiene practices for the urethral opening) is performed twice per day and includes cleansing of the peri area with soap and water or with organization approved chlorhexidine gluconate (CHG) wipes;-Cleansing the meatal surface during daily bathing is appropriate and can be included as part of the twice per day requirement and CHG wipes should be used daily for patients with an indwelling device;-Hand hygiene should be performed immediately before and after manipulation of the catheter site or collection bag. Review of the facility policy titled, Hand Hygiene, IP02-07, revised April 2025, showed the following:-Hand hygiene is the single-most effective method of reducing the transmission of microorganisms in a healthcare setting;-Perform hand hygiene before crossing the threshold/entering the patient's room, before donning sterile or non-sterile gloves, before donning any PPE (i.e. gown, mask, gloves), before inserting or handling invasive devices, before moving from a contaminated body site to a different body site during the care of the same patient, after contact with patient's skin, body fluids, excretions, mucous membranes or dressings, after contact with objects in the immediate vicinity of patients, after doffing of sterile or non-sterile gloves, after doffing of any PPE, and upon crossing the threshold when exiting the patient's room;-Gloves are not a substitute for hand hygiene;-Wear gloves when contact with blood or other potentially infectious materials, mucous membranes and non-intact skin is anticipated;-Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients;-Change gloves during patient care if moving from a contaminated body site to a different body site of the same patient;-Perform hand hygiene between glove changes;-Perform hand hygiene and change gloves if you suspect your gloves have been contaminated. 1. Review of Resident #2's face sheet showed:-admission date of 11/04/21;-Diagnoses included acute (short-term) urinary tract infections (UTI's), chronic neurogenic