STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265577	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshfield Care Center for Rehab and Healthcare	800 South White Oak Marshfield, MO 65706

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 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 interview and record review, the facility staff failed to maintain $4,000.00 cash for one resident (Resident #1) when staff had possession of the cash and could not locate the cash and provide it to the resident upon request. The facility census was 44.Review of the (undated) facility policy titled, Abuse and Neglect, showed the following:-Residents have the right to be free from verbal, sexual, physical, and mental abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, and involuntary seclusion. -Misappropriation of property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent;-Any staff member or person affiliated with this facility, including facility consultants and/or attending physician, who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report the mistreatment or offense to the Administrator;-All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, should be reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator and the designated state agency. All alleged violations must be reported immediately;-After the facility submits an immediate report of an alleged violation, the facility must conduct a thorough investigation; prevent any other incidents from occurring during the course of the investigation and report the results of the investigation to the state agency within five working days or as designated by state law. The facility may report the results of the investigation by completing the remainder of the reporting form and resubmitting to the state agency. 1.Review of the facility investigation summary, undated, showed the following:-In December 2024 or January 2025, the administrator found $4,000.00 cash belonging to the resident in the business office manager's (BOM) office. She made a log and placed the money in the facility safe per the regional BOM until the money could be taken to the bank;-The resident's family member came to the facility in the same time frame of December 2024 or January 2025 and requested money. The administrator is unsure if any money was given to the family member and the log placed with the money is missing;-Just before the BOM discontinued employment in April 2025, the BOM and administrator opened the safe and did not see the money and thought the money was given to the family member, but the log was not in the safe;-On 05/16/25, the resident requested money from the $4,000.00 that he/she had given the BOM. The resident denied giving any money to his/her family member;-On 05/21/25, after speaking with family, a friend, and looking into bank records, the money was not located and was considered missing. The state agency and law enforcement were contacted. Review of the police report, dated 05/22/25, showed no arrests were made, and the case was closed unless new evidence was found. Review of the facility record showed a copy of a check made out to the resident, dated 06/18/25, for $4,000. 00. 2. Review of Resident #1's face sheet (a brief resident profile) showed the following:-The resident admitted to the facility on [DATE];-Diagnoses included heart failure, rhabdomyolysis (a breakdown of muscle tissue that released a damaging protein into the blood), hearing loss, type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), cognitive communication deficit (difficulty communicating), Bell's palsy (sudden weakness of muscles on one half of the face) kidney failure, and respiratory failure. Review of the resident's care plan, revised on 04/16/25, showed the following:-Resident has activities of daily living (ADL) functional problems as evidenced by the need for staff assistance with ADL's related to rhabdomyolysis;-Resident has communication problems as evidenced by impaired hearing. Resident does not wear hearing aids. Face the resident when speaking. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff), dated 05/14/25, showed the resident was cognitively intact. During an interview on 07/09/25, at 10:28 A.M., the resident said the following:-The facility lost $4,000.00 of his/her money. It just disappeared;-The facility replaced the $4,000.00 about two weeks ago;-The facility made him/her aware the money was missing about a month ago when he/she tried to get a partial withdrawal;-The facility staff talked him/her into keeping $5,000.00 originally in the business office for safe keeping;-The last time he/she withdrew any money was in January for $1,000.00, leaving $4,000.00. During an interview on 07/09/25, at 1:57 P.M., Certified Nurse Assistant (CNA) A said the following:-He/she would immediately notify the charge

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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 - 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 interview and record review, the facility failed to provide care per professional standards related to pressure ulcers (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for all residents when staff failed to provide wound care per physician orders, failed to update wound care orders, failed to complete full and timely assessments and monitoring of all wounds, and failed to care plan related to wounds for one resident (Resident #1) resulting in deterioration of two wounds and infection of one wound. The facility census was 46. Review of the facility policy titled, Wound Care Policy for Long-Term Care, undated, showed the following: -Purpose to ensure standardized, evidence-based would care practices that promote healing, prevent infections, and enhance quality of life for residents in long-term care settings; -This policy applied to all licensed nurses, wound care specialists, and relevant care staff providing wound care services to residents; -Conduct initial wound assessment within 24 hours of identification or admission; -Document wound location, size (length x width x depth), stage (for pressure injuries), exudate (drainage), wound bed, and perineal (peri- area between the anus and genitals) wound condition; -Reassess wounds at least weekly or per physician's orders; -Develop an individualized wound care plan addressing etiology, treatment goals, and prevention strategies; -Update care plan based on wound progress, resident response, or change in condition; -Select dressings based on wound type, exudate level, presence of infection, and goals of care; -Follow manufacturer instructions for use; -Record assessment findings, treatments, resident response, and any complications; -Maintain accurate and timely wound care records; -Wound care practices will be reviewed quarterly by the facility's wound care team. 1. Review of Resident #1's face sheet (brief resident profile) showed the following: -admission date of 11/22/23; (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 - Actual harm Residents Affected - Few	-Diagnoses include long term effects of a stroke, type II diabetes mellitus with other circulatory complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), cellulitis of right toe (skin infection), chronic pain, and hemiplegia and hemiparesis following stroke (muscle weakness or partial paralysis on one side of the body). Review of the resident's care plan, revised 10/01/24, showed the following: -Resident at risk for pressure ulcer injury as evidenced by need of staff to assist with mobility, history of stroke with left side weakness, incontinence of urine, and admitted with a pressure ulcer; -Staff to assist resident with turning/repositioning every two hours and as needed and assist with keeping resident clean and dry as possible; -Staff to conduct a systemic skin assessment weekly; -Staff to provide treatments per physician orders and assess and document pressure ulcer size, depth, and color weekly; -Staff to monitor for effectiveness of current treatment and notify physician if no improvement noted;. -External wound care provider referral as ordered and follow any recommendations; -Staff to use moisture barrier to perineal area as needed and report any signs or symptoms of skin breakdown to charge nurse. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool administered by staff), dated 02/26/25, showed the following: -Moderate cognitive impairment; -Partial to moderate assistance required with mobility and substantial to maximal assistance required with transfers; -At risk for pressure ulcers with no unhealed pressure ulcers, ulcers, wounds, or other skin problems. Review of the resident's current Physician Order Sheet (POS) showed an order, dated 02/28/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate (highly absorbent wound dressing from brown seaweed) to wound bed, cover with ABD (highly absorbent dressing) pad, and wrap with Kerlix (a brand of gauze bandage rolls) daily one time a day for wound care. Review of the resident's March 2025 Treatment Administration Record (TAR) showed the following: -An order, dated 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, and wrap with Kerlix change daily one time a day for wound care; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Staff did not document administering the treatment on 03/01/25 and 03/03/25. Review of the resident's record showed staff did not document regarding the missed treatments on 03/01/25 and 03/03/25. Review of the resident's Skin Observation Tool, dated 03/04/25, showed the following: -Right heel pressure sore measured 5 centimeters (cm) length, 4 cm width, and 0.25 cm depth. The wound was a stage three pressure wound (full-thickness loss of skin in which subcutaneous fat may be visible in the ulcer). Pressure sore to right heel had no exudate (drainage) and wound bed was pink; -Right gluteal fold pressure sore measured 0.75 cm length and 0.75 cm width with no depth noted. The wound was a stage two pressure wound (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer). Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's March 2025 TAR showed staff did not complete the ordered treatment to the resident's right heel on 03/05/25, 03/06/25, 03/07/25, 03/08/25, and 03/10/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 03/05/25, 03/06/25, 03/07/25, 03/08/25, and 03/10/25. Review of the resident's March 2025 TAR showed the following: -An order, dated 03/05/25, to apply wound cleanser and dressing to right gluteal pressure wound in the morning; -Staff did not document administering the treatment on 03/05/25, 03/06/25, 03/07/25, 03/08/25, and 03/10/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 03/05/25, 03/06/25, 03/07/25, 03/08/25, and 03/10/25. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's progress note, dated 03/10/25, from the wound care provider showed the following: -Wound to right heel had improved this week. Wound measured smaller with less drainage and good granulation tissue (fleshy, pinkish red tissue that forms during the wound healing process). Continue with same treatment of collagen (structural protein found in skin), calcium alginate, ABD pad, and change daily; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound image measurements of area of 4.7 square cm with perimeter of 9.8 cm, length 3.8 cm, width 1.9 cm, with no depth noted; -Granulation red or pink and bumpy 75%; -No slough (non-viable tissue); -Epithelial (final layer of skin during wound healing) 25%. (The wound care provider did not document regarding the wound on the right gluteal fold wound.) Review of the resident's March 2025 TAR showed staff did not complete the ordered treatment to the resident's right heel on 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, and 03/17/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25 and 03/17/25. Review of the resident's March 2025 TAR staff did not document administering the treatment to the resident's gluteal fold wound on 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25, and 03/17/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 03/11/25, 03/12/25, 03/13/25, 03/14/25, 03/15/25, 03/16/25 and 03/17/25. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's progress note, dated 03/17/25, from the wound care provider, showed the following: - Wound to right heel had deteriorated this week. Wound measured larger with increased drainage and small amount of nonviable tissue noted. Good granulation tissue noted. Continue with same treatment of collagen, calcium alginate, ABD pad, and change daily; -Wound image measurements were area of 6.6 square cm with perimeter of 12.6 cm, length 1.9 cm, width 4.8 cm and max depth 0.3 cm; -Granulation 75%; -Slough 25%. (The wound care provider did not document regarding the wound on the right gluteal fold.) Review of the resident's March 2025 TAR showed staff did not document completing the ordered treatment to the right heel on 03/19/25, 03/20/25, 03/21/25, 03/22/25, and 03/23/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 03/19/25, 03/20/25, 03/21/25, 03/22/25, and 03/23/25. Review of the resident's March 2025 TAR showed staff did not document completing the order treatment to the right gluteal pressure wound on 03/19/25, 03/20/25, 03/21/25, and 03/22/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 03/19/25, 03/20/25, 03/21/25, and 03/22/25. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's progress note, dated 03/24/25, from the wound care provider, showed the following: -Wound to right heel had improved measuring smaller with less drainage and good granulation tissue; -Wound image measurements were area 5.5 square cm, with perimeter 11.6 cm, length 4.6 cm, width 1.7 cm, and max depth 0.2 cm; -Granulation 80%; -Slough 20%. (The wound care provider did not document regarding the wound on the right gluteal fold.) Review of the resident's March 2025 TAR showed staff did not document completing the ordered wound care for the right heel on 03/25/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, and 03/31/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 03/25/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, and 03/31/25. Review of the resident's March 2025 TAR showed staff did not document completing the ordered wound care for the right gluteal pressure wound on 03/25/25, 03/26/25, 03/27/25, 03/29/25, and 03/31/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 03/25/25, 03/26/25, 03/27/25, 03/29/25, and 03/31/25. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's progress note, dated 03/31/25, from the wound care provider, showed the following: -Wound to right heel had improved measuring smaller with less drainage and good granulation tissue; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound image measurements of area 4.5 square cm with perimeter 9.6 cm, length 4.0 cm, width 1.8 cm, and max depth 0.2 cm; -Granulation 50%; -Epithelial 50%; (The wound care provider did not document regarding the wound on the right gluteal fold.) Review of the resident's April 2025 TAR showed the following: -An order, dated 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, and wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/03/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/03/25. Review of the resident's April of 2025 TAR showed the following: -An order, dated 03/05/25, to apply wound cleanser and dressing to right gluteal pressure wound in the morning; -Staff did not document administering the treatment on 04/03/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/03/25. Review of the resident's progress note, dated 04/07/25, from the wound care provider showed the following: -Wound to right heel had deteriorated measuring larger with increased drainage and nonviable tissue noted. Nonviable tissue required debridement and resident tolerated procedure well. Change treatment to Santyl nickel (an enzyme that removes dead tissue from wounds) thick in wound bed, calcium alginate, ABD pad, Kerlix, and change daily. Will reassess next week; -Wound image measurements of area 5.7 square cm with perimeter 11.3 cm, length 3.8 cm, width 2.3 cm, max depth 0.1 cm; -Granulation 40%; -Epithelial 50%; -Eschar 10% (dead tissue). (The wound care provider did not document regarding the wound on the right gluteal fold). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actually skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's April 2025 TAR showed staff did not enter the new order from the wound care provider to change the treatment to Santyl nickel thick in wound bed, calcium alginate, ABD pad, Kerlix, and change daily. Review of the resident's April 2025 TAR showed the following: -An order, dated 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/08/25 and 04/09/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/08/25 and 04/09/25. Review of the resident's April of 2025 TAR showed staff did not document completing the ordered wound tratement to the right gluteal fold wound on 04/08/25 and 04/09/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/08/25 and 04/09/25. Review of the resident's Skin Observation Tool, dated 04/10/25, showed the following: -Right heel pressure sore measured 5 cm length, 4 cm width, and 0.25 cm depth. The wound was a stage three (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure sore. The pressure sore to right heel was pink; -Right gluteal fold pressure sore 0.75 cm length, 0.75 cm width, with no depth noted. Wound was a stage two pressure sore. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actual skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's April 2025 TAR showed the following: -An order, dated of 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/13/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/13/25. Review of the resident's April 2025 TAR showed staff did not document completion of the order treatment to the resident's gluteal fold on 04/13/25 Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/13/25. Review of the resident's progress note, dated 04/14/25, from the wound care provider, showed the following: -Wound to right heel had improved measuring smaller, with less drainage and good epithelial tissue. Will change treatment to calcium alginate, ABD pad, Kerlix, and change daily; -Wound image measurements of area 2.8 square cm with perimeter 7.2 cm, length 2.7 cm, width 1.2 cm, and max depth 0.2 cm; -Granulation 40%; -Epithelial 60%. (The wound care provider did not document regarding the wound on the resident right gluteal fold.) Review of the resident's April 2025 TAR showed the following: -An order, dated of 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/19/25 and 04/20/25, Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/19/25 and 04/20/25. Review of the resident's April 2025 TAR showed staff did not document administering the treatment to the gluteal fold on 04/19/25 and 04/20/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/19/25 and 04/20/25. Review of the resident's progress note, dated 04/21/25, from the wound care provider, showed the following: -Wound to right heel deteriorated in measurements with moderate drainage and nurse reported an odor. Non-viable tissue noted. Due to not being able to debride, will recommend Santyl ointment nickel thick to the wound bed daily x 1 week and calcium alginate; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound image measurements of area 12.60 square cm with length 3 cm, width 4.2 cm, and max depth 0.2 cm; -Granulation 20%; -Slough 75% -Eschar (dead or devitalized tissue that is hard or soft in texture) 5%; (The wound care provider did not document regarding the wound on the resident's right gluteal fold.) Review of the resident's April 2025 TAR showed staff did not enter the new order from the wound care provider to change the treatment to Santyl nickel and calcium alginate for one week. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actual skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's April 2025 TAR showed the following: -An order, dated of 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, and wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/23/25 and 04/26/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/23/25 and 04/26/25. Review of the resident's April of 2025 TAR showed staff did not complete the treatment to the resident's right gluteal pressure on 04/23/35 and 04/26/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/23/25 and 04/26/25. Review of the resident's progress note, dated 04/28/25, from the wound care provider, showed the following: -Wound to right heel had deteriorated, measuring larger, with increased drainage and non-viable tissue noted. Strong foul odor noted. Incorrect dressing on and unsure when it was last changed. Tissue culture acquired and sent to lab. Non-viable tissue required debridement. Resident tolerated procedure well. Ensured nursing staff had correct dressing orders. Will continue same treatment of Santyl nickel thick in wound bed, calcium alginate, ABD pad, Kerlix, and change daily. Will reassess next week; -Wound image measurements of area 8.7 square cm with perimeter 12.2 cm, length 4.4 cm, width 2.4 cm, and no depth noted; (continued on next page)

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	265577	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshfield Care Center for Rehab and Healthcare	800 South White Oak Marshfield, MO 65706

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Granulation 10%; -Slough 60% -Eschar 30%; (The wound care provider did not document regarding the wound on the right gluteal fold.) Review of the resident's April 2025 TAR showed staff did not enter the new order from the wound care provider to change the treatment to Santyl nickel and calcium alginate for one week. Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actual skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's current POS showed an order, dated 04/26/25, for external wound care provider to evaluate and treat for wound on buttocks (gluteal fold). Review of the resident's April 2025 TAR showed the following: -An order, dated of 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/27/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/27/25. Review of the resident's April 2025 TAR showed the following: -An order, dated 03/05/25, to apply wound cleanser and dressing to right gluteal pressure wound in the morning; -Staff did not document administering the treatment on 04/27/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/27/25. Review of the resident's current POS showed an order, dated 04/28/25, for right heel wound culture. Review of the resident's April of 2025 TAR showed staff did not document administering the treatment to the resident's gluteal fold on 04/30/35. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's gluteal fold on 04/30/25. Review of the resident's April 2025 TAR showed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-An order, dated of 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 04/30/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 04/30/25. Review of the resident's progress note, dated 05/05/25, from the wound care provider, showed the following: -Resident not feeling well; -New wound to right buttock; -Started doxycycline (antibiotic) for leg wound infection; -No culture of buttock had been done; -Resident complained of pain in buttock; -Upon rolling resident large amount of foul, purulent (pus discharge) drainage; -Dressing removed to open wound to abscess, copious amount of drainage expulsed, and wound bed deep; -Recommend for resident to be sent out for evaluation due to deteriorating status, needs cultures, x-ray with possible CT scan or MRI. Review of the resident's hospital progress notes, dated 05/07/25, showed the following: -Resident admitted on [DATE] from long term care for worsening chronic wounds to right buttock and right heel; -Evidence of tunneling (type of wound that extends deeper in the tissue than its surface) abscess noted to buttock with purulent drainage; -Surgery team consulted, taken to operating room for incision and drainage on 05/06/25; -Intravenous antibiotics with Cefepime and vancomycin (a common combination of broad-spectrum antibiotics used to treat suspected bacterial infections, particularly in hospitalized patients); -Wound care following for heel wound, plans to follow up in clinic at time of discharge; -Wound cultures obtained in emergency. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's current care plan, last revised 10/01/24, showed staff did not update the resident's care plan to reflect the actual skin breakdown and treatments for heel and gluteal fold wounds. Review of the resident's May 2025 TAR showed the following: -An order, dated 03/01/25, to cleanse right heel with wound cleanser, skin prep peri wound, apply alginate to wound bed, cover with ABD pad, wrap with Kerlix change daily one time a day for wound care; -Staff did not document administering the treatment on 05/10/25. Review of the resident's record showed staff did not document regarding the missed treatments to the wound on the resident's heel on 05/10/25. Review of the resident's progress note dated 05/12/25, from the wound care provider, showed the following: -Resident lying comfortably in bed upon entering room; -Rounded with floor nurse. Resident sleeping during visit. Recently had incision and drainage performed from an abscess noted last week to sacrum (a triangular bone in the lower back) resident was placed on oral Bactrim for treatment by hospital; -Right heel had also improved this week. Will continue same treatment with same changing frequency; -Will continue wet to dry on sacrum and reassess next week; -Right heel wound image measurements of area 4.9 square cm with perimeter 8.9 cm, length 2.0 cm, width 2. 5 cm, no depth noted, granulation 10%, and epithelial 90%; -Sacrum wound image measurements of area 10.6 square cm with perimeter 13.3 cm, length 3.0 cm, width 5. 2 cm, and no depth noted. During an interview on 05/16/25, at 10:34 A.M., Nurse Assistant (NA) D said staff should report any skin changes to the charge nurse. He/she was aware of the resident's abscess a day or two before he/she was sent out and encouraged the resident to switch from the bed to chair. During an interview on 05/16/25, at 10:48 A.M., Certified Nurse Assistant (CNA) C said staff should report any skin changes to the charge nurse. He/she noticed the resident had a small spot on his/her right buttock and was aware the wound nurse was providing treatment. During an interview on 05/16/25, at 11:03 A.M., Licensed Practical Nurse (LPN) B said the following: -He/she was hired as the wound care nurse; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Staff should document providing wound care in the TAR per physician orders and should document if unable to provide wound care with the correct code. If not documented, staff did not provide the treatment; -The TAR should not have blanks for wound care; -The resident had a wound to the right heel and a small pressure ulcer on the right buttock toward the end of March 2025; -The resident had an order to treat the right buttock with daily cream and gauze; -Nurses provide the same care as the the wound provider including taking pictures with a camera that measures the wounds; -Nurses should complete skin assessments weekly for every resident, including measurements; -The wound care provider should be providing care for all wounds on a resident under their care. During an interview on 05/16/25, at 12:40 P.M., Family Nurse Practitioner (FNP) E said the following: -He/she provided weekly wound care for the resident, including the right heel wound; -He/she did not know about the wound to the right buttock until 05/05/25, when the nurse said the resident was not feeling well. He/she was shown the wound to the right buttock, which looked like an abrasion with a little scab and was draining from the middle and from the side. He/she lanced it and notice purulent drainage with a foul smell, unsure how deep, but did not occur overnight; -There have been multiple issues with the facility staff not changing dressings, and he/she knows this was the case when the wound was not getting better. The resident's right heel worsened due to facility staff not changing dressings; -The wound dressings don't have dates on them at times or have the incorrect dressings; -He/she does not have access to the residents' physician orders and depends on staff to advise of orders. During an interview on 05/16/25, at 2:22 P.M., the MDS Coordinator said the following: -The wound care provider treated all resident wounds over stage II; -The wound care provider treated all wounds of a resident while under their care except for surgical wounds; -Staff should document providing wound care per physician order in the TAR and should document if unable to provide the wound care as well; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The week before the resident was sent out the shower aide called her into the shower room to look at the buttock. The area was hard, not opened with a couple little spots like a pressure ulcer or maybe deep tissue wound; -She was unaware the resident had a right gluteal/buttock wound in March of 2025; -He/she did not know if wound care was completed per physician order for the resident; -She did not know if the external wound care provider was treating the resident's right gluteal wound. During an interview on 05/16/25, at 3:04 P.M., the Assistant Director of Nursing (ADON) said the following: -Nurses were responsible for wound care for residents; -Nurses should complete weekly skin assessments on all residents, including wound measurements; -The wound care provider treated resident wounds every Monday at the facility; -The wound care provider should be notified of any new wounds; -The wound care provider treated all wounds of residents under their care except surgical; -Staff should document wound treatments in the TAR and/or reason not provided; -She was not aware of the resident's wound to the right buttock until the day he/she was sent to the hospital for the abscess; -Staff should change wound dressings per physician order. During an interview on 05/16/25, at 3:41 P.M., the Administrator said the following: -Staff should complete a skin assessment upon admission of a resident, and she is unsure of how frequently after admission; -Staff should document all wound care treatments on the TAR and/or if unable to provide the treatment; -Staff should follow physician orders for wound care treatments and notify the external wound care provider of any new orders or wounds. MO00254120

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and maintain an effective infection control program when staff failed to perform hand hygiene and failed to follow Enhanced Barrier Precautions (EBP - infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) while providing wound care for three residents (Residents #1, #2, and #3). The facility also failed to ensure staff were trained on EBP and EBP supplies and signage were available. The facility census was 46. Review of the facility policy titled Hand Hygiene, dated 04/28/22, showed the following: -The facility will provide guidelines to employees on proper handwashing and hand hygiene techniques that will aid in the prevention of the transmission of infections; -Hand hygiene should be performed before/after providing care; -Hand hygiene should be performed before/after performing aseptic task; -Hand hygiene should be performed when in contact with blood, body fluids, or contaminated surfaces; -Hand hygiene should be performed before/after applying/removing gloves and personal protective equipment; -Hand hygiene should be performed after handling soiled lines/items potentially contaminated with blood, body fluids, or secretions; -Employees will perform handwashing with soap and water when hands are visibly soiled; -Employees may use an alcohol-based hand rub when hands are not visibly soiled. Review of the facility policy titled Infection Control Policy, undated, showed the following: -The purpose of the policy was to prevent and control the spread of infections within the facility, ensuring a safe environment for residents, staff, and visitors by implementing evidence-based practices; -All staff are responsible for complying with infection control procedures and reporting infections or breaches; -All staff must follow standard precautions at all times. This includes hand hygiene before and after resident contact or contact with potentially infectious material and the use of personal protective equipment such as gloves, gowns, masks, or eye protection as appropriate; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When standard precautions are not sufficient use transmission-based precautions, which includes contact precautions for infections such as Methicillin-resistant Staphylococcus aureus (MRSA-a type of staph bacteria that is resistant to many antibiotics) or (C. difficile- inflammation of the colon caused by bacteria); -Signage will be placed to alert staff and visitors to required transmission-based precautions; -With resident care practices follow appropriate wound, catheter, and respiratory protocols; -Maintain proper environmental hygiene in resident rooms and common areas. Review of the facility policy titled Wound Care policy for Long-Term Care, undated, showed the following: -The purpose of the policy was to ensure standardized, evidence-based wound care practices that promoted healing, prevented infection, and enhanced the quality of life for residents in long-term care settings; -Use aseptic technique when applying or changing dressings; -For infection control follow standard and transmission-based precautions; -Perform hand hygiene before and after dressing changes; -Dispose of waste according to infection control protocols. Review of the Centers for Disease Control and Prevention (CDC)'s Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/24, showed the following: -MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs; -EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO; -Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care; -Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care (use of central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care (any skin opening requiring a dressing). -When implementing contact precautions or EBP, it was critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use; -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g., gown and gloves); -For EBP signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves; -Make PPE, including gowns and gloves, available immediately outside of the resident room Review of the facility policy titled Barrier Precautions Policy for Long-Term Care, undated, showed the following: -The purpose of the policy was to reduce the risk of transmission of infectious agents, especially MDROs, among residents and healthcare personnel in long-term care settings through the consistent application of evidence-based barrier precautions; -The facility shall implement standard transmission-based barrier precautions, guided by the latest CDC and World Health Organization recommendations, for the prevention and control of infectious diseases in residents; -With standard precautions, perform hand hygiene before and after resident contact, after contact with potentially infectious material, and before donning and after removing gloves; -Use gloves when touching blood, body fluids, mucus membranes, non-intact skin, and contaminated surfaces; -Use gowns, masks, and eye protection based on anticipated exposure; -Clean and disinfect equipment and surfaces routinely and between uses; -For transmission-based precautions, contact precautions include wearing a gown and gloves before entering the room, dedicated resident-care equipment, and prioritized room placement; -Individualized risk assessments should guide the use of precautions to balance infection control with resident quality of life. Residents with cognitive impairments or those requiring frequent hands-on care may need enhanced precautions and staff training; -Staff education and compliance include initial staff education and annual training on infection control and use of personal protective equipment, competency assessments on donning and doffing, ongoing compliance audits with feedback. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admission date of 11/22/23; -Diagnoses include long term effects of a stroke, type II diabetes mellitus with other circulatory complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), cellulitis of right toe (skin infection), depression, chronic pain, hemiplegia and hemiparesis following stroke (muscle weakness or partial paralysis on one side of the body), aphasia following stroke (language disorder caused by damage to the brain. Review of the resident's care plan, last revised on 10/01/24, showed the following: -Resident had bowel and bladder incontinence and will remain clean and dry daily with staff assistance; -Staff will provide incontinence care after each incontinent episode, apply moisture barrier to skin, and use incontinence briefs as needed; -Staff will provide routine toileting upon rising, before and after meals, at bedtime, and as needed. -Resident at risk for pressure ulcer injury as evidenced by need of staff to assist with mobility, history of stroke with left side weakness, incontinence of urine and admitted with a pressure ulcer; -Use moisture barrier to perineal area as needed and report any signs or symptoms of skin breakdown to charge nurse. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool administered by staff), dated 02/26/25, showed the following: -Moderate cognitive impairment; -Partial to moderate assistance required with mobility and substantial to maximal assistance required with transfers; -Always incontinent of bladder and bowel; -At risk for pressure ulcers with no unhealed pressure ulcers, ulcers, wounds, or other skin problems. Observations on 05/15/25, at 11:13 A.M., showed the following: -A cart was located outside the resident's room with gowns and gloves in it. There was no enhanced-barrier precautions sign posted outside the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Licensed Practical Nurse (LPN) A gathered all dressing change supplies and wound care treatments from the treatment cart in the hall. LPN A entered the resident's room and placed the hall treatment cart tablet, wound care cleanser, and supplies on the resident's bedside table. (The LPN did not place a barrier to prevent the supplies from possible contamination from the beside table.); -The MDS Coordinator entered the room to assist LPN A during the wound care; -LPN A and the MDS Coordinator applied gloves and a gown without completing hand hygiene. LPN A said they were wearing gowns and gloves due to the resident having MRSA (methicillin-resistant staphylococcus aureus infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) in the buttock wound and finishing antibiotics; -LPN A and the MDS Coordinator assisted the resident with rolling to his/her left side. The resident's incontinence brief was noted to be wet with urine and soiled with feces from a large bowel movement; -The MDS Coordinator continued to assist the resident with staying on his/her side and LPN A removed the soiled incontinence pad and placed it in the resident's trash can;. -LPN A used wipes available in the resident's room to clean the urine and feces from his/her buttocks and peri area; -The right buttock dressing was in place and contained a moderate amount of tan drainage; -A large amount of feces was noted at the bottom edge of the buttock dressing; -LPN A continued to use multiple wipes to clean the urine and feces from the resident's buttocks and peri area; -LPN A removed the buttock dressing and placed it in the resident's trash can; -He/she removed his/her gloves and placed them in the trash and applied new gloves without performing hand hygiene; -LPN A grabbed the wound cleanser bottle from the resident's bedside table that he/she brought into the room from the treatment cart in the hall and placed the bottle on the resident's bed (The LPN did not place a barrier to prevent the supplies from possible contamination from the bed.); -The right buttock wound had packing in place that was dried on the wound tissue. LPN A sprayed the packing with the wound cleanser; -Upon placing the wound cleanser bottle back on the bed, the wound cleanser bottle fell onto the floor in the resident's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN A picked the wound cleanser bottle up off the floor and placed it back on the bed without cleansing the bottle or completing hand hygiene or changing gloves. LPN A bumped the bedside table that had sealed dressing supplies on it and one sealed dressing fell on the floor. He/she picked the sealed dressing up off the floor and placed it on the resident's bed for use. LPN A did not clean the sealed package, complete hand hygiene, or change his/her gloves after picking the dressing up off the floor; -LPN A sprayed the buttock wound packing with the wound cleanser a second time, removed the packing, and threw it in the trash can. LPN A changed his/her gloves and did not complete hand hygiene; -LPN A used the bottle of wound cleanser to moisten gauze and he/she repacked the wound; -The MDS Coordinator and LPN A changed their gloves and applied new gloves without completing hand hygiene; -LPN A applied an alginate dressing over the buttock wound packing along with an ABD pad (a large pad used for wound care) and secured the ABD pad with tape; -The MDS Coordinator and LPN A changed the resident's sheets and applied a new incontinence pad; -Without completing hand hygiene, or changing his/her gloves, LPN A removed the resident's outer layer right heel dressing; -LPN A changed his/her gloves, and sprayed the smaller right heel dressing with wound cleanser to loosen the dressing from the skin and remove it; -LPN A A changed his/her gloves without completing hand hygiene. He/she cleansed the right heel wound with gauze soaked in wound cleanser, dried the area, and applied a new dry dressing secured with an ABD pad and kerlix (a type of gauze bandage roll used in wound care); -The roll of tape that LPN A took into the room from the hall treatment cart fell in the floor. He/she picked it up off the floor and placed it on the resident's bed (no barrier); -LPN A applied new gloves without completing hand hygiene. The nurse sprayed wound cleanser on the left ankle wound to help loosen it prior to removing it and placing it in the trash; -He/she did not apply new gloves or complete hand hygiene. LPN A cleansed the resident's left ankle wound with wound cleanser, applied gauze to the area that was soaked with wound cleanser, covered it with a dry dressing, applied an ABD pad to the area, and secured it with Kerlix. -Without removing his/her gloves and gown or performing hand hygiene, LPN A gathered up all the package and unused wound care supplies and bottle of wound cleanser and placed them on the resident's bedside table (no barrier); -LPN A picked up the unused wound care supplies and bottle of wound care spray from the bedside table and carried them out of the room and placed them on top of the hall treatment cart; (continued on next page)

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	265577	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshfield Care Center for Rehab and Healthcare	800 South White Oak Marshfield, MO 65706

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurse used alcohol wipes located on the treatment cart to wipe off the hall treatment cart tablet, and wound cleanser bottle that has been in the resident's room; -He/she placed the unused dressing supplies back in the treatment cart located in the hallway. During an interview on 05/16/25, at 10:34 A.M., Nurse Aide (NA) D said the following: -He/she used gloves and a gown while providing care to the resident because the resident had MRSA and was on isolation; -Staff were supposed to be wearing a mask, goggles, gloves, and a gown while caring for the resident. During an interview on 05/16/25, at 10:48 A.M., Certified Nurse Aid (CNA) C said the following: -The resident had a wound on the right side of his/her buttocks; -Staff tried to do his/her wound care during the morning shift; -The resident is on isolation. He/she thought the isolation was due to a diagnosis of MRSA; -He/she wore a gown, gloves, and mask while providing care to the resident. During an interview on 05/16/25, at 11:03 A.M., LPN B said the following: -The resident had a wound on his/her right heel; -LPN B thought the resident's right heel had MRSA in it and felt like the MRSA traveled to his/her buttock wound; -He/she wears gloves at all times while changing the resident's dressings; -Staff were to wear gloves and a mask while providing care to the resident. During an interview on 05/16/25, at 1:36 P.M., LPN A said the following: -LPN A thought the resident's buttock wound was positive for MRSA; -He/she thought the resident received an IV antibiotic for MRSA. During an interview on 05/16/25, at 2:21 P.M., the MDS Coordinator said the following: -The resident developed a pressure ulcer on his/her buttocks approximately the week before his/her hospitalization; -The resident had MRSA in his/her buttock wound, but he/she is not sure if the resident's other wounds have MRSA; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she did not observe any hand washing by LPN A while they were in the the resident's room cleaning the resident up after an incontinent bowel movement or before, during, or after the multiple dressing changes. During an interview on 05/16/25, at 3:00 P.M., the Assistant Director of Nursing (ADON) said the following: -He/she was aware of the resident's buttock wound/abscess; -The ADON is not sure if resident had a diagnosis of MRSA. 2. Review of Resident #2's face sheet (brief information sheet about the resident) showed the following: -admission date of 04/18/25; -Diagnoses included diffuse large B-cell lymphoma (a cancer that starts in the lymphatic system), unspecified protein-calorie malnutrition (a condition that occurs when the body does not receive or absorb enough nutrients to maintain health), acute (sudden) kidney failure, critical illness myopathy (a serious complication of critical illness that causes widespread muscle weakness), and thrombocytopenia (low platelet level). Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Dependent with toileting hygiene, lower body dressing, and chair/bed to chair transfer; -Substantial to maximal assistance with showering/bathing, and rolling left to right; -Always incontinent of urine and stool; -Moisture associated skin damage; -Pressure ulcer care; -Surgical wound care; -Application of nonsurgical dressings; -Skin and ulcer treatment application of ointments/medications. Review of the resident's care plan, updated 04/20/25, showed the following: -Required assistance with activities of daily living related to immobility; -Required substantial assistance with bed mobility; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dependent for toileting and transfers; -Max assist for showers and hygiene; -Change dressings per physician's order. Observations on 05/15/25, at 12:37 P.M., showed the following: -No enhanced-barrier precautions sign posted outside the resident's door and no personal protective equipment cart outside the resident's room; -LPN A gathered the wound care supplies from the treatment cart in the hallway. LPN A utilized hand sanitizer and applied gloves; -There was no dressing over the coccyx (tailbone) wound; -Certified Nurse Aide (CNA) F reported that the dressing came off while staff was changing the resident's soiled brief just prior to the LPN entering the room to complete the dressing change. He/she reported that the dressing had green and bloody drainage on it; -LPN A cleansed the wound with wound cleanser and changed his/her gloves. He/she did not perform hand hygiene. LPN A packed the tunneling area of the wound and then filled in the rest of the wound bed with packing. An ABD pad was placed over the wet to dry packing and it was taped in place; -LPN A removed his/her gloves and cleansed his/her hands with hand sanitizer; -When the nurse moved away from the resident's bed, he/she bumped the small refrigerator/freezer that a small cup which contained gauze soaked with wound cleanser was sitting on and the cup with the soaked gauze fell onto the floor. LPN A picked the cup up off the floor and put it back on the refrigerator/freezer; -LPN A put gloves on without performing hand hygiene; -With the new gloves on, the nurse grabbed the resident's bed control device and lowered the head of the resident's bed; -LPN A removed the resident's feeding tube dressing without difficulty; -Per the resident's request, LPN A soaked the midline abdominal dressing with wound cleanser to assist with removal of the dressing; -After removing the dressing, LPN A removed his/her gloves and did not perform hand hygiene; -LPN A applied new gloves and cleansed the midline abdominal incision and the wound cleanser; -The resident touched the midline abdominal incision and the feeding tube area, so LPN A recleaned both areas with Vashe wound cleanser; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN A removed his/her gloves and used hand sanitizer; -The nurse applied a dry dressing to the feeding tube site; -LPN A removed his/her gloves and put on a new pair of gloves without performing hand hygiene; -He/she soaked gauze in the wound cleanser and packed the midline abdominal wound with it. He/she applied an ABD pad over the wet gauze. During an interview on 05/16/25, at 10:48 A.M., Certified Nurse Aid (CNA) C said he/she was aware that the resident had a dressing on their buttock. He/she wore gloves while providing care to the resident, but he/she did not wear a gown. 3. Review of Resident #3's face sheet (brief information sheet about the resident) showed the following: -admission date of 05/01/25; -Diagnoses included MRSA infection, acute congestive heart failure, anxiety, and hypertension (high blood pressure). Observations on 05/15/25, at 10:48 A.M., showed the following: -No enhanced-barrier precautions sign posted outside the resident's door and no personal protective equipment cart outside the resident's room; -LPN A prepared wound care supplies at the treatment cart in the hallway for the resident; -He/she sprayed wound cleanser on gauze and put into a clean cup; -The nurse entered the resident room with prepared supplies and a bottle of wound cleanser from the treatment cart; -He/she placed all supplies on the resident's bedside table (no barrier); -The nurse applied gloves in room without performing hand hygiene; -The nurse removed the non-saturated dressing and put it in the resident's trashcan. He/she removed gloves and disposed of them in the trash can; -LPN A applied new gloves without performing hand hygiene. LPN A wiped the resident's left buttock wound with wound cleanser on the prepared gauze and patted it dry with dry gauze. He/she applied ointment to the bilateral buttock redness and scabbed area on the resident's left buttock. LPN A applied a boarder gauze dressing and secured it to the skin with tape. He/she removed his/her gloves and disposed of them in the trash can; -LPN A did not perform handy hygiene prior to leaving the resident's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she took the wound cleanser bottle from the resident's bedside table and placed it back on the treatment cart in the hallway without cleaning it. 4. During an interview on 05/16/25, at 10:34 A.M., Nurse Aide (NA) D said the following: -He/she was not familiar with what EBP were; -He/she washes his/her hands before and after resident care and wears gloves while providing resident care. During an interview on 05/16/25, at 10:48 A.M., Certified Nurse Aid (CNA) C said the following: -He/she was not aware of what EBP meant; -He/she used hand sanitizer and applied gloves prior to providing incontinence care; -He/she washed his/her hands upon leaving the resident's room. During an interview on 05/16/25, at 11:03 A.M., LPN B said the following: -He/she was the wound care nurse; -During dressing changes, he/she washed his/her hands, put on gloves, took off the dressing, washed his/her hands again, and put new gloves on to apply a new dressing; -After the dressing was changed, he/she took his/her gloves off and washed his/her hands; -While at the treatment cart, he/she used hand sanitizer prior to handling dressing change supplies; -With multiple wounds, LPN B washed his/her hands before moving to the next wound for a dressing change; -If a resident has a bowel movement while changing a dressing, he/she would change the soiled incontinence pad first, then complete hand hygiene and change his/her gloves; -Wound supplies were kept in a supply room and on the treatment cart in the hall; -Wound treatment supplies were used for all residents; -If wound supplies were taken into a room of a resident with MRSA, the supplies should be left in the room or thrown away; -The hand sanitizer was shared between staff, so it should be left outside the resident's room; -The facility had one bottle of wound cleanser that was used for all residents, so it should not be taken into a resident's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff know residents are on isolation precautions by the supply cart that is located outside a resident's room; -He/she always used gloves and hand hygiene with wound care procedures; -LPN B has not received any EBP training in the facility. He/she did not know what EBP meant; -The facility did not have any EBP signs that he/she was aware of; -Nursing staff communicate during shift change if a resident is MRSA positive; -If wound care supplies are dropped on the floor, they should be put in the trash and new supplies obtained; -If the wound cleanser bottle is dropped on the floor, he/she would get a new bottle or clean the bottle that was dropped on the floor with alcohol wipes; -He/she prevented contamination of wound care supplies by only taking the supplies that are needed into the resident's room. During an interview on 05/16/25, at 1:36 P.M., LPN A said the following: -His/her normal job was charge nurse, but he/she provided wound care infrequently; -Gloves should be applied after completing hand hygiene; -If he/she had to touch or move a resident, he/she will put gloves on; -He/she would change his/her gloves after changing a dirty dressing; -LPN A would change his/her gloves after cleaning a resident up or changing them; -He/she would put on new gloves to change a dressing after cleaning a resident up; -Hand hygiene should be done before and after each procedure; -Hand sanitizer should be used in between glove changes; -Hand washing with soap and water should be completed before and after each procedure; -Wound care supplies come from a supply room and are stocked on treatment cart in the hall; -He/she used the same bottle of wound care cleanser for all residents with wounds; -All wound care supplies were shared between residents. No resident has their own wound supplies; -If he/she takes extra wound care supplies into a resident's room and they are not used, he/she takes the unused supplies out of the room and places them back in the treatment cart in the hallway; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a wound care supply was opened in a resident room, but not used, he/she would leave the item in the room to use for the next dressing change or throw it away; -Extra wound care supplies should not be taken into a resident's room who is diagnosed with MRSA; -If extra supplies were taken into the room, they should stay in the room and not be put back on the treatment supply cart; -Wound care supplies that are dropped on the floor should be tossed in the trash; -LPN A was not familiar with EBP and he/she did not know what it meant; -He/she had not received any in-services at the facility regarding EBP; -If he/she was caring for a resident with MRSA, he/she would wear a gown, gloves, and mask; -The facility should have a sign posted outside resident rooms for things like MRSA. During an interview on 05/16/25, at 2:21 P.M., the MDS Coordinator said the following: -He/she did not know what EBP meant; -Staff had not received any in-services on EBP; -He/she was not sure how staff would know if a resident had EBP in place; -The MDS Coordinator believed there should be an EBP sign outside the resident's room; -Staff should wash their hand when entering and exiting a resident's room; -Staff should wash their hands in between caring for residents; -If a resident has MRSA, staff should not take supplies into the room and bring them back out; -Supplies that are dropped on the floor should be tossed in the trash. During an interview on 05/16/25, at 3:00 P.M., the Assistant Director of Nursing (ADON) said the following: -When changing wound dressings, staff were expected to wash their hands and wear gloves; -Staff were expected to wash their hands in between residents, before starting any care with a resident, and after taking their gloves off; -Staff were expected to wash their hands after cleaning a resident up following a bowel movement; -Staff were expected to wash their hands after they take their personal protective equipment/gown off; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A resident that was diagnosed with MRSA should have their own wound care dressing supplies and wound care cleanser bottle in their room; -Staff should not take wound care supplies in the room of a resident diagnosed with MRSA and bring the supplies back out of the room; -It was not acceptable to drop wound supplies on the floor and then use them; -It was not acceptable to lay wound care supplies on a resident's bed and then use the supplies on a resident in another room; -The facility should have more residents on EBP than they do; -Residents with EBP should have a cart outside their room stocked with gowns and gloves. They should also have a sign posted outside their room that identifies them as being on EBP; -When a resident had multiple wounds, staff should clean and dress the dirtiest wounds first and the cleanest wounds last; -If supplies were dropped on the floor they should be discarded or thrown away, not used on residents; -It was not appropriate for staff to take wound care supplies into a resident's room who has been diagnosed with MRSA and bring the supplies back out of the room. During an interview on 05/16/25, at 3:40 P.M., the Administrator said the following: -EBP should be used for any resident that has a wound; -Staff were expected to wear a gown and gloves with direct resident care; -Every resident with a wound should have their own wound care supplies in their room; -He/she was unsure if residents on EBP should have a sign placed outside their room alerting staff and visitors; however, he/she did not know how staff would know about the EBP otherwise; -Staff would know if a resident were on isolation by the isolation prevention cart being present outside the residents room; -He/she expected staff to wear a gown and gloves while caring for residents with MRSA and wounds; -He/she expected staff to use hand hygiene when they enter a resident's room or change their gloves; -He/she expected staff to wash their hands prior to leaving a resident's room; -In between glove changes, he/she expected staff to wash their hands or use hand sanitizer; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/she expected staff to throw away wound care supplies that were dropped on the floor, and get new supplies; -If a wound care cleanser bottle was taken into a resident's room that was diagnosed with MRSA, the bottle should stay in the room, rather than remove it from the room and sanitize it; -He/she expected residents on isolation to have their own equipment and supplies and not share them with other residents. MO00254120