STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure all allegations of physical abuse were reported immediately to facility management and to the State Survey Agency (Department of Health and Senior Services - DHSS) within the required time frame when staff failed to report an allegation of abuse involving one resident (Resident #1) until the following day. The facility census was 63. Review of facility policy titled Abuse, Prevention, and Prohibition Policy, dated December 2024, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion; -Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other resident, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals; -This presumes that all instances of abuse, even those in a coma, can cause physical harm, pain, or mental anguish; -Resident abuse must be reported immediately to the Administrator; -The facility employee who becomes aware of abuse shall immediately report the matter to the facility Administrator or the designated representative; -The facility Administrator, employee, or agent who is made aware of any allegation of abuse or neglect shall report to the mandated state agency per reporting criteria; -The allegation will be reported no later than 2 hours, or per state regulations, after the allegation is made. 1. Review of Resident #1's face sheet (gives basic profile information at a glance) showed the following information: -admission date of 10/15/24; -Diagnoses included left-sided weakness and paralysis following stroke, anxiety disorder, major depressive disorder, insomnia, dementia, constipation, high blood pressure, and bladder disorder. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/20/25, showed the following: -Mildly impaired cognition; -Functional limitation in range of motion of upper extremity one side and lower extremity bilateral; -Utilized a manual wheelchair; -Dependent on staff for toileting, showers/bathing, dressing, and bed mobility; -Required substantial to maximum assistance for moving from sitting on the edge of the bed to lying, lying to sitting up to edge of the bed, sitting to standing, and transfers from chair to bed/bed to chair. Review of the resident's care plan, updated 01/13/25, showed the following: -Resident at risk for falls related to gait/balance problems and paralysis. Staff to educate the resident/family/caregivers about calling for assistance prior to cares; -Resident had limited ability to transfer self related to left-sided flaccidity (loose, floppy limbs). Resident will transfer with use of two staff members and a gait belt. Staff to remind resident to not transfer without assistance. Review of the facility's Investigative Summary, undated, written by the facility Administrator showed the following: -On 04/27/25, at approximately 6:30 P.M., the Director of Nursing (DON) notified the Administrator of an incident involving an allegation of abuse at the facility which had occurred on 04/26/25 and was not reported to either the DON or the Administrator at the time. -The resident reported (unknown to whom) that Certified Nurse Aide (CNA) D had thrown the resident into bed. -The Administrator instructed the DON to notify DHSS, as well as calling the local policy department per company policy. The DON completed both reports. -According to Registered Nurse (RN) B, he/she was made aware of this incident on 04/26/25, and the RN made his/her own investigation. The result being the RN's belief there was no reportable occurrence. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse progress note dated 04/26/25, at 8:19 A.M., showed RN A documented the resident asked to get up for breakfast and within minutes he/she asked to be put back to bed. The CNA asked the resident to wait while he/she assisted another resident. The resident then proceeded to put himself/herself back to bed, landing half on the bed. The CNA went in to assist the resident and found him/her. The writer and the CNA assisted the resident to bed and reeducated the resident that he/she needed to wait for help so he/she does not end up on the floor. The resident was upset. (The nurse did not document regarding an allegation of abuse or reporting the allegation to management or DHSS.) Review of RN B's written statement, dated 04/27/25, showed the following: -CNA D reported to RN B at 9:30 A.M. that the resident was mad and upset with CNA D. The resident was gotten up for breakfast, but within a short time became insistent on going back to bed. CNA D told the resident that they were still getting others up for breakfast and they would assist him/her back to bed in just a little bit. The resident got mad and said he/she would just put him/herself in bed. Again the CNA explained that they would assist him/her back to bed shortly, but the resident reiterated that he/she would just do it him/herself. CNA D then assisted the resident to the bed. CNA D said the resident told the CNA that he/she caught the resident's foot while moving him/her. At that point in the CNA's report to RN B, the resident's family member called, saying the resident had called him/her. The resident told the family member that CNA D picked him/her up and threw him/her in bed, and the resident's feet were caught in the wheelchair and weren't good. The family member asked RN B to go in and check on the resident. -RN B went and spoke with the resident, who said CNA D grabbed the resident just below his/her neck in the upper center part of the chest one-handed, picked him/her up, and threw him/her into bed, catching the resident's feet in the wheelchair and hurting them bad. (RN did not mentioned in his/her statement reporting the allegation of abuse to management or DHSS.) Review of DHSS records showed facility staff made a self-report regarding the allegation of possible abuse on on 04/27/25, at 7:17 P.M. (the day following the allegation was voiced to RN B). During an interview on 05/01/25, at 12:51 P.M., the resident said a few days ago CNA D got mad at him/her because he/she wanted to go to bed because his/her bottom was hurting from sitting in the wheelchair. CNA D informed him/her that his/her child wanted him/her to stay up. The resident told CNA D that it was his/her right to go to bed. CNA D yanked him/her out of his/her wheelchair and put him/her back in bed. The resident said his/her feet got tangled in the wheelchair legs, but he/she does not recall any bruising or pain. The resident reported the incident to the Administrator. During an interview on 05/02/25, at 10:41 A.M., the Director of Rehab (DOR) said he/she was not aware of any abuse allegations, but he/she would tell the Administrator if anyone reported abuse or neglect to him/her. During an interview on 05/02/25, at 1:13 P.M., CNA G said if he/she witnessed resident abuse, he/she would intervene and make sure the resident was safe. He/she would also report to the charge nurse and remind him/her to report to the State within two hours. He/she would also notify the Director of Nursing (DON) and Assistant Director of Nursing (ADON). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/25, at 1:20 P.M., CNA I said any abuse or allegation of staff grabbing, hitting, or roughly handling a resident should be reported to the charge nurse, DON, or Administrator as soon as possible. The management should make a report to the State within two hours. During an interview on 05/02/25, at 1:30 P.M., RN A said grabbing, hitting, or being intentionally rough with a resident would be considered abuse. The RN said if he/she became aware of abuse or an allegation of such, he/she would immediately intervene for the resident's safety. The abuse or allegation should be immediately reported to the DON or the Administrator and a report should be made to the State agency within two hours. During an interview on 05/02/25, at 1:30 P.M., CNA H said if he/she became aware of resident abuse or neglect, he/she would report it to the charge nurse. During an interview on 05/02/25, at 1:40 P.M., RN B said if he/she witnessed abuse or received an allegation, he/she would first intervene to remove the perpetrator and protect the resident. Any abuse or allegation should be reported immediately to the charge nurse, DON, or Administrator and a report should be made to the State within two hours. During an interview on 05/02/25, at 1:49 P.M., Licensed Practical Nurse (LPN) C said he/she would immediately report any abuse or neglect to the DON and ADON, so it could be reported to the State within two hours or less. During an interview on 05/02/25, at 2:46 P.M., the DON said upon receiving an allegation of abuse, the nurse should first ensure the safety of the resident(s). If a named staff is on duty they should be suspended pending a full investigation. Notification of the allegation should be made immediately to the DON and/or Administrator and to the State agency within two hours. RN B told the DON he/she had conducted their own investigation and concluded there was no abuse; therefore, he/she did not report the allegation to the Administrator or DON. During an interview on 05/02/25, at 3:45 P.M., the Administrator said all allegations of abuse should be reported immediately to a direct supervisor and then to the Administrator and/or DON. The facility must report the allegation to the State within two hours. MO00253352

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to document a timely and thorough investigation, to include interviews with multiple staff and other residents, and steps taken to protect all residents during the investigation for an allegation of possible physical abuse involving one resident (Resident #1). The facility had a census of 63. Review of facility policy titled Abuse, Prevention, and Prohibition Policy, dated December 2024, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion; -Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other resident, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals; -This presumes that all instances of abuse, even those in a coma, can cause physical harm, pain, or mental anguish; -The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action; -While a facility investigation is under way, steps will be taken to prevent further abuse; -The facility will immediately remove any alleged perpetrator from any further contact with any resident; -When another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment options. 1. Review of Resident #1's face sheet (gives basic profile information at a glance) showed the following information: -admission date of 10/15/24; -Diagnoses included left-sided weakness and paralysis following stroke, anxiety disorder, major depressive disorder, insomnia, dementia, constipation, high blood pressure, and bladder disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/20/25, showed the following: -Mildly impaired cognition; -Functional limitation in range of motion of upper extremity one side and lower extremity bilateral; -Utilized a manual wheelchair; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dependent on staff for toileting, showers/bathing, dressing, and bed mobility; -Required substantial to maximum assistance for moving from sitting on the edge of the bed to lying, lying to sitting up to edge of the bed, sitting to standing, and transfers from chair to bed/bed to chair. Review of the resident's care plan, updated 01/13/25, showed the following: -Resident at risk for falls related to gait/balance problems and paralysis. Staff to educate the resident/family/caregivers about calling for assistance prior to cares; -Resident had limited ability to transfer self related to left-sided flaccidity (loose, floppy limbs). Resident will transfer with use of two staff members and a gait belt. Staff to remind resident to not transfer without assistance. Review of the facility's Investigative Summary, undated, written by the facility Administrator showed the following: -On 04/27/25, at approximately 6:30 P.M., the Director of Nursing (DON) notified the Administrator of an incident involving an allegation of abuse at the facility which had occurred on 04/26/25 and was not reported to either the DON or the Administrator at the time. -The resident reported (unknown to whom) that Certified Nurse Aide (CNA) D had thrown the resident into bed. -The Administrator instructed the DON to notify DHSS, as well as calling the local policy department per company policy. The DON completed both reports. -According to Registered Nurse (RN) B, he/she was made aware of this incident on 04/26/25, and the RN made his/her own investigation. The result being the RN's belief there was no reportable occurrence. -The investigation included written statements by Certified Nurse Aide (CNA) D, RN A, and RN B. (The documentation did not show documented interview with other staff or with other residents.) Review of RN B's written statement, dated 04/27/25, showed the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA D reported to RN B at 9:30 A.M. that the resident was mad and upset with CNA D. The resident was gotten up for breakfast, but within a short time became insistent on going back to bed. CNA D told the resident that they were still getting others up for breakfast and they would assist him/her back to bed in just a little bit. The resident got mad and said he/she would just put him/herself in bed. Again the CNA explained that they would assist him/her back to bed shortly, but the resident reiterated that he/she would just do it him/herself. CNA D then assisted the resident to the bed. CNA D said the resident told the CNA that he/she caught the resident's foot while moving him/her. At that point in the CNA's report to RN B, the resident's family member called, saying the resident had called him/her. The resident told the family member that CNA D picked him/her up and threw him/her in bed, and the resident's feet were caught in the wheelchair and weren't good. The family member asked RN B to go in and check on the resident. -RN B went and spoke with the resident, who said CNA D grabbed the resident just below his/her neck in the upper center part of the chest one-handed, picked him/her up, and threw him/her into bed, catching the resident's feet in the wheelchair and hurting them bad. (The RN did not mentioned interviews completed with other staff and residents or steps taken to protect all residents during the investigation.) During an interview on 05/02/25, at 1:20 P.M., CNA I said he/she would intervene to ensure the resident's safety if he/she witnessed abuse. The management would conduct an investigation. During an interview on 05/02/25, at 1:30 P.M., RN A said if he/she became aware of abuse or an allegation of such, he/she would immediately intervene for the resident's safety. The abuse or allegation should be immediately reported to the Director of Nursing (DON) or the Administrator so they could start an investigation. During an interview on 05/02/25, at 1:40 P.M., RN E said if he/she witnessed abuse or received an allegation, he/she would first intervene to remove the perpetrator and protect the resident. Any abuse or allegation should be reported immediately to the charge nurse, DON, or Administrator, who would do an investigation. During an interview on 05/02/25, at 1:49 P.M., Licensed Practical Nurse (LPN) C said he/she would immediately report any abuse or neglect to the DON and Assistant Director of Nursing (ADON) so it could be investigated. During an interview on 05/02/25, at 2:46 P.M., the DON said upon receiving an allegation of abuse, the nurse should first ensure the safety of the resident(s) and then report the allegation to the Administrator and/or DON, who would initiate a full investigation. The investigation should include documented interviews with other staff who were on duty at the time of the alleged incident and with residents who may have received care by the same named perpetrator. The DON said RN B told the DON that he/she had conducted his/her own investigation and concluded there was no abuse; therefore, he/she did not report the allegation to the Administrator or DON and did not suspend the named CNA. Other than the written statements by CNA D and RN A, there was no documentation made by RN B of interviews with other staff or with residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/25, at 3:45 P.M., the Administrator said all allegations of abuse should be reported immediately to a direct supervisor and then to the Administrator and/or DON. If there is a named staff member, they should be suspended pending an investigation. Full investigation should include documented interviews with and/or written statements by staff and interviews with residents. The Administrator said RN B did not have documented interviews with staff other than CNA D and RN A or with any residents other than Resident #1. MO00253352

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide care for all residents per standards of practice when staff failed to obtain and enter wound care orders, failed to document wound care provided, and failed to care plan current wounds and current treatments for three residents (Residents #2, #3, and #4) of six sampled residents. The facility census was 63. Review showed the facility did not provide a policy regarding obtaining, entering, and following treatment/monitoring orders. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admission date of 06/20/23; -Diagnoses included dementia (loss of memory), depression, fractured right hip, and muscle weakness. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 11/15/24, showed the following: -Resident had severe cognitive impairment; -Had a pressure reducing device for bed; -At risk for pressure ulcers. Review of the resident's care plan, revised 11/12/24, showed the following: -Resident at risk for pressure ulcer/injury related to decreased bed mobility; -Resident's skin will remain intact; -Keep clean and dry as possible. Minimize skin exposure to moisture; -Report any signs of skin breakdown (sore, tender, red, or broken areas); -Apply moisture barrier to skin; -Provide incontinence care after each incontinent episode. Review of the resident's hospital discharge orders, dated 04/11/25, showed the following: -Weight bearing as tolerated with posterior hip precautions to right lower extremity; -Keep incision site clean and dry at all times; (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Do not submerge incision site and no tub bathing; -May shower post-surgery, day five, pat dry; -If dressing becomes wet or saturated, call orthopedic provided's office; -If continued drainage, apply daily dry dressing; -If no continued drainage, leave open to air; -Do not pick at incision site; -Do not apply topical ointments or creams to incision site; -Follow up with orthopedic surgeon's office on 04/29/25. Review of the resident's progress note dated 04/11/25, at 8:24 P.M., showed the following: -The resident returned to the facility at 3:40 P.M. per ambulance; -Hospital staff said the resident was weight bearing as tolerated, but the facility physical therapy department had not assessed him/her yet; -Staff will continue to monitor. (Staff did not document regarding wound care orders on the hospital discharge orders.) Review of the resident's April 2025 and May 2025 Physician Order Sheet (POS) showed staff did not document orders related to the resident's wound care from the hospital discharge summary. Review of the resident's care plan report, with an admission date of 04/11/25, showed the following: -Resident had actual impairment to skin integrity to the right heel and left hip related to decreased mobility; -Intervention to offload pressure from heels while up in chair; -Pressure reduction mattress on bed. (Staff did not care plan related to hip incision's and ordered care of the hip incision.) Review of the resident's progress note dated 04/13/25, at 6:07 A.M., showed the following: -The resident had no drainage from the surgical site; -He/she had a low-grade fever of 100.2 degrees Fahrenheit (F); (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff applied cool wash cloths and the resident's temperature came down to 98.8 degrees F as of 5:00 A.M.; -No other signs and symptoms of infection noted; -Staff will continue to monitor. Review of the resident's progress note dated 04/14/25, at 7:36 A.M., showed the following: -The resident continued on high alert charting due to recent surgical procedure of right hip; -Resident denied pain and discomfort; -Incision site assessed by this nurse, and no redness, warmth, or signs of infection noted; -Dressing was dry and intact with no drainage noted. Review of the resident's progress note dated 04/14/25, at 4:42 P.M., showed the resident continued on high alert charting due to fracture. The resident denied pain and discomfort. Review of the resident's progress note dated 04/15/25, at 2:51 A.M., showed the resident denied pain and distress related to right hip surgery. Incision site with no signs and symptoms of infection. Review of the resident's progress notes dated 04/17/25, at 3:46 A.M., showed the resident had no complaints of pain. Dressing to right hip remains clean, dry, and intact. Review of the resident's April 2025 and May 2025 Treatment Administration Record (TAR) showed staff did not document dressing changes or continued monitoring of the resident incision cite. 2. Review of Resident #3's face sheet showed the following: -admission date of 03/22/24; -Diagnoses included dementia (loss of memory), depression, multiple fractures of left ribs, open wound to skin on top of the head, laceration of other part of head, traumatic subdural hemorrhage (blood between the brain and its outermost covering) with loss of consciousness, fracture of left clavicle (bone that connects the shoulder blade to the breastbone), and fracture of left hip. Review of the resident's annual MDS, dated [DATE], showed the resident had severe cognitive impairment. Review of the resident's care plan, revised 12/27/24, showed the following: -Resident at risk for pressure ulcers related to the need for assist with toileting and activities of daily living cares; -Resident's skin will remain intact; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Keep skin as clean and dry as possible and minimize skin exposure to moisture. Review of the resident's care plan report, with re-admission date 06/22/24, showed the following: -Potential or actual impairment to skin integrity; -Apply moisture barrier with each incontinence episode; -Float heels while in bed. Review of the resident's care plan, revised 01/07/25, showed fall on 01/05/24 with laceration to the forehead and sent to the emergency room. Review of the resident's care plan, revised 01/31/25, showed the following: -Resident had a laceration to the forehead; -Treat area per physician's orders; -Monitor and treat signs of localized infection (swelling, redness, pain, tenderness, heat at the infected area, purulent drainage, and/or loss of function). Review of the resident's progress notes on 04/20/25, at 2:50 P.M., showed the following: -The resident arrived at the facility by emergency medical services (EMS) via stretcher from the hospital with a diagnosis of subdural hematoma (swelling caused by a collection of blood leaked from vessels and clotted in the body's tissues) related to a fall; -Head-to-toe assessment and skin assessment performed by the receiving nurse; -Large bruise to left forehead with dissolvable sutures intact and another large bruise to left hip; -Multiple other scattered bruising noted on bilateral upper and lower extremities; -Staff will continue to monitor for safety and needs. (Staff did not document contact with physician to obtain wound orders related to sutures.) Review of the resident's hospital discharge instructions, dated [DATE], showed no orders related to caring for the resident's head laceration. Review of the resident's progress note dated 04/25/25, at 5:38 A.M., showed the following: -Sutures intact to wound on head from previous fall and bruising surrounding area resolving; -Bruising light green in color; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265656	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strafford Care Center	505 West Evergreen Strafford, MO 65757

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff will continue to monitor. Review of the resident's progress note dated 04/25/25, at 7:01 P.M., showed the following: -Sutures intact to previous resolving forehead wound from fall without signs and symptoms of infection and no drainage; -Yellow bruising noted surrounding the wound; -Scattered bruising to bilateral upper and lower extremities reported to be from previous fall; -Staff will continue to observe. Review of the resident's skin assessment, dated 05/01/25, showed stitches to right side of upper forehead related to a fall. Review of the resident's care plan showed staff did not update the care plan to reflect the most recent fall and laceration. Review of the resident's April 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed no orders or treatments related to the resident's head laceration. 3. Review of Resident #4's face sheet showed the following: -admission date of 03/08/23; -Diagnoses included muscle wasting, dementia with other behavioral disturbance, cognitive communication deficit, abnormalities of gait and mobility, repeated falls, low back pain, arthritis in multiple joints, and tremors. Review of the resident's annual MDS, dated [DATE], showed resident had moderately impaired cognition. Review of the resident's nurse progress notes showed the following documentation: -On 04/21/25, at 1:40 P.M., staff noted per notification by housekeeping nurse observed resident sitting on his/her floor mat next to his/her bed. Resident had skin tear to his/her right elbow noted with no other injury. Area to right elbow cleansed, dried, and steri-strips applied. The area was well approximated. Staff notified the family, Administrator, and Physician Assistant. -On 04/22/25, at 1:46 P.M., staff noted resident continued on fall follow-up monitoring with no signs/symptoms of delayed injury or complaint of pain/discomfort related to incident. Steri-strips to right elbow were intact at this time; -On 04/22/25, at 8:57 P.M., staff noted the resident continued on fall follow-up monitoring. Resident had no signs/symptoms of delayed injury or complaint of pain/discomfort related to incident. Steri-strips to right elbow were intact at this time; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 04/23/25, at 2:21 A.M., staff continued on incident charting post fall and had no complaint of pain/discomfort related to fall incident and no signs/symptoms of delayed injury. Steri-strips to right elbow were intact; -On 04/23/25, at 9:14 A.M., staff noted resident continued on monitoring after recent fall with no complaint of pain/discomfort related to fall incident and no signs/symptoms of delayed injury. Steri-strips to right elbow were intact; -On 04/23/25, at 8:52 P.M., staff noted resident continued with no complaint of pan/discomfort related to incident and no signs/symptoms of delayed injury. Steri-strips to right elbow were intact. Review of the resident's care plan, last updated 03/13/25, showed staff did not care plan related to the skin tear on the resident's right elbow. Review of the resident's April 2025 POS showed staff did not document orders related to treatment or monitoring of the skin tear on the resident's right elbow. Review of the resident's nurse progress notes showed the following documentation: -On 05/01/25, at 6:07 A.M., staff noted skin tear dressing to left upper extremity (LUE) remained clean, dry and intact; -On 05/02/25, at 5:56 A.M., staff noted dressing to LUE skin tear remains clean, dry, and intact. Review of the resident's care plan, last updated 03/13/25, showed staff did not care plan related to the skin tear on the LUE. Review of the resident's May 2025 POS showed staff did not document orders related to treatment or monitoring of the skin tear on the resident's LUE. Observation on 05/02/25, at 9:02 A.M., showed the resident sat in his/her wheelchair in his/her room. His/her left arm was wrapped with gauze from above the wrist upward and no date was indicated on the dressing. During the observation, the resident said he/she had cut his/her arm on the equipment, indicating the wheelchair. He/she said staff had been changing the dressing every day, except for the previous day. During the observation, Registered Nurse (RN) A said he/she wound status. He/she would check the orders regarding wound treatment. Observation on 05/02/25, at 10:05 A.M., showed the resident sat in his/her wheelchair in his/her room. RN A said he/she had just finished changing the resident's left arm dressing. He/she cleansed the wound area, covered the intact steri-strips with a non-stick pad, and wrapped the arm with Kerlix (gauze strip). RN A said the Assistant Director of Nursing (ADON) came and told him/her what the treatment order would be. RN A reviewed the electronic medical record (EMR) with the surveyor present. No treatment orders were in the physician order sheet (POS) or listed on the treatment administration record (TAR) at that time. RN A said he/she would have to document the treatment after the orders were entered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/25, at 1:40 P.M., RN B said the resident had told RN B that the resident had rolled out of the wheelchair, causing a skin tear. RN B followed physician protocol orders to cleanse and dress the wound, but did not enter orders into the electronic system. Since the incident happened right at shift change, RN B passed on the information to the oncoming shift who verbalized understanding and said they would enter the wound treatment orders into the POS and TAR. RN B was not aware that the orders had not been entered. Review of the April 2025 POS showed no treatment order pertaining to the resident's skin tear had been entered as of 05/02/25, at 3:25 P.M., when the report was generated by staff. Review of the April 2025 and May 2025 TAR showed staff did not document treatment pertaining to the resident's skin tear as of 05/02/25, at 3:25 P.M., when the report was generated by staff. 4. During an interview on 05/02/25, at 1:49 P.M., Licensed Practical Nurse (LPN) C said wound care was done by the LPNs and RNs. Wound care orders came from the physician and they were in the TAR. LPN C would document wound care in the TAR and he/she would document anything out of the ordinary with wounds or any changes in wounds in the resident's progress notes. A designated staff member in the facility completes a wound care report weekly. During an interview on 05/02/25, at 1:30 P.M., RN A said a resident should have treatment orders upon transfer from a hospital. If there are no wound treatment orders, or the resident obtains an injury after admission, staff should call either the discharging hospital or the facility physician to obtain orders for wound treatment. The staff receiving the orders should enter the order into the MAR. Treatments should be documented on the TAR and/or in nurses notes. During an interview on 05/02/25, at 2:46 P.M., the Director of Nursing (DON) said staff should obtain wound treatment orders from the hospital, if a resident is admitted with a surgical or other type of wound. If the resident had a new wound while in the facility, the charge nurse should call the physician for treatment orders. The facility can also notify the contracted wound care service to assess the resident and give treatment orders. The nurse receiving the orders should enter them into the electronic medical record (EMR) and the floor nurses should complete and document the wound treatments as ordered. During an interview on 05/02/25, at 3:45 P.M., the Administrator said the nurses should get wound treatment orders from the hospital on admission, or they can call the physician for orders and enter them into the EMR. The nurses should then follow the physician orders for the treatment and should document completion. MO00253174