STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265749	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	1347 East Valley Watermill Road Springfield, MO 65803

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for all residents when staff failed to address the use of, care of, and monitoring of and related to an indwelling urinary catheter (a sterile tube inserted into the bladder to drain urine) for one resident (Resident #5). The facility census was 88. Review of the facility policy Urinary Catheter Care, revised August 2022, showed the following: -Purpose of procedure was to prevent urinary catheter-associated complications, including urinary tract infections; -Empty the collection bag at least every eight hours using a separate, clean collection container; -Be sure the catheter tubing and drainage bag are kept off the floor; -Observe the resident's urine level for noticeable increases or decreased. If the level stays the same, or increases rapidly, report it to the physician; -Follow the facility procedure for measuring and documenting input and output; -Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder; -If the catheter material contributes to obstruction, notify the physician and change the catheter if instructed to do so; -Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction; -Observe the resident for complications associated with urinary catheters. Report unusual finding to the physician or supervisor immediately if resident indicates that bladder was full or that need to void or urinate; if urine had an unusual appearance such as color, blood, etc, in event of bleeding or if the catheter was accidentally removed; complaint of burning, tenderness, or pain the urethral area (extends from the bladder to the urinary meatus or opening); or signs and symptoms of urinary tract infection or urinary retention occurred. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #5's face sheet (admission information at a glance) showed the following: -admitted [DATE]; -Diagnoses included neuromuscular dysfunction of bladder (lack of bladder control due to a brain, spinal cord, or nerve condition). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 11/08/24, showed the following: -Severely impaired cognition; -Did not reject care; -Indwelling urinary catheter; -Dependent on staff for toileting hygiene, personal hygiene, upper and lower body dressing, roll left to right, chair to bed transfer, lying to sitting, and sitting to lying. Review of the resident's physician's orders, dated 01/31/25, showed the following: -Provide foley catheter care every shift; -Change foley catheter as needed (PRN) for leaking or blockage. Review of the resident's care plan, dated 01/31/25, showed staff did not care plan the use of, care of, and monitoring of and related to an indwelling urinary catheter. Review of the resident's Treatment Administration Record (TAR), dated 02/22/25, showed Licensed Practical Nurse (LPN) D attempted to flush the indwelling urinary catheter when there was no urinary output. The tubing was blocked. During interview on 03/20/25, at 1:52 P.M., LPN D said he/she had changed the resident's catheter once because the resident had no urinary output. He/she tried to flush the catheter and it was clogged. He/she changed the catheter and had a urine return. If there had been a problem after changing the catheter, he/she would have called the physician but there was a urine return after changing it. There was a physician's protocol to change the catheter if it clogged up. Review of the resident's progress notes showed the following: -On 03/05/25, the resident had a change in condition when the resident was lethargic and nonresponsive but awake, opened eyes and moaned. The resident had decreased urine output. Staff sent the resident to the hospital; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 03/06/25, the Assistant Director of Nursing (ADON) documented the certified nurse aide (CNA) saw the resident at 3:00 A.M. on 03/05/25 and the resident sat on the bed drinking water. Later that day, the resident was lethargic and had minimal urine output in the indwelling urinary catheter. The CNA notified the charge nurse who notified the physician who sent the resident to the hospital on 03/05/25. -On 03/14/25, the resident returned from the hospital with indwelling foley catheter in place and draining light yellow urine with sediment. Fluids encouraged and offered frequently. Review of the resident's care plan, dated 01/31/25, showed staff did not care plan the use of, care of, and monitoring of and related to an indwelling urinary catheter. Observation on 03/19/25, at 9:25 A.M., showed the resident lying in a low bed with fall mat on the right side of the bed. The urinary catheter bag with urine in the tubing was sitting on the fall mat. Observation on 03/20/25, at 1:40 P.M., showed the resident in the low bed with eyes closed. The urinary catheter bag was tucked under the bed and rested on the blue mat. CNA E pulled the catheter bag out from under the low bed and attached it to the bed. He/she raised the bed a little for it to hang down. During an interview on 03/20/25, at 1:20 P.M., CNA E said they were to empty or drain the urinary catheter bag every one and a half to two hours. He/she had drained the resident's catheter bag and would check if the urine was cloudy or had sediment in it. He/she would provide perineal care if the resident had a bowel movement and would provide catheter care by cleaning the tubing. During an interview on 03/20/25, at 1:30 P.M., CNA G said when a resident had a urinary foley catheter, he/she would provide perineal care with the catheter every two hours when turn and reposition the resident or when the resident had a bowel movement, and do catheter care at least once a shift. They were to empty the catheter bag once a shift unless it was full before the end of the shift. They were to report to the nurse if the resident was complaining of the catheter and yanking on it, if the catheter was leaking urine, any odor, excess drainage, and would report any urine output if under 50 cubic centimeters (cc) of urine. During observation and interview on 03/20/25, at 1:45 P.M., CNA E said the nurse aides chart on paper and the certified medication technicians (CMTs) and the nurses chart in the electronic medical record. He/she found the book on the nurses' desk for their charting. Under the resident, there was no fluid intake or urinary output tracking. CNA E said he/she had not charted any urinary output on this resident, but thought they did on other residents here in the facility. During an interview on 03/20/25, at 1:52 P.M., LPN D said the following: -He/she would change the resident's catheter if he/she would assess the catheter by trying to flush the tubing, and if there was no return, he/she would change the catheter. There were no standing orders to do this. Another resident had orders to flush his/her catheter tubing daily; -If there were no orders for flushing the catheter, there was a PRN order to change the catheter; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did change the resident's catheter once. There was no urinary output and he/she tried to flush it but it was clogged. He/she changed the catheter and there was a urine return; -They do not chart urinary outputs on the resident but they should chart this; -There was a place to chart urinary outputs for one resident on another hall; -The nurse aides do come to him/her and report at the end of the shift and have put it on the vital signs sheet but not on this particular hall for the resident; -Staff were to check if the resident's indwelling urinary catheter was cleaned and draining urine properly with the catheter bad hanging below the level of the bladder.; -They were to check if the urine was clear and monitor for any blood in the urine, assess and check for decreased urine output and check for kinks in the tubing; -If they go and flush the catheter and there was no return, he/she would change the urinary catheter; -The nurse aides report the resident's urine output every day; -He/she would expect staff to let him/her know if the catheter bag had at least 600 milliliters (ml) of urine in a shift. It would depend on the resident's fluid intake too. It would concern him/her if the urinary output was not more than 600 ml; -When staff check and change the resident every two hours, they were to empty the catheter bag if over 600 ml or check on it at least a couple of times a shift. It depends on the nurse aides' routine. During record review and interview on 03/20/25, at 4:00 P.M., LPN H said the following: -There was an expectation for intake and outputs for residents with catheters; -Catheter care with perineal care should be done at minimum every shift since the resident was incontinent of bowel; -The nurse aides working were usually good to let the nurses know if they did not have urinary output; -They were to check for sediment in the resident's catheter tubing; -He/she would check to see if the resident was drinking well; -If the tubing was kinked and not positioned right, he/she would call the physician and go back to see the resident and re-assess and see if any urinary output; -They have a input and output form but not sure if the resident had a form. It was a daily form they used and it was not in the notebook; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 03/20/25, at 2:50 P.M., the Director of Nursing (DON) said the following: -She would expect staff to provide perineal care with foley catheter care; -Staff were to document the intakes and outputs for residents with catheters and anyone on fluid restrictions were monitored; -The aides and nurses were to check catheters for leaking and if clogged. They were to flush the catheters twice a shift if ordered and in their plan of care for the resident; -The output is usually 30 ml/hour if a good drinker or what the resident can tolerate orally; -The aide was to report to the charge nurse if no urinary output, foul odor, discoloration, sediment, blood, and anything else not normal for the resident; -She would expect staff to hang the urinary catheter bag below the level of the resident's bladder and off the floor. During interviews on 03/19/25, at 2:00 P.M. and 4:20 P.M., the Administrator said the following: -There were standing orders on the nurse's MAR for the nurse to keep the intake and output on residents with urinary catheters; -They do also have standing orders for irrigation and changing the catheter on the computer; -The physician did have standing orders for nurses to irrigate with normal saline and if the resident's catheter tubing was more difficult to flush, they could order the acetic acid if needed to clear the tubing; -She expected nurse aides to check the urinary catheter for sediment, blood, etc. and report this to the charge nurse; -The nurses were to do the intakes and outputs and the aides to drain the catheter bag every shift or when the catheter bag was full of urine. MO00250596

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on interview and record review, the facility failed to provide care per standard of practice when facility staff failed to accurately and consistently track one resident's skin conditions, failed to document timely full assessments of skin conditions, and failed to document orders for completion of skin care for one resident's (Resident #1) who developed cellulitis (a potentially serious bacterial skin infection). The facility census was 88. Review of the facility's policy Change in a Resident's Condition or Status, revised February 2021, showed the following: -The nurse will notify the resident's attending physician or physician on-call when there has been a significant change in the resident's physical, emotional, or mental condition; a need to alter the resident's medical treatment significantly; or specific instruction to notify the physician of changes in the resident's condition; -A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff; impacts more than one area of the resident's health status; and requires interdisciplinary review and/or revision to the care plan. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. Review of the facility's undated policy Assessment, Treatment, and Notification of Wounds, showed the following: Review of the facility's Wound Care Protocol other than Pressure Ulcers, and Stasis Ulcers, undated, showed the following: -Purpose to resolve and prevent infection; -Residents will be free of wounds if possible; -Should a wound occur, treatment and healing is a priority; -Complete skin assessment upon admission, readmission, and weekly; -Document in nurses' notes the wound size length by width by depth, drainage, wound bed, peri-wound and edges weekly with skin assessments; -Treat as directed by physician; -Notify physician for all wounds and get treatment orders at time of notification; -Notify Director of Nursing (DON) or Assistant Director of Nursing (ADON) of all wounds. 1. Review of Resident #1's face sheet (admission information) showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Diagnoses included vascular dementia (progressive impairments in memory, thinking, and behavior which negatively impacts a persons' ability to function and carry out every day activities), chronic kidney disease stage 3 (moderate damage to the kidneys where they are less efficient at filtering waste from the blood, causing a buildup that can lead to high blood pressure and anemia), cellulitis (bacterial skin infection that causes redness, swelling, and pain), type 2 diabetes mellitus (high blood sugar), hypertension (high blood pressure), anemia (lack of red blood cells that leads to reduced oxygen flow to the body's organs), and edema (excess fluid trapped in the body's tissues). Review of the resident's care plan, dated 09/24/24, showed the following: -Resident had a pressure ulcer related to not wearing socks with ill-fitting shoes. -Avoid friction and shearing forces during transfers or position changes; -Conduct a systematic skin inspection weekly; -Report any signs of further skin breakdown; -Resident will wear socks with her shoes. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 10/1/24, showed the following: -Moderately impaired cognition; -Required supervision or touching assistance where the helper provides verbal clues or touching/steadying assistance as resident completes the activity for toileting, upper and lower body dressing, and putting on and taking off footwear; -Required substantial/maximal assistance where the helper does more than half the effort for showering; -At risk for pressure ulcer development. Review of the resident's Weekly Skin Assessment, dated 11/14/24, showed the following: -At risk for developing pressure ulcers/injuries; -Diabetic foot check showed bilateral (both sides) feet with no findings; -Alteration in skin location and details showed a slight redness to the right lower extremity calf (lower back of leg) to the ankle. (The assessment did not include a full description of the resident's skin condition.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse practitioner's (NP) visit for the resident's change in condition, dated 11/16/24, showed the following: -Reason for visit was pain and redness to right leg; -Resident complained of right leg redness and pain. The resident reported right leg pain for about one week that had been gradually getting worse. He/she also noticed some increased redness in his/her right leg and foot over the last few days. Resident had a history of peripheral arterial disease (condition in which narrowed arteries reduce blood flow to the arms or legs) and had struggled with cellulitis in the past. Resident did have several chronic appearing wounds to right toes and heels. -Bilateral lower extremity with chronic-appearing redness, worse on the right. Area of increased color discrepancy noted to top of right foot, marked; -Non-pressure chronic ulcer of other part of right foot with fat layer exposed; -Recurrent diabetic foot ulcers, now with wound to right heel. No drainage, redness, warmth noted to wounds. Concerns for right lower extremity cellulitis given generalized right calf redness, treating with antibiotics. Continue to monitor for sites for worsening or infection, continue to off load pressure as able. Keep wounds clean, wash with soap and water. Dry well after washing. Further evaluation with arterial/venous ultrasound as ordered. Review of the resident's progress note dated 11/16/24, at 2:51 P.M., showed the NP looked at the resident's right foot at the request of the staff. The right foot was discolored. Staff received new orders to start doxycycline (an antibiotic for wound healing) 100 milligrams (mg) twice a day for seven days. Review of the resident's Physician Orders showed an order, dated 11/16/24 to 11/22/24, for doxycycline 100 mg, one tablet by mouth twice a day for cellulitis. (Staff did not document an order regarding wound care including keeping wound clean with soap and water and drying after washing.) Review of the resident's progress notes showed the following: -On 11/17/24, at 9:35 A.M., the resident continued to receive doxycycline 100 mg twice a day for possible right foot cellulitis. There was no change in the appearance of the right foot; -On 11/18/24, at 3:14 P.M., the resident remained on antibiotic for right lower extremity. The area reddened with no increase warmth to the area noted; -On 11/18/24, at 8:32 P.M., the resident continued on antibiotic for right lower extremity cellulitis. Slight redness to right lower extremity with minimal swelling; -On 11/19/24, the resident continued on antibiotic for cellulitis. The leg was a little red. Resident had venous Doppler done today and waiting results; -On 11/20/24, at 2:01 P.M., the resident continued on antibiotic for cellulitis to right lower extremity . The right lower extremity remained slightly reddened with no warmth or edema noted. The resident was able to extend and retract foot without complaints of pain or discomfort; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/21/24, at 5:52 A.M. and 4:55 P.M., the resident continued on antibiotic for right lower extremity cellulitis. Resident stated it felt much better and was not as red. Review of the resident's weekly skin assessment, dated 11/21/24, showed slight redness to right lower extremity. Currently on antibiotic for cellulitis. (The assessment did not include a full description of the resident's skin condition.) Review of the resident's progress notes showed the following: -On 11/22/24, at 6:43 P.M., the resident on antibiotic for leg. Improvement to leg notes. No Doppler report received and physician unaware of any report; -On 11/24/24, at 10:33 A.M., the resident continued on antibiotic for cellulitis; -On 11/26/24, at 3:37 P.M., the resident left the facility at approximately 2:40 P.M. with family as planned. Narcotics, insulins, and regular medications sent. Review of the resident's shower sheet, dated 11/26/24, showed staff documented no issues with the resident's skin. Review of the resident's progress notes, dated 11/26/24 to 12/04/24, showed staff did not document regarding the resident's right lower leg and foot (a period of 8 days). Review of the resident's weekly skin assessment, dated 11/28/24, showed the following: -At risk for developing pressure ulcers/injuries; -Diabetic foot check: alteration in right foot. Blistered areas to 5th toe. Skin split on heel. -Skin and Ulcer/Injury Treatments: wound care. (The assessment did not include a full description of the resident's skin condition.) Review of the resident's Physician's Order, dated 11/17/24 to 11/28/24, showed staff did not note any wound care orders. Review of the resident's shower sheet, dated 11/28/24, showed staff documented no issues with the resident's skin. Review of the facility's Skin/Wound Logs, dated 11/24/24 and for 12/1/24, showed the resident was not listed as having wounds. Review of the resident's shower sheets, dated 12/2/24 and 12/4/24, showed staff documented no issues with the resident's skin. Review of the resident's NP's visit for the resident's change in condition, dated 12/04/24, showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Reason for visit: malaise (feeling tired, no energy), follow up of labs; -Completed antibiotics for cellulitis and feels right leg looks better than before. Review of the resident's shower sheet, dated 12/5/24, showed staff documented no issues with the resident's skin. Review of the resident's medical record showed staff did not complete the weekly skin assessment, scheduled for 12/05/24. Review of the resident's progress note, dated 12/6/24, showed the resident complained of pain to the right lower extremity. The nurse practitioner ordered an ultrasound to rule out deep vein thrombosis (blood clot) since the leg was red with diminished pedal (foot) pulses. Wound was present. Order for consult with wound company for right foot multiple wounds. Review of the resident's NP's visit for the resident's change in condition, dated 12/07/24, showed the following: -Reason for visit: follow-up; -Complained of new right leg tenderness and discomfort at chronic right heel wound. -Non-pressure ulcer on the right foot, 2 cm by 0.25 cm, and under treatment. Right lower leg with redness and mild warmth, new since exam on 12/4, also with tenderness to palpation. Right heel wound/fissure (a narrow opening or crack, or split), no drainage or surrounding redness; -Concerns for developing right lower extremity cellulitis with peripheral artery disease(affects blood flow) and right heel wound as evidenced by new right lower leg redness, mild warmth, and tenderness. Orders placed for Keflex (antibiotic for skin infection) 500 mg twice a day for seven days. Orders for wound care and dressing to right heel per facility protocol such as mepilex or hydrogel. Refer to wound care company. If any decreased right lower extremity distal (moves away from the center of the body) sensation, consider transfer to acute setting for prompt evaluation. Review of the resident's physician's orders from 11/29/24 to 12/07/24, showed staff did not document orders for wound treatment for wounds to the right lower leg, feet, and/or toes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24, at 1:50 P.M., and on 12/13/24, at 12:36 P.M., Licensed Practical Nurse (LPN) B said the spot on the resident's foot comes and goes. The wound care company nurse had told the resident not to wear the ill fitting shoes, but the resident would stop a while and then begin wearing them again. Resident was on services for the wound care company when he/she had wounds, then when the area was healed, the resident is discharged off their services. If the wound opened up, they get a referral to see them again. If a wound was on his/her lower leg and foot, no one had reported this to the physician. The resident's foot looked the same as before, but he/she was non-compliant with wearing proper shoes and no socks. The resident had seen the wound care company a few times before. All nurses do weekly skin assessments and it depends on the day of the week which residents he/she will do a skin assessment on. This will trigger on the electronic medical record to do. He/she looks at all skin from head to toe. If he/she noticed something, he/she will get a measurement and then pulls the wound protocol book for wound, do a wound report and give copy to the physician and to the wound nurse. During an interview on 12/13/24, at 10:19 A.M., Certified Nurse Aide (CNA) G said he/she worked the past month as the shower aide on the resident's hall. He/she will put lotion on resident's skin and in the red skin folds. If he/she saw any skin issues, he/she would tell the nurse and would fill out the shower sheet by marking on the figure, circling it even if new bruising, and give a description. The resident was very private and did not want help. He/she would ask for the aide's help if scared to take a step. He/she did not check the resident's skin. He/she sat in a chair by the door in the shower room to assist the resident if needed. The resident pulled the shower curtain and did his/her own shower. The resident walked to the shower room and used a shower chair. He/she was unaware of any lower leg wounds on the resident. If he/she had seen any bruising or was checking the skin and saw redness, open areas on lower legs, feet, and heels, he/she would have reported this. No other nurses came in to check the resident's skin. Some of the nurses will say to let them know when he/she gives a certain resident a shower so they can come and check the resident's skin. During interviews on 12/12/24, at 3:05 P.M. and 3:17 P.M., and on 12/13/24, at 9:20 A.M. and 1:26 P.M., the Wound Nurse, Registered Nurse (RN) C said, there was no weekly skin assessment done for the resident on 12/05/24 and he/she was not sure why it was not completed. He/she was unaware of the resident having multiple wounds on his/her feet until he/she saw the NP's order on 12/06/24 for an order for an ultrasound to the right lower leg and a consult for the wound care company which only comes on Wednesdays. The wound management report showed on 09/24/24, the resident had a right pinky toe ulcer that was healed on 10/08/24. It was a diabetic stasis ulcer and he/she had a chronic history of wearing inappropriate shoes. RN C did not get a treatment order from the NP until today, 12/13/24, for the resident's wound care, when he/she had to request the NP's notes for each visit. These visit notes had not been uploaded into the resident's electronic medical record. During interview on 12/12/24, at 11:54 A.M., CNA A said the resident had nerve pain on his/her feet and the staff did treat the wound on his/her right ankle. During an interview on 12/13/24, at 8:31 A.M., LPN D said the resident went out with family for the holiday on Thanksgiving and came back on 11/29/24. The family had noticed blisters on the resident's lower legs and told the nurse. The night nurse, RN E, told LPN D and the wound nurse about the red and edematous legs with blisters. LPN D did assess the resident's lower legs and feet and did not see any blisters, just red and edematous. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/13/24 at 1:52 P.M., LPN H said the resident had issues on his/her feet. The NP gave order for the wound care company and he/she made a copy of the order to give to the wound nurse. There were no orders for the resident's feet for wound care, but the resident wore ill fitting shoes and he/she put mineral cream and lotion on the resident's feet since he/she was diabetic too. During an interview on 12/13/24, at 8:40 A.M., RN F said he/she was unaware of any skin issues with the resident. During an interview on 12/13/24, at 3:00 P.M., the Administrator said he/she would expect the charge nurses to do a skin assessment on all residents upon admission and weekly. The shower aides were to complete the shower sheets for each resident and were to report any skin redness, bruising, open areas to the charge nurse. The charge nurse was to assess the resident's wound and initiate treatment. They have a wound protocol they fill out and give to the wound nurse. This form will go to the physician for the physician to fill out and sign. The nurses were to contact the physician and follow the wound protocol. If the wound protocol was not appropriate for the wound, they were to call the physician. The nurse that finds the wound or assess a wound is to initiate treatment. MO00246398

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility failed to provide care per standard of practice for all residents with pressure ulcers when the facility staff failed to complete and document full wound assessments in a consistent and timely fashion to track if wounds improved or declined for four residents (Residents #1, #2, #3, and #4) who had identified pressure ulcers. The facility census was 88. Review of the facility's policy Wound Protocol/Procedure, undated, showed the following: -The charge nurse should document in the wound event or progress note about the wound's drainage, wound bed, peri-wound and edges. This is also charted in the weekly skin assessment while the the wound is present, until healed; -The wound nurse will follow the wounds weekly with measurements and assessment and staging of the wounds or other skin issues until the wound heals. 1. Review of Resident #1's face sheet (admission information) showed the following: -admitted [DATE]; -Diagnoses included orthopedic aftercare following surgical amputation, absences of left leg above the knee, diabetic neuropathy (complication of diabetes that damages the nerves), non-pressure chronic ulcer of skin with unspecified severity, cellulitis (a bacterial infection of your skin and the tissues beneath your skin), and venous insufficiency (condition in which veins have problems moving blood back to the hear). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 01/09/25, showed the following: -No cognitive impairment; -No record of behaviors; -No record of pressure ulcers. Review of the resident's care plan, dated 03/17/25, showed the following: -Resident had a left above the knee amputation; -Resident had history of refusing wound care to right leg; -Resident had diabetes; -Resident had open wounds to right leg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Wound Management Report showed on 02/13/25, at 12:22 P.M., staff noted a new 0.8 centimeter (cm) x 0.5 cm x 0.1 cm stage three pressure ulcer (full thickness tissue loss) to residents' right thigh. Review of the resident's progress note dated 02/13/25, at 7:21 P.M., showed staff identified a new open area to resident's inner thigh of his/her right leg and notified the wound nurse. Review of the resident's Wound Management Reports, dated 02/14/25 to 03/19/25, showed the facility staff did not document wound measurements or wound descriptions for the staff identified pressure ulcer. Review of the resident's progress notes, dated 02/14/25 to 03/19/25, showed staff did not document full assessments of the staff identified pressure ulcer. 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included quadriplegia (a condition that causes paralysis in all four limbs), stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed bone, tendon, or muscle) of right buttock, and unspecified injury at unspecified level of cervical spinal cord. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 10/01/24, showed the following: -No cognitive impairment; -At risk for pressure ulcers; -Two stage four pressure ulcers. Review of resident's care plan, dated 03/20/25, showed the following: -Resident had a stage 4 pressure ulcer; -Resident utilized an air mattress; -Resident had dementia; -Resident had a suprapubic catheter (a thin, flexible tube inserted into the bladder through a small incision in the lower abdomen); -Resident was at risk for pressure ulcer due to friction and shear. Review of the resident's Wound Management Report dated 02/01/25, at 4:20 P.M., showed a stage 4 wound to the right ischial (bony area above the back side of the thigh and beneath the buttocks), that measured 2.2 cm x 2.5 cm x 0.5 cm with serosanguineous (thin watery drainage, light pink or pale red in color) drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Wound Management Report dated 03/12/25, at 4:22 P.M., showed a stage 4 wound to the right ischial measuring 3.0 cm x 2.0 cm x 0.8 cm with moderate serous (thin, watery drainage clear or yellow in color) drainage and a foul odor. Review of the resident's progress notes, dated from 02/01/25 to 03/22/25, showed staff did not document a completed assessment of the resident's pressure ulcer. 3. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included acquired absence of right leg below the knee following surgical amputation, type 2 diabetes mellitus (high blood glucose) with diabetic nephropathy (damaged kidneys can't filter blood properly), and cellulitis (bacterial skin infection that causes redness, swelling, and pain). Review of the resident's care plan, dated 01/24/25, showed the following: -At risk of a pressure ulcer related to not wearing socks with shoes; -Resident had a diabetic ulcer(s) related to diabetic neuropathy (nerve damage that often affects the legs and feet) and poor circulation on the left lower extremity. Currently a wound care company monitored wound healing process; -Resident recently had a right below the knee amputation. Review of the resident's admission MDS, dated [DATE], showed the following: -Moderately impaired cognition; -At risk for pressure ulcers; -Open lesion on foot; -Surgical wound with wound care; -Applications of dressing to feet with or without topical medications. Review of the facility's Skin/Wound Log for Non-Pressure Wounds, dated 02/09/25, showed the resident had a facility acquired abrasion (type of pressure ulcer) on the left heel that measured 1.6 cm length by 3.9 cm width by 0.2 cm depth and was an ulcer injury. Interventions included therapeutic bed, heel protectors, positioning pillows, turning/positioning, nutrition/hydration, application of dressings, application of ointments/medications and wound care company. Review of the resident's Wound Tracker Report, in the electronic medical record, dated 2/12/25, showed the wound care nurse documented the arterial ulcer (left heel) measured 3.9 cm length by 1.6 cm width by 0.2 cm depth with light serous exudate with slough. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's wound log, dated 02/12/25, in the electronic medical record (EMR) under Wound Management Detail Report tab showed a nurse documented the left heel ulcer measured 1.6 cm length by 3. 9 cm width by 0.2 centimeters depth with light exudate (drainage), serous (clear, amber, thin and watery) and slough (a soft, yellow or white, stringy or thick substance that is on the wound bed which can hinder healing and increase infection). Staff noted to see wound care company progress notes. Review of the resident's medical record showed no wound care company progress noted related to the 02/12/25 entry present on-site. Review of the resident's Skin/Wound Log for Non-Pressure Wounds (binder), on 3/19/25 at approximately 3:00 P.M., showed staff did not document a complete wound assessment of the ulcer on the resident's heel after 02/09/25. Review of the resident's progress notes, dated 02/24/25 to 03/17/25, showed staff did not document an assessment or regarding the left heel wound. Observation and interview on 03/19/25, at 12:15 P.M., showed Licensed Practical Nurse (LPN) B said he/she had a wound treatment to do on the resident's left heel pressure ulcer. LPN completed the treatment to the resident's left hell. The resident's heel had an ulcer that measured approximately a 2.7 cm length by 1.5 cm width by 0.2 cm depth with scant clear drainage. LPN B did not measure the pressure ulcer on the left heel. 4. Review of Resident #4's face sheet showed the following: -admitted [DATE]; -Diagnoses included deep vein thrombosis (blood clots) of lower bilateral extremities and cellulitis. Review of the resident's care plan, dated 05/23/24, showed following: -The resident had edema (build up of fluid in the body's tissues) related to congestive heart failure (chronic condition where the heart doesn't pump the body as well as it should); -The resident had actual skin impairment to skin integrity related to poor safety awareness, impaired mobility, weakness, and incontinence; -The resident had a healed wound on right buttock that will reopen often because of choice to stay in wheelchair all day or will lay on back when in bed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -At risk for pressure ulcers; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Does not have any unhealed pressure ulcer at Stage 1 (intact skin with non-blanchable redness of a localized area usually over a bony prominence) or higher; -Used a wheelchair. Review of the facility's Skin/Wound Log, dated 02/09/25, showed the resident had a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister) pressure injury on the right buttock that measured 1.1 cm by 0.5 cm by 0.1 cm depth. Interventions included turning and positioning, nutrition/hydration, application of dressings, and application of ointments/medications. Review of the resident's progress notes, dated 03/19/25, showed the Director of Nursing (DON) and unknown certified nurse aide (CNA) went in to do a skin assessment on resident to rule out possible skin breakdown. The nurse observed an area of irritation on right lower buttocks and noted an area of redness 2. 5 cm length by 0.5 cm width with no depth or open areas. DON advised CNA to use barrier after toileting and showering resident. Nursing staff advised to place 4 by 4 dressing after barrier cream application to prevent further irritation. Review of the resident's progress notes and Skin/Wound log, dated 02/10/25 to 03/18/25, showed staff did not document a complete assessment of the pressure ulcer, or if the ulcer had healed. 5. During an interview on 03/20/25, at 12:50 P.M., LPN D said the following: -The charge nurses complete the treatments from the tar (treatment administration record); -If staff are not sure about a wound, they can check the charting to see if its new; -If staff have a resident with a new wound, staff will assess it and report to the doctor. During an interview on 03/19/25, at 3:15 P.M., Registered Nurse (RN) C said the following: -The administrator and the ADON track the wounds; -Charge nurses do weekly skin assessments and the treatments; -If staff report a new wound the charge nurse, the nurse will go assess it and will report it to the doctor if necessary. During an interview on 03/19/25, at 2:39 P.M., the Assistant Director of Nursing (ADON) said the following: -They had a wound care nurse here until a few weeks ago; -When the wound care company nurse practitioner was at the facility, he/she rounded with him/her; -He/she rounded with the wound care company nurse practitioner last on 03/05/25; (-The charge nurses handled the daily wound dressings; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurses do the weekly skin assessments on all residents; - If the charge nurse, or aide, or shower aide/restorative aide on the floor discovers a skin problem, they fill out a form and get this to the administrator and to the facility physician; -The former wound care nurse, RN A, would round with the wound care nurse practitioner and would keep the wound log; -The Administrator was now doing rounds and measuring wounds; -The facility was responsible for oversight and tracking of wounds. During an interview on 03/19/25, at 12:54 P.M., the Director of Nursing (DON) said the following: -The Administrator and her were now tracking wounds in the facility; -The wound care company tracked treatments when they were in the building. A nurse will go on rounds with them since the former wound nurse left 02/22/25. During an interview on 03/19/25, at 1:00 P.M., the Administrator said the following: -The former wound care nurse tried to measure wounds on the day the wound care nurse practitioner (NP) was at the facility that week. Sometimes the nurse would do measurements on Saturday or Sunday that he/she worked; -The former wound nurse did monitor all wounds with the wound care NP and did track the wounds in a wound log. If the wound care NP had changes in treatment orders, they would initiate treatment at that time; -The facility physician had a wound protocol. If a nurse found a wound on a resident, the nurse would uses this protocol to initiate treatment, then the nurse would call the on-call physician, the facility physician, or the physician's nurse practitioner, and the family. They would send a wound report to the facility physician to know what treatment to initiate for the resident; -When a wound was found, the charge nurse would report it to the DON or Administrator since the wound care nurse left; -The nurse does call the DON and the Administrator if they find a wound on a resident; -Since the wound care nurse left on 02/22/25, the Administrator tracked the wounds that the wound care company did not see or follow at the facility. The wound care company NP looked at the residents' wounds that they follow in the facility; -The ADON would do rounds with this wound care NP. The ADON was to chart in the resident's electronic medical record; -The Administrator did room rounds on residents if the wound care NP did not come as scheduled; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Administrator did talk to staff about the residents' skin when she saw a wound problem, but did not keep a running wound log with the weekly assessments. -The wound care nurse last documented measurements of wounds on 02/09/25. 51940