STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265753	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Nursing and Care Center	1486 North Riverside Rd Ozark, MO 65721

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on record review and interview, the facility failed to ensure the facility promoted each resident's right to self-determination when staff failed to provide bath/showers as preferred for four residents (Resident #5, Resident #6, Resident #7 and Resident #8) out of a sample of 14 residents. The facility had a census of 68. Review of the facility's policy titled, Shower Protocol, undated showed the following: -A and B wing shower schedule: Monday and Thursday hall one and two receive showers and Tuesday and Friday hall three and four receive showers. Wednesday is a make up day; -Document in the computer if shower given or not; -If resident refuses, fill out refusal form and have charge nurse chart refusal; -Shower list should be done daily and turned into front office with refusal forms. 1. Review of Resident #5's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD-a group of lung disease that blocks airflow and makes it difficult to breathe), pain in right knee, and Alzheimer's disease. Review of the resident's care plan, revised 04/25/24, showed the following: -Required limited to extensive assistance with activities of daily living (ADL's-dressing, grooming, bathing, eating and toileting) as needed; -Provide assistance with bathing as needed. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/23/24, showed the following: -Severely impaired cognitive skills; (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required partial/moderate assistance with toileting and personal hygiene; -Required substantial/maximal assistance with showering/bathing. Review of the resident's shower sheets, dated 08/01/24 through 09/05/24, showed the resident received, or was offered, a shower on the following days: -On 08/01/24, the resident refused a shower; -On 08/14/24, the resident received a shower (14 days after attempted shower); -On 08/27/24, the resident received a shower (13 days after prior shower); -On 09/03/24, (the resident received a shower (7 days after prior shower). During an interview on 09/05/24, at 1:50 P.M., the resident said the following: -He/she did not get showers; -The facility had a shower staff person awhile ago and he/she received showers two times a week; -He/she would like a showers at least one time a week; -He/she feels grungy when he/she does not receive his/her showers. During an interview on 09/05/24, at 3:12 P.M., the Director of Nursing (DON) said the resident should have received a shower before 14 days past. 2. Review of Resident #6's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included pain in right shoulder, edema, major depressive disorder and generalized anxiety disorder. Review of the resident's care plan, revised 08/07/24, showed the following: -Required limited to extensive assistance with ADLS; -Required assistance with bathing as needed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact skills; -Required set up or clean up assistance with showers and bathing. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower sheets, dated 08/01/24 through 09/05/24, showed the resident received a shower on the following days: -On 08/09/24 (at least nine day after prior shower); -On 08/14/24 (five days after prior shower); -On 08/16/24; -On 08/22/24 (six days after prior shower); -On 08/26/24; -On 09/02/24 (six days after prior shower); -On 09/08/24 (six days after prior shower). During interviews on 09/05/24, at 9:25 A.M. and 1:53 P.M., the resident said the following: -The shower aide quit; -He/she would like a shower at least twice a week; -He/she did not feel clean when he/she gives himself/herself a bath and he/she needed a staff person in the shower room with him/her to help. During an interview on 09/05/24, at 3:12 P.M., the DON said the resident should have stand-by assistance with showering. 3. Review of Resident #7's face sheet showed the following: -admitted [DATE]; -Diagnoses included heart failure, repeated falls, and generalized anxiety disorder. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact skills; -Supervision assistance required with tub/shower transfer. Review of the resident's care plan, dated 07/02/24, showed the following: -Needed minimum assistance and supervision with ADL's; -Provide assistance with bathing body parts he/she is unable to do; -Provide shower/bath two times a week. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's shower sheets, dated 08/01/24 through 09/01/24, showed the resident received a shower on the following days: -On 08/07/24 (at least seven day since previous shower); -On 08/13/24, staff documented the resident refused a shower (six days after prior shower); -On 08/27/24, staff documented the resident refused a shower (twenty days after prior shower and 14 days after last documented shower attempt); -On 08/28/24 (21 days after prior shower); -On 08/29/24. During an interview on 09/05/24, at 1:53 P.M., the resident said the following: -Staff's lack of help was reason he/she did not get showers; -He/she said it did not feel good to not receive a shower. During an interview on 09/05/24, at 3:12 P.M., the DON said the resident should have had a shower, or show offer, more frequently. 4. Review of Resident #8's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included anxiety disorder, overactive bladder, repeated falls, and unsteadiness on feet. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact skills; -Supervision required for shower/bathing. Review of the resident's care plan, revised 08/21/24, showed the following: -Needed minimum assistance and supervision with ADL's; -Provide assistance with bathing body parts the resident is unable to do; -Provide the resident a shower/bath two times a week. Review of the resident's shower sheets, dated 08/01/24 through 09/05/24, showed the resident received a shower on the following days: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 08/08/24 (at lest eight days since prior shower); -On 08/28/24 (20 days after prior shower); -On 09/04/24, staff documented the resident refused a shower (seven days after prior shower). During an interview on 09/05/24, at 1:45 P.M., the resident said the following: -He/she must give the staff a hard time to get a shower; -You are lucky to get a shower and that is not right; -He/she did not feel clean, which bothers him/her, when he/she did not get showers; -Staff do not give him/her a reason for not receiving a shower. During an interview on 09/05/24, at 3:12 P.M., the DON said the resident should have a shower before 20 days. 5. During an interview on 09/12/24, at 8:32 A.M., Certified Nurse Aide (CNA) F said he/she was assigned as the shower aide that day, but someone called in so he/she was pulled to work the floor as a CNA. 6. During an interview on 09/12/24, at 8:38 A.M., CNA G said the residents were not receiving showers as scheduled due to not enough staff. 7. During an interview on 09/05/24, at 10:27 A.M., Licensed Practical Nurse (LPN) D said the following: -The shower aide gets pulled from the floor due to staff turnover at times; -The nurse aides usually get a few showers completed each day. 8. During an interview on 09/05/24, at 10:30 A.M., Certified Nurse Aide (CNA) B said the following: -There have been decreased showers for residents since the shower aide quit: -The other shower aide works on the B wing as a CNA since the facility is short staffed. 9. During an interview on 09/05/24, at 1:56 P.M., Licensed Practical Nurse (LPN) C said the following: -Staff frequently pull the shower aides to work on the floor; -Showers are not happening. 10. During an interview on 09/10/24, at 5:30 A.M., LPN E said the following: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The residents' showers are iffy lately due to not a lot of staff. A lot of staff quit a month or two ago; -It is hit and miss with staff completing residents' showers; -Some residents complain of not receiving showers; -Staff try to give residents' one shower per week. Residents should get a shower twice per week; -Facility staff aware the residents' showers are not getting done. 11. During an interview on 09/05/24, at 3:12 P.M., the DON said the following: -There has not been a set shower aide during the day due to staffing; -The is no designated staff per hall for showers; -She expected the residents to have a shower more than every 10 to 12 days in between. 12. During an interview on 09/05/24, at 3:12 P.M., the Administrator said she expected residents to receive a shower before more than every 10 or 12 days. MO00240126, MO00241649 51208

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to consistently assess and document complete, thorough, and accurate weekly skin assessments and when staff failed to complete weekly wound tracking for three residents (Resident #1, Resident #2, and Resident #3) with pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) out of a sample of four residents. The facility census was 68. Review of the facility's policy titled Skin Integrity/Wound Policy, dated 01/19/24, showed the following: -The Director of Nursing (DON)/designee will perform weekly skin assessments for all reported residents with alteration of skin integrity related to ulceration of skin and document stage, size, description, color. and odor; -Weekly skin assessments on all residents will be completed and documented by the charge nurse. Weekly skin assessment documentation will include size, description, color, odor, and any change in skin condition. Any ulcerations will be expected to be documented with measurements, once weekly in the computer system by the charge nurse; -The charge nurse will notify the physician and DON/designee upon discovery of any change in skin condition, measure, accurately document and initiate treatment promptly; -The DON/designee will audit all new admissions records for accuracy related to skin within 72 hours after admission; -All charge nurses are required to complete documentation as instructed. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses included chronic kidney disease stage four, local infection of the skin and subcutaneous (something is located or inserted beneath the skin) tissue, and cognitive communication deficit. Review of resident's current Physician Order Sheet (POS) showed the following: -An order, dated 10/18/23, for staff to apply phisoderm anti-blem gel (skin cleanser), use to cleanse genital area, groin area, and buttocks two times daily; -An order, dated 11/07/23, for staff to apply calmoseptine (moisture barrier ointment that can help treat and prevent minor skin irritations) 0.44-20.6% to coccyx areas three times daily (TID). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's pressure ulcer list showed the resident acquired a pressure ulcer on 07/29/24. The list did not contain any documentation of the type, location, or measurements of the new pressure ulcer. Review of the resident's weekly skin assessment, dated 07/29/24 at 10:49 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location is moist pannus (excess skin), groin, and gluteal (buttock); -Moisture associated skin damage (MASD); -MASD location: gluteal with treatment in place; -Interdry treatment under pannus; -Skin turgor (tension) normal; -Resident at risk for developing pressure ulcers/injuries marked yes; -Skin and ulcer/injury treatments: nutrition or hydration intervention, pressure reducing device for chair and bed, and turning/repositioning program. (Staff did not identify a new pressure ulcer or provide a description of the new pressure ulcer.) Review of the resident's progress notes, dated 07/29/24 through 08/03/24, showed staff did not document regarding the pressure ulcer. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/03/24, showed the following: -Cognitively intact skills; -At risk for development of pressure ulcers; -No pressure ulcers; -Pressure reducing device for chair and bed; -Application of nonsurgical dressings other than to feet; -Applications of ointment/medications other than to feet. (Staff did not identify the pressure ulcer on the MDS assessment.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress notes, dated 08/04/24 through 08/14/24, showed staff did not document regarding the pressure ulcer. Review of the resident's medication record, dated 08/04/24 through 08/14/24, showed staff did not complete a weekly skin assessment for the resident. (The prior skin assessments was completed on 07/29/24.) Review of the resident's care plan, revised 08/14/24, showed the following: -Incontinent of bowel and bladder and at risk for pressure ulcers; -Pressure ulcer to his/her buttock and receiving treatment; -History of pressure ulcers in the past; -Licensed nurse to audit the resident's skin weekly; -Apply calmoseptine to peri-area as preventative moisture barrier; -Examine skin while bathing for any concerns or abnormalities; -The resident has an overall decline, not getting up as much. Review of the resident's medication record, dated 08/15/24 through 08/31/24, showed staff did not complete a weekly skin assessment for the resident. (The prior skin assessments was completed on 07/29/24.) Review of the resident's progress notes, dated 08/15/24 through 08/31/24, showed staff did not document regarding the pressure ulcer. Review of the DON's weekly wound tracking sheet, dated 08/26/24 through 08/30/24, showed the DON measured the resident's right buttock/coccyx ulcer. The ulcer measured 1.2 centimeters (cm) long by 2 cm wide by 0.1 cm deep. (The tracking did not contain any additional information regarding the wound or a description of the wound.) Review of the resident's medication record, dated 09/01/24 through 09/08/24, showed staff did not complete a weekly skin assessment for the resident. (The prior skin assessments was completed on 07/29/24.) Review of the resident's progress notes, dated 09/01/24 through 09/08/24, showed staff did not document regarding the pressure ulcer. Review of the resident's weekly skin assessment, dated 09/09/24 at 10:13 A.M., showed a nurse documented the following: -Skin temperature warm; -Skin color normal; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin moisture location dry; -Skin turgor normal; -The resident at risk for developing pressure ulcers/injuries marked yes; -Skin and ulcer/injury treatments: nutrition or hydration intervention, pressure reducing device for chair and bed, and turning/repositioning program. (Staff did not provide a description of the new pressure ulcer or measurements of the pressure ulcer.) During an interview on 09/10/24, at 10:08 A.M., the resident lay in his/her bed and said he/she reportedsoreness to his/her coccyx (tailbone area) wound if barrier cream was not applied. During interviews on 09/10/24, at 9:59 A.M. and 11:37 A.M. the Assistant Director of Nursing (ADON) said the following: -The resident has a chronic wound. Staff treat it and a few weeks later the wound returns which is part of his/her disease process; -She did not know the resident's wounds were not measured weekly and she had not seen the resident's wound; -She did not find any other weekly skin assessments from 07/29/24 through 09/09/24. During interviews on 09/10/24, at 09:28 A.M., 10:08 A.M., and 12:11 P.M., and on 09/12/24, at 10:48 A.M., the DON said the following: -She did not measure the resident's wounds from 07/29/24 through 08/26/24; -The resident had a bariatric chronic wound on his/her bottom which closed and opened; -On 08/26/24, she measured the wound at 1.2 cm long by 2 cm wide. She did not measure the wound since due to she worked as an aide on the floor; -She expected nurses to complete the resident's weekly skin assessments and document on skin concerns. 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included pain, edema (swelling), and chronic obstructive pulmonary disease (COPD-lung disease that causes breathing problems and restricted airflow). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 07/07/24, at 10:04 A.M., showed Licensed Practical Nurse (LPN) A documented the resident arrived to the facility from the hospital at 9:05 A.M. He/she notified the on-call nurse practitioner (NP). The resident was readmitted to the facility under the medical director. Review of the DON's skin document showed the resident readmitted with MASD on 07/07/24. Review of the resident's admission observation dated 07/08/24, at 10:28 A.M., showed LPN A documented the following: -Skin color normal; -Skin temperature warm; -Skin moisture dry; -Skin turgor normal; -MASD-moisuture associated skin damage; -Describe each skin integrity condition checked in detail, include location, color, size, drainage, redness, exudate, shape and degree: staff documented buttocks; -Did the resident have any pressure ulcer (s) or injury check the sacrum (triangle shaped bone between the hip bones) , heels, hips, ankles, elbows and ears and any other bony prominences-staff marked no; -The resident had no other pressure ulcers or injury. (Staff did not provide a description, measurements, or location of MASD.) Review of the resident's weekly skin assessment dated [DATE], at 1:59 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Skin turgor normal; -The resident at risk for developing pressure ulcer/injuries; -The resident's skin was clean, dry, and intact. The resident denied any bumps, bruises, cuts, scrapes, scratches, scabs, or abnormalities at this time. (Staff did not provide a description, measurements, or location of MASD.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's skilled daily nurses note dated 07/13/24, at 3:56 P.M., showed a nurse documented the following: -Skin desensitized to pain/pressure; -Open lesions; -MASD; -Shear to buttocks; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description, measurements, or location of MASD, lesions, or shear.) Review of the resident's skilled daily nurses note dated 07/14/24, at 10:19 A.M., showed a nurse documented the following: -Skin desensitized to pain/pressure; -MASD; -Shear to buttocks; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description, measurements, or location of MASD.) Review of the resident's daily skilled nurses note dated 07/14/24, at 12:32 P.M., showed a nurse documented the following: -Skin color normal/intact with no problems; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description, measurements, or location of MASD.) Review of the resident's daily skilled nurses note dated 07/14/24, at 11:15 P.M. showed a nurse documented the following: -Skin color normal/intact with no problems; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description, measurements, or location of MASD.) Review of the resident's weekly skin assessment dated [DATE], at 11:11 P.M., showed a nurse documented the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Skin turgor normal; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description, measurements, or location of prior identified MASD.) Review of the resident's skilled daily nurses note dated 07/15/24, at 11:09 A.M., showed the MDS Coordinator documented the following: -Skin color normal/intact with no problems; -Area that is sore to bottom, barrier cream for preventative/protection. -Staff did not document any other information regarding the resident's kin. (Staff did not provide a description or measurements of sore.) During an interview on 09/12/24, at 9:46 A.M., the MDS Coordinator said she did not remember what she meant by area sore to bottom. Review of the resident's medical record, dated 07/15/24, to 08/04/24, showed staff did not complete or document a weekly skin assessment on the resident. Review of the resident's weekly skin assessment dated [DATE], at 05:20 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Skin turgor normal; -Staff did not document any other information regarding the resident's skin. (Staff did not prior identified MASD or sore.) Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact skills; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ozark Nursing and Care Center	1486 North Riverside Rd Ozark, MO 65721

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At risk for development of pressure ulcers; -No presence of pressure ulcers; -Pressure reducing device for chair and bed; -Application of nonsurgical dressing other than to feet; -Application of ointments/medications other than to feet. Review of the resident's weekly skin assessment dated [DATE], at 1:17 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color locations normal; -Skin moisture location dry; -Pressure area on coccyx stage 2 (partial-thickness skin loss with exposed dermis); -Skin turgor normal; -Resident at risk for developing pressure ulcers/injuries; -Skin and ulcer/injury treatments wound care, nutrition or hydration intervention, pressure reducing device for chair, and turning/repositioning; -Staff did not document any other information regarding the wound. (Staff did not provide a description or measurements of the stage 2 pressure ulcer.) Review of the resident's weekly skin assessment dated [DATE], at 4:05 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Stage 2 on coccyx; -Skin turgor normal; -The resident at risk for developing pressure ulcers/injuries; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had breakdown on coccyx, resident turned and repositioned every two hours, and bedside ointment applied. Resident states understanding, continuing to monitor. (Staff did not provide a description or measurements of the stage 2 pressure ulcer.) Review of the resident's weekly skin assessment dated [DATE], at 3:00 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Additional details-intact; -Skin turgor normal; -The resident at risk for developing pressure ulcers/injuries; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description or measurements of the stage 2 pressure ulcer.) Review of the resident's progress note dated 08/27/24, at 9:54 A.M., showed LPN C documented a CNA informed him/her that the resident's bottom was worse. The had several open areas and excoriated areas on both sides of his/her buttocks. Treatment applied at this time. Staff to address with the provider. Review of the resident's POS, dated 08/30/24, showed an order for mepilex (foam bandage) 4 by 4 topical to coccyx every three days and when soiled until wounds are healed, once a morning every three days AM med pass. Review of the resident's weekly skin assessment dated [DATE], at 4:23 A.M. showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Skin turgor normal; -The resident at risk for developing pressure ulcers/injuries; -Coccyx area reddened with what appears as MASD, skin remains intact at this time, barrier cream applied, resident turned and repositioned every two hours this shift and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Staff did not provide a description or measurements regarding the MASD or follow-up on the stage-2 ulcer.) Review of the resident's care plan, revised 09/02/24, showed the following: -Incontinent of bowel and bladder and at risk for pressure ulcers; -Reddened coccyx/MASD barrier cream applied; -Staff to conduct skin audit weekly by licensed nurse; -Apply calmoseptine to peri-area as preventative moisture barrier. Review of the DON's wound tracking document, dated 09/02/24 through 09/06/24, showed the resident's wound on his/her left buttock measured 0.5 cm long by 0.5 cm wide by 0.1 cm in depth. Review of the resident's weekly skin assessment dated [DATE], at 12:21 P.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location dry; -Skin turgor normal; -Staff did not document any other information regarding the resident's skin. (Staff did not provide a description or measurements previously identified MASD or ulcer on left buttock.) Observation and interview on 09/10/24 at 10:25 A.M. showed the following: -The resident sat in a chair in his/her room said he/she did not have a dressing on his/her coccyx wound; -The resident stood up from his/her chair and the DON performed wound care to the resident's coccyx; -Observation showed no dressing on the coccyx wound;. -The DON measured the resident's wound on the coccyx at 0.4 cm long x 0.3 cm wide and no depth; -The DON applied barrier cream to the resident's coccyx wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/24, at 12:46 P.M., LPN C said on 08/27/24 the resident's wound was to both sides of his/her buttock, excoriated and opened. Both sides were red. The skin sloughed off and resident had shearing areas on both sides. He/she had not seen the wound since then. During interviews on 09/10/24, at 9:28 A.M., 10:25 A.M., and 12:11 P.M., and on 09/12/24, at 10:48 A.M., the DON said the following: -The resident had a chronic wound on his/her buttock which heals and comes back; -The week of 09/2/24 through 09/6/24 she measured the wound at 0.5 cm long by 0.5 cm wide by 0.1 cm deep; -She did not have a specific date for when the resident's wound started, she only measured the wound on 09/02/24; -On 09/10/24, during the observation with the surveyor, the resident did not have an ordered bandage on. The DON said the resident should have a bandage on and the nurses should contact the physician if a change was needed; -On 09/10/24, the resident's wound was not open or draining. During interviews on 09/10/24, at 9:59 A.M. and 11:37 A.M., the Assistant Director of Nursing (ADON) said the following: -She was not aware the DON did not measure the resident's wound weekly and had not seen the resident's wound since she had worked night shift; -The nurses should document in the comment section on the weekly wound assessment of the wound's location, if an infection, description of the wound and if a new wound. 3. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included multiple sclerosis (a chronic disease of the central nervous system), acquired absence of left leg above knee, and chronic pain. Review of the resident's current POS showed an order, dated 10/18/23, for calmoseptine ointment 0.44-20. 6% topical, apply topically to coccyx two times daily. Review of the resident's progress note dated 06/30/24, at 7:18 P.M., showed a nurse documented 4 cm diameter wound found on the resident's coccyx. The resident's wound was a stage 2 with no drainage noted. Nurse applied calmoseptine applied to the wound bed. Staff passed this information on to the second shift. Review of the resident's annual MDS, dated [DATE], showed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Moderately impaired cognitive skills; -The resident had a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device; -At risk for development of pressure ulcer; -One or more unhealed pressure ulcer at stage one or higher; -One stage 2 pressure ulcer; -Pressure reducing device for chair and bed; -Nutrition or hydration intervention to manage skin problems; -Applications of ointments/medications other than to feet. Review of the resident's medical record dated 07/01/24 to 07/19/24, showed staff did not document completion of a skin assessment. Review of the resident's weekly skin assessment dated [DATE], at 3:07 P.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location moisture to the buttocks, groin; -Redness noted to the groin and buttocks at this time; -Skin turgor normal; -The resident at risk for developing pressure ulcers/injuries; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Review of the resident's weekly skin assessment dated [DATE], at 3:58 P.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location moist, MASD to buttocks; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin turgor normal; -Resident at risk for developing pressure ulcers/injuries; -Skin and ulcer/injury treatments-wound care, pressure reducing device for chair and bed, turning/repositioning program; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Review of the resident's weekly skin assessment dated [DATE], at 3:53 P.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin turgor normal; -Resident at risk for developing pressure ulcers/injuries; -Redness to buttocks; -Skin and ulcer/injury treatments-nutrition or hydration intervention, pressure reducing device for chair and bed, turning/repositioning program; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Review of the DON's weekly wound tracking document, dated 08/12/24 through 08/16/24, showed the resident's left buttock wound measured 0.8 cm long by 1 cm wide by 0.1 cm in depth. Review of the resident's weekly skin assessment dated [DATE], at 11:57 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location moist-MASD; -MASD to perianal area due to incontinence and leaking from catheter (tube that drains urine from the bladder); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin turgor normal; -Resident at risk for developing pressure ulcers/injuries; -Skin and ulcer/injury treatments-wound care, pressure reducing device for chair and bed ,and turning/repositioning program; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Review of the resident's care plan, revised 08/24/24, showed the following: -Resident at risk for pressure ulcers related to mobility; -Staff conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence; -Staff should keep the resident clean and dry as possible; -Staff should report any signs of skin breakdown (sore, tender, red or broken areas); -MASD to perineal area. Review of the resident's weekly skin assessment dated [DATE], at 10:19 A.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; -Skin moisture location moist buttocks; -Resident at risk for developing pressure ulcers/injuries-staff marked no; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Review of the resident's weekly skin assessment dated [DATE], at 4:53 P.M., showed a nurse documented the following: -Skin temperature location warm; -Skin color location normal; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin moisture location dry; -Skin turgor normal; -Resident at risk for developing pressure ulcers/injuries; -Skin and ulcer/injury treatments - wound care, nutrition or hydration intervention, and pressure reducing device for chair and bed; -Staff did not document any other information regarding the resident's skin. (Staff did not document a description of the resident's previously identified wound or follow-up on the the wound.) Observation and interview on 09/10/24, at 10:35 A.M., with the DON and resident showed the following: -The resident lay in his/her bed; -The resident said his/her wound was not as sore as it had been; -The wound was resolved, there was nothing to measure. During interviews on 09/10/24, at 9:28 A.M. and 12:11 P.M., and on 09/12/24, at 10:48 A.M., the DON said the following: -On 08/16/24, the resident's coccyx wound measured 0.8 cm long by 0.1 cm wide. She did not have current measurements. The resident's wound had not got worse since his/her last observation; -She did not measure the resident's wound during the dates of 06/30/24 through 08/16/24; -She expected the nurses to document and complete weekly assessments on the resident. During interviews on 09/10/24, at 9:59 A.M. and 11:37 A.M the ADON said the following: -She did not know the DON did not measure the resident's wound weekly; -She did not find the resident's 08/03/24 weekly skin assessment. 4. During an interview on 09/10/24, at 10:17 A.M., LPN D said the following: -Nurses complete assigned weekly skin assessments; -Nurses assess the resident's skin and document in the computer; -The CNA's or the shower aide inform the nurse of any skin concerns; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurses should assess a resident's wound for tunneling, type of tissue, if the wound is open or closed, any redness, signs of an infection, or if new wound; -Nurses turn in the weekly skin assessments to the DON or ADON; -Nurses approximate a wound if it is open; -He/she believes the DON is responsible for tracking and measuring wounds weekly; -Nurses report any changes in skin or open areas in the shift report; -Tracking and measuring wounds is important to know if the treatment works, if small or worse, infections and need to look at changing treatment -The DON informs the physician with a new skin area. 5. During an interview on 09/10/24, at 12:34 P.M., LPN I/Infection Preventionist said the following: -The DON was responsible for weekly wound tracking; -She did not know the weekly wound tracking was not getting done; -Staff meet weekly and discuss wounds; -Nurses complete assigned weekly skin assessments which are in the computer; -Staff should document in the comments section on the weekly skin assessment of any open areas and bruises; -Staff should document of the wound location, size, any signs of infection or redness, drainage, and call the provider if needed. 6. During an interview on 09/10/24, at 11:11 A.M., and the MDS Coordinator said the following: -She reviewed weekly skin assessments which are in the computer; -The nurses complete the weekly skin assessments; -She asked the nursing staff about any wounds; -The DON was responsible for the weekly wound tracking; -The aides report any open areas to the nurses; -Staff conduct weekly meetings to discuss wounds, weight loss, and concerns; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The weekly meetings include the Administrator, DON, Infection Preventionist, ADON, Dietary Manager, social services staff, and medical record staff; -Staff discussed if a resident's wound was better, worse, or healed; -She updated the care plans regarding wounds. 7. During interviews on 09/10/24, at 9:59 A.M. and 11:37 A.M., the ADON said the following: -The aides should report any changes in a resident's skin to the nurse; -The nurses complete assigned weekly skin assessments and document in the computer; -Nurses notify the physician of skin changes and get an order for treatment; -Nurses or aides notify her or the DON of any changes to a resident's skin; -The DON was responsible for monitoring wounds; -The shower aides complete a shower sheet and include wounds and give to the DON; -The DON measures the wounds and keeps the measurements in a notebook; -Staff have a weekly meeting which included reviewing wounds, falls, and other concerns; -Staff should measure a resident's wound weekly; -The MDS Coordinator updates the care plans. 8. During interviews on 09/10/24, at 9:28 A.M., and on 09/12/24, at 10:48 A.M., the DON said the following: -She was behind on the weekly wound tracking due she worked the floor as a charge nurse; -She is responsible to complete the weekly wound tracking; -She should assess residents' wounds weekly; -She measured residents' wound when she works as an aide or charge nurse, but did not document; -She should complete weekly wound measurements and assessments and document in the medical record. -When the nurses complete the weekly skin assessments, they should conduct full head to toe assessment and look for bruising, rash, open areas and current open areas; -Nurses should document approximation size of a wound, what it looks like, treatment in place, and if improving or not. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. During an interview on 09/12/24, at 9:16 A.M., the Nurse Practitioner for the facility said the following: -She expected skin assessments and measurements of wounds to be completed; -She expected staff to check residents skin and document weekly. 10. During an interview on 09/12/24, at 1:22 P.M., the Medical Director said the following: -He expected staff to complete the weekly wound measurements; -He expected staff to complete the weekly skin assessments and document on wounds. 11. During an interview on 09/12/24, at 9:46 A.M. the Administrator said the following: -Staff should report any open areas or pressure ulcers to the her and the DON; -Weekly tracking is to monitor wounds; -Staff meet weekly on Thursdays to discuss falls, wounds, and other areas of concerns; -The DON missed weekly meetings due to working the floor and night shift in the nursing department; -She was not aware of missed weekly skin assessments. 51208

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34871 Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) did not serve as a charge nurse or certified nurse aide (CNA) when the facility census was greater than 60. The facility census was 68. Review showed the facility did not provide a policy regarding the responsibilities of the DON position. 1. Review of the facility provided nurse schedules and staff rosters, dated August 2024, showed the following: -On 08/09/24, the DON worked as a charge nurse on the 3:00 P.M. to 7:00 P.M. evening shift. The facility census was 72; -On 08/13/24, the DON worked as a certified nurse aide (CNA)/nurse aide (NA) on the 6:30 P.M. to 11:00 P.M. evening shift. The facility census was 71; -On 08/16/24, the DON worked as a Licensed Practical Nurse (LPN)/Certified Medication Technician (CMT) on the 6:30 A.M. to 3:00 P.M. day shift. The facility census was 71; -On 08/19/24, the DON worked as a CNA/NA on the 6:30 P.M. to 11:00 P.M. evening shift. The census was 73; -On 08/23/24, the DON worked as a CNA/NA on the 6:30 P.M. to 11:00 P.M. evening shift. The census was 71. During an interview on 09/12/24. at 10:48 A.M., the DON said she worked the following shifts: -On 08/09/24 as a charge nurse; -On 08/13/24 as a CNA; -On 08/16/24 as a LPN/CMT; -On 08/19/24 as a CNA/NA; -On 08/23/24 as a CNA/NA. During an interview on 09/12/24, at 08:30 A.M., LPN A said the DON worked as a charge nurse or CNA when needed. During an interview on 09/12/24, at 9:46 A.M., the Minimum Data Set (MDS - federally mandated assessment tool completed by facility staff) Coordinator said the following: (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Administration staff works the floor as nursing staff at times; -The DON worked on the floor as a CNA and charge nurse at times; -Duties for DON are difficult to complete since she works so much. During an interview on 09/12/24, at 10:48 AM, the DON said she was behind on her DON duties due to covering the floor. During an interview on 09/12/24, at 10:48 A.M., Administrator said she was aware of the DON working shifts as charge nurse and aides. 51208