STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265835	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing & Rehab	3405 West MT Vernon Springfield, MO 65802

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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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide care per standarda of practice when staff failed to correctly enter and follow the wound care specialist recommendations for the wound care treatment of one resident (Resident #1). The census was 64.Review of the facility's policy, Wound Care and Treatment, undated, showed the following:-It is the purpose of the facility is to prevent and treat all wounds;-There must be a specific order for the treatment;-The care plan should reflect the current status of the wound and appropriate goals and approaches.1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 09/26/25;-Diagnoses included cellulitis (a common, potentially serious bacterial skin infection affecting the dermis and subcutaneous tissues, typically causing red, hot, swollen, and tender skin) and gangrene.Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/25, showed the following:-The resident was cognitively intact;-The resident requires moderate assistance for transfers.Review of the resident's care plan, updated 10/31/25, showed the following: -Resident had impaired skin integrity with risk for poor skin healing, additional breakdown due to bilateral lower leg cellulitis-Treatments will be in place to improve/heal existing skin issues and prevent further skin breakdown to the extent possible secondary to medical complexities through review;-Treatments per physician orders, assess/document/review with physician for wounds without improvement for treatments order changes;-Observe, document and report any indications of dehydration to the physician;-Encourage hydration by offering fluids, ensure fresh water is at bedside, offer and assist with drinks of water as needed;-Nutritional consultation as needed for wound healing nutritional approaches;-Wound dressing changes twice daily. Cleanse all areas and apply Dakins(a widely used, hospital-grade antiseptic used to cleanse skin and soft tissue wounds, prevent infections, and treat burns or chronic ulcers) to the left foot and cover with dry gauze and rolled gauze;-Treatments were changed when the Family Nurse Practitioner (FNP) rounded. Betadine (a trusted, broad-spectrum antiseptic used to treat minor cuts, scrapes, and burns by killing bacteria, fungi, and viruses to prevent infection) for the left toe treatment and cover loosely with gauze, start date 10/31/25;Review of the resident's December 2025 Physician Order Sheet (POS) showed an order, dated 11/14/25, for left big toe. Staff to cleanse wound with hypochlorous acid (wound cleanser), do not rinse from wounds or skin, and paint with Betadine two times a day. Review of the resident's Wound Care Specialist progress note, dated 12/12/26, showed the following:-The treatment will remain the same for the left big toe wound;-The wound care FNP completed wound care and debridement of the resident's wounds;-The resident's wound measured 7.2 cm length, 3.5 cm width, eschar (dead, devitalized tissue that is hard pr soft in texture, usually black, brown, or tan in color) 90%, slough(non-viable yellow, tan, gray, green, or brown tissue usually moist) 10%;-Wound Recommendations/orders and certified plan of care: Cleanse wound with hypochlorous acid, do not rinse, use to irrigate and scrub the wound bed, paint with betadine, and apply calcium alginate (a highly absorptive, biodegradable, and biocompatible material derived from brown seaweed, commonly used as a medical dressing for moderate to heavily exuding wounds) dressing to the wound base. Cut to fit inside of wound edges and do not place on the skin. Change dressing daily and as needed for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiling, saturation or unscheduled removal;-All orders will remain in effect until discontinued, revised, or replaced with additional orders. It is okay to continue current treatment orders until able to obtain supplies/medications for updated orders.-Signed by the wound care FNP.Review of the resident's December 2025 POS showed an order change, dated 12/15/25, for the left big toe. Staff to cleanse wound with hypochlorous acid (product is non-cytoxic. Do not use with silver), do not rinse from wounds or skin, paint with Betadine two times a daily. Treatment once every other day. (Order was updated three days after the FNP visit and did not include orders for use of the calcium alginate dressing.)Review of the resident's Wound Care Specialist progress note, dated 12/19/25, showed the following:-The treatment will remain the same for the left big toe wound;-The wound care FNP completed wound care and debridement of the resident's wounds;-The resident's wound measured 7.2 cm length, 1.2 cm width, eschar 90% and slough 10%;-Wound Recommendations/orders and certified plan of care: Cleanse wound with hypochlorous acid, do not rinse, use to irrigate and scrub the wound bed, paint with betadine, and apply calcium alginate dressing to the wound base. Cut to fit inside of wound edges and do not place on the skin. Change dressing daily and as needed for soiling, saturation or unscheduled removal;-All orders will remain in effect until discontinued, revised, or replaced with additional orders. It is okay to continue current treatment orders until able to obtain supplies/medications for updated orders.-Signed by the wound care FNP.Review of the resident's nursing note dated 12/19/25, at 1:35 PM, showed the wound care FNP rounded and clarified orders for undressing cleansing, debriding, and taking manual measurements. Staff should paint the big toe in betadine and calcium alginate placed around the toe in the crevice between the toe and the healthy foot tissue. The resident is considering getting the great toe removed surgically but is unsure if insurance will cover it. Review of the resident's December 2025 POS showed an order change, dated 12/19/25, for the left big toe. Staff to cleanse wound with hypochlorous acid, do not rinse from wounds or skin, paint with Betadine two times a day, and apply calcium alginate to crevice between the toe and foot once every other day. (The FNP ordered the dressing change daily and calcium alginate to be cut to fit in wound.)Review of the resident's care plan, updated 12/19/25, showed the following added:-Wound care FNP rounded and clarified orders for undressing cleansing, debriding, and taking manual measurements;-Wound care throughout left leg should be done every other day and as needed when soiled/dislodged;-The big toe should be painted in Betadine and calcium alginate placed around the toe in the crevice between the toe and the healthy foot tissue;-Resident is considering getting the great toe removed surgically but being unsure if insurance will cover it.Review of the resident's care plan, updated 12/29/25, showed the following added: -When seen by the wound care FNP, he/she asked if the facility could get an order for podiatry consult for the resident's left foot great toe due to dry gangrene.Review of the resident's Wound Care Specialist Progress Note, dated 01/02/26, showed the following:-The wound care FNP completed wound care and debridement of the resident's wounds;-The resident's wound measured 7cm length, 3.2cm width, granulation 10%, eschar)70%, slough 20%;-Wound recommendations/orders and certified plan of cares for left big toe: Cleanse wound with hypochlorous acid, do not rinse, use to irrigate and scrub the wound bed, paint with betadine and apply Calcium alginate dressing to the wound base. Cut to fit inside of wound edges and do not place on the skin. Change dressing daily and as needed for soiling, saturation or unscheduled removal;-All orders will remain in effect until discontinued, revised, or replaced with additional orders. It is okay to continue current treatment orders until able to obtain supplies/medications for updated orders.-Signed by the wound care FNP.Review of the resident's January 2026 POS showed staff did not update the order to reflect the correct frequency (daily) and direction to cut calcium alginate to fit in the wound. Review of the resident's Wound Care Specialist Progress Note, dated 01/09/26 showed the following:-The wound care FNP completed assessment of the resident's wounds;-All orders will remain in effect until discontinued, revised, or replaced with additional orders. It is okay to continue current treatment orders until able to obtain supplies/medications for updated orders.-Signed by the wound care FNP.Review of the resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 2026 POS showed staff did not update the order to reflect the correct frequency (daily) and direction to cut calcium alginate to fit in the wound. During an interview on 04/24/26, at 11:21 A.M., Licensed Practical Nurse (LPN) A said the following:-He/she completed wound care on the resident. He/she remembered doing wound care every day for a while, but then thought the order changed to every other day;-The wound care FNP visited the facility once a week. The FNP assessed the resident's wounds and made recommendations for wound care. The facility nurse entered the order into the computer, and the physician signed off on it;-The facility staff follow the recommendations of the wound care FNP if they assess the resident's wounds;-He/she did not know why the orders would not match the recommendations of the wound care FNP.During an interview on 04/24/26, at 1:28 P.M., LPN C said the following:-The resident's left big toe was being treated by staff to prevent infection;-He/she performed wound care on the resident the day before he/she left the facility;-The nurses follow the wound care recommendations made by the wound care FNP. If the wound care FNP updated wound care recommendations or orders the facility nurse wrote an order and the physician signed it;-He/she did not know the order for the big toe treatment frequency changed. He/she did not know decreasing treatment to every other day had not been recommended by the FNP. He/she does not know why the order was changed;-The orders in the computer should match the recommendations made by the wound care FNP.During an interview on 04/24/26, at 1:54 P.M., Registered Nurse (RN) D said the following:-He/she believed the nurses were supposed to follow the wound care recommendations from the wound care FNP unless the physician gives different orders;-He/she would contact the physician if the wound care orders did not match the recommendations made by the wound care FNP.During an interview on 04/24/26, at 12:33 P.M., the Wound Care FNP said the following:-The resident's left big toe had dry gangrene and was necrotic. He/she was trying to get the left big toe to dry up to facilitate self-amputation;-He/she came to the facility once a week and assessed the resident's wounds. He/she made recommendations for wound care, and the facility nurse would enter those recommendations into the computer as an order for the physician to sign;-He/she believed that the recommendations were being followed by the facility nurses;-He/she did not know the nurses had decreased the frequency of the left big toe treatment order for every other day. He/she did not regularly look at the orders in the computer after he/she relayed those orders to the nurse;-He/she did not decrease the frequency for the left big toe due to the increased drainage. The residents' increased activity caused the left big toe to have more drainage;-He/she expected the staff at the facility to follow his/her and the physician's recommendations/orders for wound treatment;-The facility staff should contact him/her if they need an order changed or if they have any concerns;-If the facility staff had questions regarding the wound care orders/recommendations, they can check his/her wound care progress notes.During an interview on 05/05/26, at 9:11 A.M., the resident's physician said the following: -The wound care FNP assessed and treated the resident's wounds;-He/she expected the facility staff to follow the wound care FNP's recommendations for wound care;-The staff generally rounded with the wound care FNP and would update or add any orders based on the wound care FNP's recommendations;-He/she did not know the wound order placed by the nurse for the resident's big toe did not match the recommendations from the wound care FNP;-He/she assumed that the order the nurse put in the computer matched the recommendations from the wound care FNP. During an interview on 04/24/26, at 4:32 P.M., the Director of Nursing (DON) said the following:-The wound care FNP came in once a week to assess and provide recommendations for the resident's wounds;-A facility nurse rounded with the wound care FNP while they completed their assessments of the wounds;-The wound care FNP communicates with the nurse recommendations for wound care treatments, and the nurse entered them into the computer for the physician to sign;-The nurse was expected to put the recommendations into the computer as a physician's order, they should match what is written in the wound care progress note;-He/she did not know that the order frequency for the left big toe did not match the recommendations in the wound care FNP note. He/she thinks it may have been a miscommunication (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the nurse that put in the orders.During an interview on 04/24/26, at 5:15 P.M, the Administrator said the following:-He/she expected the nurses to enter orders per the recommendations from the wound care FNP. If the staff has concerns, they should contact the physician;-He/she expected staff to follow physician orders for wound care treatments.Complaint #2992931