STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265842	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ssm Health Depaul Hospital - Anna House	12284 Depaul Drive Bridgeton, MO 63044

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 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. 42247 Based on observation, interview and record review, the facility failed to ensure one resident with pressure ulcers (injury to the skin and underlying tissues as a result of pressure or friction) received services, consistent with professional standards of practice, when staff failed to enter physician orders for wound care into the medical record for one of four residents sampled, which could have resulted in wound care not being provided. (Resident #1). The census was 60. Review of the facility's Pressure Sore Care Policy, undated, showed: Procedures for Stage 2 (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister) or greater pressure sore: Notify physician of pressure sore for treatment orders. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 3/16/24, showed: -Moderately impaired cognition; -Functional limited range of motion: upper extremity: impairment on one side, lower extremity: impairment on both sides; -Personal hygiene: partial/moderate assistance helper does less than half of the effort; -Roll left to right: substantial/maximal assistance; -Diagnoses included: progressive neurological condition, aphasia (loss of ability to understand or express speech) hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm or face), multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness impairment of speech and muscular coordination, blurred vision and severe fatigue); -At risk for developing pressure ulcers. Review of the care plan, in use at the time of the survey, showed: (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: The resident was at risk of pressure ulcer due to history of, prefers to stay in bed, refuses to get up out of bed. 4/15/2024 Pressure injury (localized damage to the skin as well as underlying soft tissue), noted to coccyx (tailbone) and left buttock requiring treatment and observation; -Goal: Treatment as ordered to coccyx and left buttock. During an observation and interview on 4/17/24 at 11:40 A.M., the resident lay in bed positioned towards the window watching TV. The resident said he/she had a sore on his/her butt. Review of the Wound Evaluation, dated 4/15/24, showed: -Body location: left ischial tuberosity (IT, V-shaped bone at the bottom of the pelvis that contacts a surface when a person is sitting down); -New: seven days old; -In house acquired; -Length: 3 centimeters (cm) X Width: 1.83 cm; Depth: no depth was documented; -Type of wound: pressure; -Stage: 2. Observation of the wound evaluation photo, dated 4/15/24, showed the wound had defined edges, inside the wound bed was a dark brownish colored area with a small amount of yellowish slough (dead tissue separating from living tissue) noted around the dark brownish area and a small yellowish string of slough. Review of the physician's order summary report, dated 4/17/24, showed, there no treatment order for the wound on the left IT. Review of the Treatment Administration Record (TAR), dated 4/1/24 through 4/17/24, showed, there no treatment order for the wound on the left IT. Review of the progress notes, dated 4/1/24 through 4/10/24, showed: -On 4/10/24 at 3:42 P.M., physician progress note, new sacral (tailbone) decubitus (pressure injury). Plan: turn side to side every two hours. Discussed local treatment of wound with nursing: -On 4/10/24 at 3:56 P.M., seen by the doctor, no new orders noted. Observation on 4/18/24 at 3:00 P.M., showed the resident lay in bed. The wound nurse removed the dressing off the left IT. The wound was open, no depth, irregular shaped with a small brownish colored spot noted inside the wound bed. Review of the Wound Evaluation, dated 4/18/24, showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Body location: left IT; -Improving: 10 days old; Review of the Skin and Wound Evaluation, dated 4/18/24, showed: -Description: pressure; -Stage: Stage 2: Partial-thickness skin loss with exposed dermis (skin); -Location: Left IT; -In-House Acquired; -How long has the wound been present? 1 week. During an interview on 4/18/24 at 11:53 A.M., the Wound Nurse said the resident was being treated for wounds on his/her buttocks/coccyx and the left IT. The wound on the left IT was from 4/15/24. She staged the wound as a stage 2 wound, but had been thinking about changing the wound to unstageable (a type of bed sore that occurs due to prolonged pressure on a specific area of the skin, resulting in the lack of blood flow and oxygen to the tissue) because of the dark spot inside the wound bed. She did not know what was under the dark spot. The order for the santyl (used to remove damaged tissue from chronic skin ulcers) was obtained two days ago. She hoped the nurse on the floor would enter the order into the computer. The Wound Nurse verified the yellowish around the dark spot noted in the photo on 4/15/24 was slough. Review of the progress notes, dated 4/11/24 through 4/18/24, showed no documentation of the wound on the left IT or a treatment order was received. During an interview on 4/17/24 at 9:25 A.M., Certified Medication Technician (CMT) B said if a resident had an open area, he/she would tell the nurse. During an interview on 4/17/24 at 9:35 A.M., Care Partner C said if a resident had a redden area, he/she would tell the nurse and document it in the medical record. If the resident had an open area, he/she would tell the nurse and have them look at it. During an interview on 4/18/24 at 9:15 A.M., Registered Nurse (RN) D said if a resident had an open area, he/she would assess and measure the wound, call the doctor, and obtain treatment orders. Wounds are documented in the progress notes and on the 24-hour report sheet and the Wound Nurse would be notified. The Wound Nurse measured and staged the wound. The nurse who found the wound was responsible for notifying the doctor and obtaining the orders. All wounds should have a treatment order. (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 4/18/24 at 3:55 P.M., the Assistant Director of Nursing (ADON) said if a resident had an open area, she would expect for staff to notify the doctor and obtain treatment orders. Wounds were documented in the progress notes and/or on the skin sheet and passed along in report. The nurse should document a description of what the wound looked like and the location of the wound along with the measurements. The person who obtained the treatment order was responsible for entering them into the computer. The ADON would expect staff to follow the facility's policies and procedures. During an interview on 4/18/24 at 4:18 P.M. the Administrator and Director of Nursing said if a wound was found, they expected staff to communicate to the doctor the location and a description of the wound. Wounds should be documented in the progress notes and under the skin integrity section of the medical record. The Wound Nurse was notified, and she measured and staged the wounds for consistency. The nurse who obtained physician orders was responsible for entering the orders into the computer. The administrator would expect for treatment orders to be put in the medical record within 24 to 72 hours. Staff should follow the facility's policies and procedures. MO00234253

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42247 Based on interview and record review, the facility failed to ensure that in accordance with acceptable professional standards and practices, medical records maintained were complete and accurately documented for one resident (Resident #1). The sample was five. The census was 60. Review of the facility's job description for Certified Medication Technician (CMT) dated: effective date 7/1/22, showed: -Duties and responsibilities: -Administer prescribed medications to residents; -Pass oral, topical, ophthalmic (having to do with the eyes) and inhalation medications; -Document all medications administered to residents. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 3/16/24, showed: -Moderately impaired cognition; -Diagnoses included: progressive neurological condition, aphasia (loss of ability to understand or express speech) hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) or hemiparesis (slight weakness in a leg, arm or face), multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness impairment of speech and muscular coordination, blurred vision and severe fatigue). Review of the care plan, in use at the time of the survey, showed: -Focus: The resident was at risk of pressure ulcer (localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) due to history of, prefers to stay in bed, refuses to get up out of bed. 4/15/2024 Pressure injury (localized damage to the skin as well as underlying soft tissue), noted to coccyx (tailbone) and left buttock requiring treatment and observation; -Goal: Treatment as ordered to coccyx and left buttock. Review of the Medication Administration Record (MAR), dated 4/1/24 through 4/17/24, showed: -A physician's order for: Wound Gel (promotes wound healing), first clean the coccyx with wound cleaner or soap & water, apply wound gel, cover with dry dressing or foam padding, change daily. Discontinued on 4/3/24; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Documentation showed: On 4/2 and 4/3/24 CMT E's initials and a 9 (9 meant: other/see progress notes) documented; -A physician's order for: Collagenase Ointment (Santyl, a prescription medication, sterile enzymatic debriding ointment) 250 unit/gram (GM): cleanse coccyx with wound cleanser, apply Santyl, cover with dry dressing change daily and as needed until healed, start date 4/4/24; -Documentation showed: on 4/4, 4/6, 4/8, 4/9, 4/10, and 4/12/24 all showed CMT E's initials and a 9 was documented; -Documentation showed: on 4/5, 4/11, 4/16 and 4/17/24 showed CMT E's initials. Review of the progress notes, dated 4/1/24 through 4/17/24, showed on 4/2, 4/3, 4/4, 4/5, 4/6, 4/8, 4/9, 4/10, 4/11, 4/12, 4/16 and 4/17/24 all medications given were documented. During an interview on 4/18/24 at 9:00 A.M., CMT E said most of the time the nurse supervisor would do the pressure ulcer treatments. CMT's could do pressure ulcer treatments such as applying prescription medications and applying dressings. If the CMT felt comfortable doing a treatment and if they had supplies, they could do it. If a dressing came off CMT E would either reinforce the dressing or apply a new dressing. CMT E said he/she felt comfortable doing the treatments. During an interview on 4/18/24 at 11:53 A.M., the Wound Nurse said she provided wound care for residents one to two times a week. Once a week she completed the wound assessment. The other days she completed wound care on the unit where the CMT was in charge of the unit. The wound nurse said she did not know if CMT's were allowed to complete treatments or not. During an interview on 4/18/24 at 3:55 P.M., the Assistant Director of Nursing (ADON) said the nurse on the floor was responsible for providing the wound the care. CMT's could provide some wound care, such as barrier creams. The person who provided the treatment should be the person who documented the treatment was completed. The staff member whose initials are documented on the MAR was CMT E. She did not know if the documentation which said all medications given included treatments. During an interview on 4/18/24 at 4:08 A.M., the Director of Nursing (DON) said sometimes when the staff documented a medications or treatment in the computer, the computer would not accept it. When that happened, staff sometimes would choose to document a 9. When staff documented all medication given, that would include treatments. The nurses provided wound care. If there was a CMT on the floor, the wound care was provided by the Wound Nurse. If the Wound Nurse was off, the nursing supervisor would provide the treatment. The person who administered the medication/treatment should be the person who documented it. Sometimes the nurses would go to the computer and click on the treatment to document it was completed without the CMT signing out and the nurse signing in. That was why CMT E's initials would appear in the box in place of the nurse's. During an interview on 4/23/24 at 10:30 A.M., the Administrator said, she would expect for the person who completed the task to document it. She expected for the medical record to be complete and accurate, and she would expect for staff to follow the facility's policies and procedures.