STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265843	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton City Manor	600 North Ohio Appleton City, MO 64724

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 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, failed to complete weekly wound tracking, and failed to obtain treatment orders for all wounds for one resident (Resident #1) 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 three residents. The facility census was 29. Review of the facility policy titled, Treatment/Services to Prevent/Heal Pressure Ulcers, undated, showed the following: -The facility will ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing; -Pressure sores will be evaluated weekly and the nurse will document the size, location, odor (if any), drainage (if any), and current treatment order; -The nurse will notify physician anytime the pressure sore is showing signs of non-healing or infection and request treatment order changes. Review of the facility policy titled, Wound Management, undated, showed the following: -The admitting nurse will complete an initial wound exam for each wound identified; -The unit manager or supervisor will document wounds on appropriate tracking log; -Unit manager or supervisor will update the log and every Thursday turn the completed tracking logs to the Director of Nursing (DON), Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff) Department, and Dietary Department. -Facility provides an outside wound care specialist who visits residents with wounds weekly; -Unit manager or designee will be responsible for completing the wound exam observation form. 1. Review of Resident #1's face sheet (admission data) showed the following: (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	-admitted [DATE]; -Diagnoses included multiple sclerosis (disease in which the immune system attacks the protective covering of the nerve cells), heart failure (chronic condition where the heart doesn't pump as well as it should), and type two diabetes mellitus (the body has trouble controlling blood sugar and using it for energy). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills; -At risk for development of pressure ulcers; -Three Stage 2 (shallow open ulcer with red or pink wound bed) pressure ulcers; -Pressure reducing device for chair and bed; -Application of non-surgical dressings other than to feet; -Applications of ointment/medications other than to feet. Review of the resident's care plan, revised 11/04/24, showed the following: -Resident had potential impairment to skin integrity related to fragile skin, multiple sclerosis, immobility, and incontinence; -Resident was dependent on staff for bed mobility, dressing, toileting, and showers. Review of the resident's nursing progress note, dated 09/17/24, showed an open area in crevice of his/her buttock measuring 1 centimeter (cm) by 0.4 cm by 0.2. Staff cleansed area with wound wash and covered with hydrocellular foam dressing. Review of the resident's nursing progress note, dated 10/15/24, showed Durable Power of Attorney (DPOA) concerned about open area to coccyx (small triangular bone at the base of the spinal column). Staff notified clinic of wound and asked to advise. Review of the resident's nursing progress notes, dated 10/15/24 to 10/24/24, showed staff did not document again regarding the wound or treatment until 10/24/24. Review of a nursing progress note, dated 10/24/24, showed a new treatment order for wound on buttock crevice. Wound measured 1.6 cm by 0.5 cm by 0.2 cm with a beefy red wound bed. Surrounding skin was fragile and no drainage. Wound is open to air. Review of resident's current Physician Order Sheet (POS) 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	-An order, dated 10/24/24, to cleanse the wound to the buttock crease with wound wash and pat dry. Pack wound with calcium alginate rope (dressing used for wounds with moderate to heavy drainage) and cover with hydro cellular foam dressing (highly absorptive foam dressing). Change as needed every time dressing is soiled. Review of resident's November Treatment Administration Record (TAR) showed the dressing to the buttocks documented as changed when soiled. Review of the resident's skin monitoring shower sheet, dated 10/30/24, showed a nurse assessment stating wound cleansed and dry dressing applied as ordered. The area on both buttocks were open, small area crevice wound open and packed. Review of a the resident's weekly skin assessment, dated 10/30/24, showed a nurse documented resident had an open area to buttocks on each side and crevice area with no odor or drainage. The areas were small on each buttock and treatment orders in place. Review of resident's POS showed no order for treatment of the areas on the resident's buttocks. Review of the resident's weekly skin assessment, dated 10/31/24, showed a nurse documented wound treatment in place and completed as ordered. Wound approximately 1 cm by 0.3 cm by 0.2 cm. (The nurse did not document regarding wounds to right and left buttock.) Review of the resident's weekly skin assessment, dated 11/07/24, showed a nurse documented wound treatment in place and completed as ordered. (Staff did not document an assessment of wound or indication of wounds to right and left buttock.) Review of the resident's skin monitoring shower sheet, dated 11/04/24, showed Certified Nurse Assistant (CNA) A documented an open break down area to buttocks with medicine and new patches applied with charge nurse. Review of the resident's nurse progress note, dated 11/06/24, showed treatment done to buttocks as ordered. Dressing applied to all three areas on buttocks. Red angry area with some clear drainage. Skin fragile with bumpy type blister. Review of resident's POS showed no order for treatment of the areas on the resident's buttocks. Observation and interview on 11/06/24, at 3:18 P.M., showed the following: -Licensed Practical Nurse (LPN) C obtained supplies from the treatment cart and entered the resident's room to visualize and measure resident's wound. -Resident rested in bed on left side with no dressing noted to buttocks. -LPN C measured the resident's wounds on the gluteal fold, the right buttocks, and left buttocks; -After measuring all wounds, LPN C removed gloves and threw gloves and measuring tape in trash; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN C reported resident's buttocks were excoriated (raw, irritated, or red skin) with two wounds on each buttock; -Right buttock wound measured 4 cm by 3 cm and had a red wound bed; -Left buttock wound measured 4 cm x 3 cm with a red wound bed. Observation and interview on 11/07/24, at 9:48 A.M. showed the following: -The corporate nurse and LPN E entered resident's room; -LPN E peeled off a dressing placed over the gluteal fold and measured the wound bed with a disposable measuring device, then replaced the dressing. -LPN E reported gluteal fold wound was approximately 1 cm by 0.3 cm by 0.2 cm and had a beefy red colored wound bed with white macerated (softened broken down skin related to prolonged exposure to moisture) surrounding skin. -LPN E then measured two wounds on the right buttocks and one wound on the left buttocks. -LPN E reported the buttocks had excoriation to both sides with scarring and dry peeling skin with reddened areas from previous wounds. -The wound on the left buttock measured 0.5 cm by 0.4 cm with a beefy red wound bed. -The wounds on the right buttock measured 1.5 cm by 0.6 cm and 1.4 cm x 0.5 cm, both with beefy red wound beds. -LPN E reported physician should be notified about additional open areas to obtain an order. During an interview on 11/07/24, at 9:48 A.M., the Corporate Nurse said the following: -The resident's wounds on right and left buttock appear to be stage two pressure ulcers; -He/she would expect the nurse to notify the physician and obtain orders; -The nurse should document description and measure wounds then notify physician and family. During an interview on 11/07/24, at 11:56 A.M., Nurse Aide (NA) B said the following: -CNA's inform the nurse, DON, or Administrator of any wounds; -Staff monitor for discoloration, redness, breakdown, and sore or raw spots on resident's skin; -The resident has two areas, dime size to his/her right buttock which opened a couple of weeks ago or longer; (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 has one smaller than the ones on the right buttock, but open a little on the left buttock; -Nurses change the resident's bandage and apply ointment on it. The nurses place a bandage on each buttock which is about the size of a sticky note pad. During an interview on 11/07/24, at 10:30 A.M., Certified Nurse Aide (CNA) A said the following: -He/she informed the nurse of any skin concerns; -On approximately 10/30/24, the resident had three open areas on his/her buttocks; -The resident had open areas on his/her right buttock for about two months; -The resident's right buttock had two large open areas in the middle of a larger deteriorated area; -The resident's left buttock was red and started to deteriorate in the middle with more depth, bubbled up and open; -Some nurses place a large dressing over all the open areas on the resident's buttocks and some nurses place a bandage on each open area on the right and left buttock. During an interview on 11/07/24, at 10:57 A.M., LPN E said the following: -Wound assessments should include length and width of wound, description, and if there is any drainage; -Wound assessments should be in the progress notes or on the skin assessment sheet; -Charge nurses are responsible for documenting and monitoring of wounds; -Nurses should notify the clinic of any new wounds; -The resident had areas on buttocks that open and close with excoriation for a long time; -Any redness or open areas on skin should be included in the skin assessment; -He/she did not document the redness or open areas in the skin assessment done this morning; -He/she did not know why he/she did not document the maceration and open areas on the skin assessment this morning; -He/she probably did not document redness or open areas due to the problem has been going on so long with buttocks. During an interview on 11/07/24, at 3:30 P.M., LPN C said the resident had one area on either side of his/her buttocks. He/she put bandages on the crease and each buttock. The resident's buttocks had redness just recently. He/she initialed the bandage on each buttock. (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 11/07/24, at 2:00 P.M., the Nurse Practitioner (NP) said the following: -The resident was observed to have redness to buttocks during sixty-day exam and he/she wrote an order for barrier cream; -He/she wrote a treatment order for the buttock crease wound when staff notified him/her; -He/she had not been notified of any skin concerns except for the buttock crease wound; -The resident had frail skin with some stage two pressure ulcers on buttocks; -LPN E notified him/her this morning to come reassess the wound; -The resident had three or four open areas with excoriation to buttocks; -Nurses should not do any treatment that is not ordered; -He/she does not want any bandages on right and left buttocks as it may peel skin off. During an interview on 11/13/24 at 09:28 A.M., the corporate nurse said the following: -Nurses should complete weekly skin assessments on residents; -Nurses should include a full wound description and measurements on the weekly skin assessments; -Staff should notify the physician of a new wound, document in the medical record, obtain a treatment order , and notify the responsible party. MO00243801, MO00244324 34871

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection control program when the facility failed to implement enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities) and when staff failed to follow infection control practices, per standard of practice, when staff failed to wash or sanitize hands at appropriate times during wound care to two residents (Resident #1 and Resident #2) out of a sample of three residents. The facility census was 29. Review showed the facility did not provide a policy for Enhanced Barrier Precautions. Review of the Centers for Disease Control's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 07/12/22, showed the following: -MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs; -EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities; -EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status or infection or colonization with an MDRO. -Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care. Review of a facility policy titled, Infection Control - Clean Dressing Change, undated, showed the following: -Facility to ensure clean dressing changes in accordance with state and federal regulations and national guidelines; -Staff should clean bedside table with a germicidal cloth and establish a clean field; -Supplies should be set up on a barrier; -Hand hygiene should be performed after supplies are set up, after removing used dressing, after wound is cleansed, and when wound care is complete. 1. Review of Resident #1's face sheet (admission data) showed the following: -admitted [DATE]; (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Diagnoses included multiple sclerosis (disease in which the immune system attacks the protective covering of the nerve cells), heart failure (chronic condition where the heart doesn't pump as well as it should), and type two diabetes mellitus (the body has trouble controlling blood sugar and using it for energy). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/17/24, showed the following: -Moderately impaired cognitive skills; -At risk for development of pressure ulcers; -Three Stage 2 (shallow open ulcer with red or pink wound bed) 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. Review of the resident's care plan, revised 11/04/24, showed the resident had potential impairment to skin integrity related to fragile skin, multiple sclerosis, immobility, and incontinence. Review of resident's current Physician Order Sheet (POS) showed an order, dated 10/24/24, to cleanse the wound to the buttock crease with wound wash and pat dry. Pack wound with calcium alginate rope (dressing used for wounds with moderate to heavy drainage) and cover with hydro cellular foam dressing (highly absorptive foam dressing). Change as needed every time dressing is soiled. Observation and interview on 11/06/24, at 3:18 P.M., showed the following: -Licensed Practical Nurse (LPN) C obtained supplies from the treatment cart and entered the resident's room to visualize and measure resident's wound. There was no sign or indication of EBP or PPE outside of the resident's room. -LPN C washed hands upon entering room and applied gloves. LPN C did not don a gown. -Resident rested in bed on left side with no dressing noted to buttocks. LPN C proceeded to measure the resident's wounds on the gluteal fold, the right buttocks, and left buttocks with the same disposable measurement device. LPN C did not change gloves or sanitize between measurements of each wound possibly contaminating multiple wounds with infectious materials. -After measuring all wounds, LPN C removed gloves and threw gloves and measuring tape in trash. -LPN C reported resident's buttocks was excoriated (raw, irritated, or red skin) with two wounds on each buttock. -LPN C did not perform hand hygiene upon completion of task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 11/07/24, at 9:48 A.M. showed the following: -The corporate nurse and LPN E entered resident's room, washed hands, and donned gloves. There was no sign or indication of EBP or PPE observed outside of resident's room. Neither staff donned a gown. -LPN E peeled off a dressing placed over the gluteal fold and measured the wound bed with a disposable measuring device, then replaced the dressing. -LPN E then proceeded to measure two wounds on the right buttocks and one wound on the left buttocks. LPN E did not change gloves, sanitize hands, or obtain a new measurement device which could possibly contaminate wounds with infectious material. -LPN E and the corporate nurse then removed gloves, disposed of trash, and washed hands prior to leaving room. 2. Review of Resident 2's face sheet showed the following: -admitted [DATE]; -Diagnoses included unspecified dementia, depression, hypertension (high blood pressure) and type two diabetes mellitus (the body has trouble controlling blood sugar and using it for energy) with diabetic neuropathy (weakness, numbness, and pain from nerve damage). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severely impaired decisions; -At risk for development of pressure ulcers; -No unhealed pressure ulcers. Review of the resident's nurses' notes dated 11/04/24, at 8:50 A.M., showed a nurse documented two nurse aides came to the nurses' desk with the resident at approximately 8:20 A.M. and stated the resident spilt his/her coffee. This nurse went to the resident's room and carefully removed the resident's pants and noted an open area approximate 17 1/2 cm by 21 cm by 0.1 cm. The nurse applied a cool, moist towel and notified the physician's office of the incident. The physician ordered staff to apply Silvadene (topical antimicrobial drug used to prevent wound infections)1% cream daily and non-adherent telfa dressing and secure with gauze. Staff covered the resident's wound with non-adherent dressing and waited for the medication to be delivered. The wound nurse from the hospital came to the facility and assessed the resident's wound later in the afternoon and change the order to twice a day. Review of resident's current POS showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An order, dated 11/04/24, for staff to apply Silvadene 1 percent (%) topical cream to burn area twice a day and as needed until healed. Change dressing daily and as needed to keep area clean and dry, use Silvadene as ordered, cover with non-adherent telfa and secure with gauze wrap and tape, do not apply tape to bare skin, tape gauze to itself; -Wound consult with hospital wound nurse; -The hospital wound nurse wrote an order, dated 11/04/24, for staff to apply Silvadene 1% twice a day to burn area; -An order, dated 11/07/24, for wound care. Staff to apply maxorb alginate silver wound dressing, cover with 6 by 6 island dressing, cover with stocking, and change every two days and as needed. Review of the resident's care plan, revised 11/04/24, showed the following: -The resident was at risk for skin breakdown due to incontinent episodes and required assistance with bed mobility transfers and hygiene due to severely impaired cognition; -The resident had a burn to left thigh received on 11/04/24. Observation 11/06/24, at 2:49 P.M., showed the following: -LPN C obtained supplies from the treatment cart and entered the resident's room to provide wound care. There was no sign or indication of EBP or PPE observed outside of the resident's room. Nurse Assistant (NA) D was present to assist with positioning resident during wound care. -LPN C placed the wound care supplies including wound cleanser, bandage, medication, and gauze on resident's bedside table without a barrier possibly contaminating supplies or resident's bed with infectious organisms. Both staff washed hands prior to donning gloves. LPN C and NA D did not don gowns to provide wound care. -NA D assisted with positioning of resident during the procedure. LPN C removed a dressing from resident's left leg and did not change gloves or perform hand hygiene. LPN C cleansed the wound using wound cleanser and gauze and then measured the wound. -LPN C described the wound as 27 cm x 11 cm and reported the wound bed was red with some skin sloughing off. -LPN C did not sanitize hands and then gathered supplies from the bedside table and placed them on resident bed without a barrier. LPN C opened two nonadherent dressing packages and placed the Silvadene cream on top of each dressing. LPN C placed the dressings with medication on top of the wound and then removed gloves. The LPN did not perform hand hygiene. LPN C then wrapped the resident leg with gauze wrap and placed tape on the gauze to secure in place. -LPN C then gathered trash and threw the trash away. LPN C collected the remaining supplies and placed them in the treatment cart possibly contaminating the inside of the cart and other treatment supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The LPN did not perform hand hygiene after wound care. 3. During an interview on 11/07/24, at 2:48 P.M., LPN E said the following: -He/she did not know what EBP were; -Nurses should wear gloves and a gown and possibly a mask when providing wound care; -The facility did not require staff to follow EBP; -Hand hygiene should be done before wound care, after removing dirty dressings, and when wound care is complete; -He/she usually sets wound care supplies on the bedside table and is unsure if he/she needs to do anything else. 4. During an interview on 11/07/24, at 3:30 P.M., LPN C said the following: -He/she did not know of the EBP procedures; -Staff should wear glasses, gown, mask, and gloves when providing care with splatters or airborne; -Staff should wear gloves and place wound care products on table or blanket for a clean barrier, change gloves and take off dirty gloves and wash hands when providing wound care. 5. During an interview on 11/07/24, at 2:33 P.M., Registered Nurse (RN) F said the following: -He/she did not know what EBP were; -Nurses should wear gloves for wound care, but if the wound has a lot of drainage a gown should be used as well; -All wound care supplies should be kept inside the package and the packaging should be used for a barrier when opened. 6. During an interview on 11/07/24, at 11:48 A.M., the Nurse Practitioner (NP) said the following: -He/she did not know what EBP were; -Nurses should sanitize and use gloves when providing wound care; -He/she would like nurses to provide a clean barrier for wound care supplies. 7. During an interview on 11/13/24, at 09:28 A.M., the Corporate Nurse said the following: -The facility did not implement EBP; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff should place a clean barrier, wash hands, and change gloves with wound care. Staff should wash hands when completing dirty to clean wound care and wash hands after wound treatment. MO00244324, MO00243801 34871