STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265864	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Independence	19200 E 37th Terrace S Independence, MO 64057

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** Based on interview and record review, the facility failed to document a comprehensive wound assessment and obtain physician's order for a pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) upon admission for one sampled resident (Resident #10) out of seven sampled residents. The facility census was 36 residents. Review of the facility's Wound Management Policy dated revised 7/2024 showed: -To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. --Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. --In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 1. Review of Resident #10's Face Sheet showed the resident admitted to the facility on [DATE] with following diagnosis of: -Traumatic Hemorrhage of brain tissue (head injury cause bleeding between brain and skull). -End stage Renal disease (is when you have permanent kidney failure that requires a regular course of dialysis (process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood) or a kidney transplant). -Diabetic neuropathy (damage to the nerves resulting in sensory loss in the extremities). -Multiple rib fractures (is a painful crack or actual break in a rib). -Left femur fracture (long thigh bone). -He/she was admitted for skilled therapy services. Review of the resident's Nursing admission assessment dated [DATE] at 8:11 P.M. showed: (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident admitted to the facility with a coccyx wound. -The skin section was check marked. -The resident had an area on his/her coccyx (tail bone) and buttocks. He/she had redness on buttocks. -There were no initial wound measurements or comprehensive assessment documented. Review of the resident's Physician Order Sheet (POS) dated 11/1/24 to 11/12/24 showed: -On 11/3/24 Registered Nurse (RN) A transcribed physician order for coccyx wound care to clean with wound cleanser, then pat dry and then apply Santyl, (an ointment used for the debridement of pressure ulcers) and calcium alginate (made from seaweed, they absorb fluids (exudate) from covered wounds and form a protective gel layer) to wound. Cover the wound with Optfoam (a thick pad dressing) dressing. Change wound dressing every day and as needed on day shift. Review of the resident's Treatment Administration Record (TAR) order dated 11/1/24 to 11/12/24 showed: -On 11/3/24: Coccyx wound care to clean with wound cleanser, then pat dry and then apply Santyl, and calcium alginate to wound. Cover the wound with Optifoam dressing. Change wound dressing every day and as needed on day shift. -Note: This order was obtained two days after admission. Review of the facility's Weekly Wound report dated 11/5/24 showed: -The resident had a coccyx wound upon admission on [DATE]. -The coccyx wound was an unstageable pressure injury. -Note: A comprehensive wound assessment was not documented until 4 days after admission. During an interview on 12/9/24 at 2:25 P.M., Wound Nurse said: -The admitting nurse was responsible for completing the resident's initial wound assessment. -He/she was onsite when the resident was admitted to the facility. -The resident was assessed by Licensed Practical Nurse (LPN) B and him/her. -The LPNs would been responsible for documenting the resident's initial skin assessment. -He/she would expect nursing staff to document more detail description of the resident's wounds upon admission. (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's wound was assessed upon admission but did not get documented in the medical record. -He/she would expect the nursing staff to obtain physician's orders for wound care when admitted . During an interview on 12/9/24 at 3:40 P.M. Director of Nursing (DON) said: -He/she would expect nursing staff to document detail wound assessment of to include the appearance or descriptive observation of the resident's coccyx wound. -The admitting nurse would be responsible for completing the initial admission assessment including any pressure wounds found. -The resident's coccyx wound was assessed upon admission by LPN B and the wound nurse, but they did not document a detail wound assessment to include general description and size of the resident's wound and obtaining treatment orders. -He/she would expect nursing staff document wound care and comprehensive wound assessment in the resident's progress notes and TAR upon admission. During an interview on 12/9/24 at 4:00 P.M., LPN B said: -He/she did assess the resident's coccyx wound on 11/1/24. -He/she did not document a comprehensive wound assessment but should have. -He/she only documented the resident had a coccyx wound and had redness. -He/she notified the wound nurse that the resident had a coccyx wound upon admission. -The wound nurse observed the resident coccyx wound on 11/1/24. -He/she was not aware if the wound nurse had document the resident initial wound assessment. -The corporation central intake office obtains and reviews the hospital physician orders and would transcribed the orders to the residents' POS and TAR. -He/she should have obtained physician's orders for wound care if they were not found on POS. During an interview on 12/11/14 at 8:38 A.M., RN A said: -On Saturday 11/2/24, an unknown Certified Nursing Assistant (CNA) informed him/her the resident dressing needed changed. -The resident had a wound to his/her coccyx area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she called the physician and obtained orders for the resident's wound and treated the wound on 11/2/24. -He/she had forgot to transcribe the physician order and the treatment completed on 11/2/24 but update the information in the resident's medical record on 11/3/24. -The wound treatments was competed for the resident on 11/2/24. MO 00245262