STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265865	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Pointe Health and Rehabilitation	3705 S Jefferson Ave Springfield, MO 65807

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on interview and record review, the facility failed to provide care per standards of practice when facility staff failed to assess, monitor, care plan, and provide treatment for one resident (Resident #1) related to his/her surgical incision to his/her cervical (C) spine (back of neck) resulting in the incision dehiscing (surgical incision edges separated) and greenish-white drainage. The facility census was 111. Review of the facility policy/procedure titled, Wound Care, revised October 2010, showed the following: -The purpose of the procedure was to provide guidelines for the care of wounds to promote healing; -Staff to verify there is a physician's order for the procedure; -Staff to review the resident's care plan to assess for any special needs of the resident; -Staff to document all assessment data obtained when inspecting the wound (wound bed color, size, drainage, etc.); -Staff to document if the resident refused the treatment and the reason why; -Staff to notify the supervisor if the resident refused wound care; -Staff to report other information in accordance with the facility policy and professional standards of practice. 1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included spinal stenosis (narrowing of the spaces between the disks) of the cervical (neck) region, encounter for surgical aftercare following surgery on the nervous system, abnormalities of gait and mobility, acute pain due to trauma, generalized anxiety disorder, obsessive compulsive disorder, and a history of falling. Review of the resident's hospital after visit summary, dated 07/25/24, 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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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Resident hospitalized from 07/03/24 to 07/25/24; -Procedures performed included cervical cord decompression (to relieve the pressure off the spine) and posterior and cervical fusion (surgical procedure to stabilize the spine in the neck region); -Discharge instructions for posterior cervical decompression showed neck brace to be worn at all times; -Incisional care said sutures in the incision will fall out on their own. Wash the area daily with warm, soapy water, and pat it dry. Keep the area clean and dry. You may cover it with a gauze bandage if it weeps or rubs against clothing. Change the dressing every day; -Call the physician immediately or seek immediate medical care if you have pain that does not get better after you take pain pills; have loose stitches; incision comes open; have blood or fluid draining from the incision; or have signs of infection such as increased pain, swelling, warmth, redness, red streaks leading from the site, swollen lymph nodes in the neck or armpits, or a fever. Review of the resident's admission summary progress note dated 07/25/24, at 12:10 P.M., showed the following in regards to the C-spine: -Resident arrived at the facility at this time via facility transport. Resident admitted to the hospital for a C-spine surgery on 07/03/24; -Resident's C-collar (a neck collar used to control head and neck movement) in place at all times related to recent surgical procedure. Review of the resident's July 2024 Physician Order Sheet showed staff did not document orders to assess, monitor, or treat the resident's surgical incision. Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 07/29/24, showed the following: -Cognitively intact; -Recent surgery requiring skilled nursing facility (SNF) care with fusion of spinal bones; -Did not reject care; -Inattention and disorganized thinking continuously present; -Range of motion to bilateral (both sides) lower extremities impaired; -Used walker and wheelchair. Review of the resident's (facility) Nurse Practitioner progress note, dated 07/29/24, showed the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-admitted to the hospital on 07/03/24 for further evaluation of global weakness in all his/her limbs as well as numbness in both upper extremities from the elbows down. The resident was taken to the operating room for a scheduled C 3-4 and C 4-5 laminotomy (removal of a portion of the vertebra to relief pressure), foraminotomy (surgical procedure to widen the opening in the spine where nerves exist), and decompression of spinal cord and nerve roots and posterior cervical fusion (surgical procedure to stabilize a portion of the spine) of C 3, C 4 and C 5 with lateral mass screws and rod on the right side only; -discharged to the facility on [DATE] for post-acute care; -Resident seen and examined today in the nursing facility. He/she was up in his/her wheelchair in the hall at the time of the visit; -Resident's cervical collar in place. The resident has a surgical incision to his/her posterior neck with silver dressing in place. Resident denied any specific complaints at that time. He/she denied pain or discomfort. Resident working with therapy and doing well; -Follow up with neurosurgery on 08/20/24; -Clean incision with soap and water and pat dry, wear cervical collar at all times; -Monitor for signs/symptoms of infection. Review of the resident's July 2024 Physician Order Sheet showed staff did not document orders to assess, monitor, or treat the resident's surgical incision. Review of the resident's nurse skin observation sheet, dated 07/29/24, showed surgical incision, post laminectomy (a removal of a portion of the vertebra to relieve pressure on the spine) with skin tears to left hand and small abrasion to bridge of the resident's nose. (The nurse did not document a full assessment and description of the incision.) Review of the resident's August 2024 Physician Order Sheet showed staff did not document orders to assess, monitor, or treat the resident's surgical incision. Review of the resident's social service progress note dated 08/05/24, at 11:40 A.M., showed the Admissions Coordinator documented the following: -Met with the resident to discuss discharge plans as staff stated the resident was not wanting to remain in LTC. Resident's medicare non-coverage letter explained to the resident. Resident stated was aware and would have family pick him/her up at the facility tomorrow, 08/06/24. -Resident was anxious about his/her neck collar that got wet. Notified therapy and nursing to assist the resident with the collar. Notified the resident the Social Service Director (SSD) would update the resident with home health information and any follow-up appointments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's nurse skin audit sheet, dated 08/05/24, showed surgical incision without redness. Skin tears to hand healing well without signs of infection and redness to resident's coccyx (tailbone area), blanchable. (The nurse did not document a full assessment and description of the incision.) Review of the resident's medical record showed staff did not document treatments completed to the resident's surgical incision, resident's refusal to allow for removal of the C-collar, physician notification of the incision care not provided or resident refusals, or full assessments and descriptions of the incision. Review of the resident's home health admission assessment, dated 08/07/24, showed the home health nurse documented the following: -The resident had a spinal surgery and stated that no one at the facility changed his/her dressing; -The resident had what appeared to be the original surgical dressing in place. The dressing was saturated with drainage and so was the collar; -The home health nurse called the facility to inquire what their wound care orders were and the facility said the sutures were to dissolve on their own and to leave open to air; -The home health nurse notified the resident of a large open wound; -The home health nurse also notified the surgeon and was able to schedule an appointment for the next day, 08/08/24; -Resident had an observable surgical wound to the upper spine that was open. Wounds size measured length of 4.5 centimeters (cm), width of 2.5 cm, and a depth of 0.3 cm with wound bed of 75% slough (collection of dead tissue and other debris that can build up in a wound, often appearing yellow, white, or tan) and tunneling (extending into the body tissues) 1.3 cm at 1 o'clock and 1.1 cm at 7 o'clock. During an interview on 08/22/24, at 10:30 A.M., the neurosurgeon's Nurse Practitioner (NP) said the following: -Facility staff should have followed hospital discharge instructions for wound care/monitoring of the resident's neck incision; -The C-collar was to remain in place, except for when the nurses were performing wound care; -On 08/07/24, the home health nurse sent the NP a photo of the resident's neck dressing and it appeared to be the type of dressing applied at the hospital prior to discharge, indicating the facility did not change the resident's incisional dressing; -On 08/08/24, the NP saw the resident in his/her office and the resident's neck incision had dehisced and the wound contained greenish-white drainage; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On one occasion, the resident wanted wet padding inside the C-collar changed after a shower, but the resident did not want the nurse to touch it. The resident went to therapy to have the padding changed out of his/her C-collar; He/she did not recall speaking with the resident's physician or nurse practitioner about the resident's neck or refusal to remove the C-collar; -The wound nurse worked Monday thru Friday each week at the facility and was responsible for resident skin treatments, including the treatment of surgical incisions; -If the wound nurse was not working, the nurses were responsible for the skin/surgical treatments; -After the resident discharged home, the Director of Nursing (DON) asked the nurse if he/she had ever removed the resident's brace and the nurse informed the DON the resident had refused to have the brace removed. During an interview on 08/21/24, at 11:15 A.M., LPN B said the following: -The resident admitted to the facility for rehabilitation after a cervical spine fusion and wore a C-collar; -The nurse was not aware of any orders for the resident for a skin treatment or incisional care; -The nurse was not aware the resident had an incision on his/her neck; -The resident refused to allow the nurse to remove his/her C-collar; -He/she probably could have done a better skin assessment on the resident; -The nurse did not think he/she notified anyone of the resident's refusal to allow removal of the C-collar, but should have notified the DON; -The wound care nurse usually performed care of resident surgical incisions, but the nurse was unsure if the wound nurse performed any incisional care for the resident during his/her stay at the facility; -Nurses were assigned weekly skin assessments for the residents, he/she tried to complete the assessments, but nurses were not consistently completing weekly skin assessments. During an interview on 08/21/24, at 11:35 A.M., Certified Nurse Assistant (CNA) C said the resident wore a neck collar at all times. He/she did not know the resident had an incision under the collar. During an interview on 08/21/24, at 11:39 A.M., Certified Medication Technician (CMT) D said the following: -The resident requested pain medications frequently and the CMT assumed the medication was for the resident's neck due to the neck brace; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-The nurse usually asked about the resident's pain location and rating; -The CMT was unsure if the resident had a neck incision. During an interview on 08/21/24, at 12:17 P.M., LPN E said the following: -Upon admission, the admitting nurse was responsible for completing a head to toe skin assessment; -If he/she admitted a resident with a C-collar, he/she would look for a physician's order for the collar and assess the resident for any incision underneath the collar; -He/she would obtain a physician's order to assess the resident's incision for signs and symptoms of infection and for treatment orders to the incision; -He/she would notify the facility wound nurse about the resident's incision on admission. During an interview on 08/21/24, at 12:24 P.M., the Wound Nurse said the following: -He/she was responsible for resident weekly wound assessments and treatments for approximately the past year at the facility; -He/she generally performed the treatments Monday through Friday that required a dressing or monitoring, the nurses generally treated residents with superficial skin tears or abrasions; -The nurses were responsible for weekly skin assessments; -On admission, the charge nurses were responsible for completing head to toe skin assessments for all residents; -He/she looked at the resident's admission nurse assessment and the assessment did not show any skin concerns and therefore there was no reason for the Wound Nurse to see the resident; -After the resident's discharge, he/she heard from other staff the resident had a surgical dressing left in place on his/her neck; -If the resident refused to have his/her C-collar removed on admission. The nurse should notify the facility physician and the resident's surgeon and document the refusal in the progress notes; -If the resident was admitted following a C-spine surgery the nurses charting should be geared toward that and the nurses should assess the resident's incision every shift; -The facility would need to obtain orders for incisional care/monitoring every shift for signs and symptoms of infection from the physician; -To his/her knowledge, the resident had no orders related to his/her incision. During an interview on 08/21/24, at 12:55 P.M., the Occupational Therapist (OT) F said the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Last week, a representative from former resident's home health agency came to the facility to inform the facility Administrator that the resident's neck incision dressing had not been changed during his/her time at the facility and when the home health nurse removed the dressing, the incision had dehisced; -Facility nurses should have clarified any orders on admission for treatment and/or monitoring of the resident's incision; -Staff should have included information in the resident's care plan regarding care and monitoring of the resident's C-collar and surgical incision. During an interview on 08/22/24, at 5:20 P.M., the Administrator said the following: -If a resident was admitted with a surgical incision, facility nurses should obtain a physician's order for monitoring and/or treatment of the incision; -If there is a discrepancy on the admission orders, the nurse should contact the primary care provider or surgeon's office for clarification; -Orders pertaining to the surgical incision should be on the care plan. MO00240762