STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265866	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide Activities of Daily Living (ADLs) assistance for seven residents (Resident #2, #11, #50, #1, #31, #15 and #20) out of 19 sampled residents who required assistance with ADLs. The facility Census was 50. 1. Review of the facility's policy titled Activities of Daily Living (ADLs), Supporting, dated March 2018, showed Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, dressing and grooming. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. Review of the facility policy titled, Bath, Shower/Tub, dated February 2018, showed the purposes of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Staff will document: -The date and time the shower/tub bath was performed. -The name and title of the individual(s) who assisted the resident with the shower/tub bath. -All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. -How the resident tolerated the shower/tub bath. -If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. -The signature and title of the person recording the data. 2. Review of Resident #2's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/27/26, showed staff assessed the resident as: -Cognitively intact; -Rejection of care-behavior not exhibited; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Impairment on both sides of lower extremities; -Substantial/maximal assistance with shower/bath, upper and lower body dressing, and personal hygiene. -Diagnosis of Osteoporosis (a chronic bone disease) and other fracture. Review of resident's care plan, dated 03/12/26, showed staff documented resident required substantial/max assistance with bathing/showering, provide sponge bath when a full bath or shower cannot be tolerated; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 03/06/26. Observation on 04/20/26 at 11:15 A.M., showed the resident in bed with upper lip hair and chin hair. Observation on 04/21/26 at 9:00 A.M., showed the resident in bed with upper lip hair and chin hair. During an interview on 04/21/26 at 9:00 A.M., the resident said he/she has only received one shower since he/she was admitted in January. He/She said staff uses wipes in diaper area, but his/her arms, legs, and back don't get washed. He/She said that the staff does not even ask if he/she wants a bed bath. He/She said staff do not offer to shave or use tweezers on his/her facial hair and he/she can't see well enough to do it him/herself. Observation on 04/22/26 at 11:25 A.M., showed the resident in bed with upper lip hair and chin hair. 3. Review of Resident #11's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Unable to be cognitively assessed; -Short/long-term memory problems; - Rejected care one to three days, but less than daily; - Dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, and personal hygiene; - Diagnoses of dementia; traumatic brain injury (TBI – a disruption in brain function), Bipolar Disorder (a mental health condition), and schizophrenia (chronic brain disorder). Review of the resident's care plan, dated 12/22/25, showed staff documented resident is dependent on one staff to provide bath/shower, and he/she prefers one shower per week; staff failed to document the resident's facial hair preference and behaviors with showering/bathing. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident received one partial bed bath on March 31, 2026. Observation on 04/20/26 at 11:59 A.M., showed the resident with his/her hair disheveled and knotted in appearance, wearing a long-sleeved gray sweatshirt, with long hairs curled under on his/her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/21/26 at 9:22 A.M., showed the resident with his/her hair combed back into messy bun with a disheveled appearance, wearing the same long-sleeved gray sweatshirt, with long hairs curled under on his/her chin. Observation on 04/22/26 at 10:03 A.M., showed the resident walking in the hallway with disheveled hair in a ponytail, with long hairs curled under on his/her chin. Observation on 04/23/26 at 10:00 A.M., the resident was walking in the hallway with disheveled hair and a disarrayed ponytail, with long hairs curled under on his/her chin. During an interview on 04/22/26 at 10:03 A.M., Certified Medication Technician/Certified Nurse Aide (CMT/CNA) G said the resident is combative with cares, clothing changes and showers, and it has to be two people to do his/her showers, and he/she has an as needed medication to take before showers too, and the CMT cannot do it with just one staff. CMT G said the resident gets agitated when staff try to get near his/her face, the resident pushed his/her hand away this morning when trying to clean the resident's face. CMT G said he/she will try to reapproach later, but there is usually only one staff member working on the Special Care Unit (SCU). CMT G said he/she tries to chart behaviors, but he/she cannot really make a note in the charting system, so he/she will pass the information to the charge nurse to chart a more detailed note, and he/she is not sure if that is being done. During an interview on 04/22/26 at 2:58 P.M., Certified Nurse Aide (CNA) J said the resident takes two to three people to do his/her showers, and the resident is fidgety and will fight and be combative, so it is hard to get him/her shaved and showered, although sometimes the resident can be more cooperative. During an interview on 04/23/26 at 10:04 A.M., CMT G said there is a shower room on the SCU, so staff will do those residents showers on the unit, and there is a shower schedule, but it is hard to do them because there is usually only one staff back here, sometimes there is a CMT but they are usually on the unit to pass medications, and it is hard to shower residents with one staff, since there are residents that wander and need to be watched. 4. Review of Resident #50's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Dependent on staff members for bathing and lower body dressing; -Maximal assistance from staff members for bed mobility and transfers. Review of the residents' care plan, dated 04/01/26, showed staff did had not documented the assistance the resident needed with ADLs. Review of shower sheets from February 2026 through April 2026, showed received showers on 02/11/26, 02/25/26, 03/02/26, 03/11/26, 03/23/26 and 04/13/26. Observation on 04/20/26 at 1:17 P.M., showed resident in room. When the door opened a strong, sour odor percolated into the hall. The resident's room filled with body odor and odors came directly from resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/21/26 at 11:26 A.M., the resident said he/she does not get enough showers, yesterday was one week from his/her last shower, and it was three weeks in between that one and the one before. The resident said he/she is pretty sure it is supposed to be twice a week, but that has never happened since he/she has been at the facility. The resident said it makes him/her feel gross. The resident said he/she can smell the bad odors he/she has, and it makes him/her not want to leave his/her room. 5. Review of Resident #1's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; -Dependent on staff for shower/bathe self, upper and lower body dressing, and tub/shower transfers; -Partial/Moderate assistance with personal hygiene; -Diagnoses of Alzheimer's, Arthritis, and seizure disorder. Review of resident's care plan, dated 02/17/26, showed staff documented resident is dependent on one staff with bathing/showering, and he/she prefers to bathe one time a week; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 03/02/26 and 03/29/26. Observation on 04/20/26 at 1:53 P.M., showed the resident in bed with several white chin hairs. Observation on 04/21/26 at 10:16 A.M., showed the resident in bed with several white chin hairs. Observation on 04/22/26 at 12:02 P.M., showed the resident in the dining room for lunch with several white chin hairs. During an interview on 04/22/26 at 12:02 P.M., resident said he/she does not remember the last time he/she had a shower but said it has been a while. He/She said staff usually shave him/her in shower. Observation on 04/23/26 at 2:38 P.M., showed the resident in bed with several white chin hairs. 6. Review of Resident #31's admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Very important to choose between a tub bath, shower, bed bath, or sponge bath; -Impairment on one side of upper and lower extremities; -Dependent of staff with shower/bathe, upper and lower body dressing, and personal hygiene; -Diagnosis of Arthritis, Cerebrovascular Accident (interrupted blood flow to the brain), (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Non-Alzheimer's Dementia, Traumatic Brain Injury (TBI). Review of resident's care plan, dated 03/11/26, showed staff documented resident is dependent on staff with bathing/showering, provide sponge bath when a full bath or shower cannot be tolerated; staff failed to document the resident's facial hair preference. Review of Shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 02/26/26 and 03/11/26. Observation on 04/20/26 at 1:58 P.M., showed resident in wheelchair by nurse's station. Residents' hair disheveled and facial hair about 0.5 inches long. Observation on 04/21/26 at 1:08 P.M., showed resident in wheelchair by nurse's station. The resident wore a grey hoodie with hood up and facial hair about 0.5 inches long. During an interview on 04/21/26 at 2:28 P.M., resident said he/she does not remember the last time he/she got a shower. He/She said he/she normally likes to be clean shaven on his/her face, but because he/she has not gotten a shower he/she has not been shaved. Observation on 04/22/26 at 8:51 A.M., showed resident in wheelchair by nurse's station wearing same grey hoodie as yesterday with hood up and facial hair about 0.5 inches long. 7. Review of Resident #15's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Rejection of care one to three days of look back period; -Occasionally incontinent of bladder; -Maximal assistance from staff members for bathing and lower body dressing; -Moderate assistance from staff members for upper body dressing, bed mobility and transfers. Review of the resident's care plan, dated 04/05/26, showed staff documented ADL self-care performance deficit due to fatigue. Resident requires limited assistance by one staff with bathing/showering. The resident prefers one shower per week. Please ensure that the resident gets at least one shower per week. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident refused shower on 02/11/26 and did not receive another shower until 03/03/26. Staff documented the resident received showers on 03/10/26 and 03/11/26. Observation on 04/21/26 at 10:00 A.M., showed the resident in bed with eyes closed. Strong odor of urine can be detected in the room and on the resident's person. Observation on 04/21/26 at 3:21 P.M., showed the resident in his/her wheelchair, in his/her room. The resident's hair appeared oily and clumped together. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/21/26 at 3:21 P.M., the resident said he/she is lucky to get one shower a week. The resident said he/she is happy if he/she can get a shower every week. The resident said he/she does not always get one shower a week, the facility is low staffed. The resident said the facility does not have enough staff to do showers. The resident said it's bad, but he/she can't recall his/her last shower, it has been at least two weeks. The resident said it makes him/her feel gross. 8. Review of Resident #20's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Intact cognition; -Rejection of care not exhibited; -Always incontinent of bowel and bladder; -Dependent on staff members for bed mobility, transfers and lower body dressing; -Maximal assistance from staff members for bathing and upper body dressing. Review of the resident's care plan, dated 01/29/26, showed staff documented resident has ADL self-care deficit due to pain from fracture. The resident requires extensive assistance from one staff with bathing/showering. The resident prefers one shower per week. Review of shower sheets from February 2026 through April 2026, showed staff documented the resident received a shower on 02/02/26, 02/16/26, 03/06/26, 03/11/26 and 04/14/26. The resident received two showers a month for the last three months. Observation on 04/21/26 at 10:14 A.M., showed resident in bed, covered up. Mild body odors detected in the room. During an interview on 04/21/26 at 10:14 A.M., the resident said he/she has not had a shower in probably a month, he/she asked staff for shower the other day, and staff said they would see, and the staff never came back. The resident said he/she has been having to give himself/herself bed baths. During an interview on 04/22/26 at 2:45 P.M., CNA J said he/she was put as a shower aide for two weeks and then they told him/her, he/she couldn't do showers anymore, they need him/her on the floor. The CNA said on a good day, the facility is lucky to have two aides on floor. The CNA said it has been a couple weeks since residents got a shower, they get showers at least once a week and never two a week. The CNA said the dates for showers on the shower sheets are absolutely correct, because 3/23/26 was the day he/she was the shower aide. During an interview on 04/22/26 at 2:46 P.M., CMT I said residents are not getting showers. The CMT said residents have missed their showers this week, due to staffing issues. During an interview on 04/23/26 at 2:01 P.M., CNA N said the facility doesn't have the staff to provide the care needed, like showers are horrendous. The CNA said it has been upwards to 16 days for residents to get showers. During an interview on 04/23/26 at 2:13 P.M., CNA D said residents get upset needing showers. The residents are not getting showers. The CNA said residents are going a couple of weeks without (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers, if not more. The CNA said it probably makes the residents feel awful and neglected, not cared for. During an interview on 04/23/26 at 3:03 P.M., Registered Nurse (RN) K said the reports I have gotten from residents, the biggest thing not getting done is showers. The RN said he/she has noticed the odors walking through the halls. During an interview on 04/23/26 at 4:12 P.M., the Director of Nursing (DON) said he/she is aware of the shower issue. The DON said the facility has initiated a Performance Improvement Plan (PIP), because residents had expressed the concern of not getting showers. The DON said even with the PIP, he/she knows it has been a struggle to get residents showers, because we had a lot of call ins last week. The DON said the charge nurse is responsible for making sure the staff know what showers they need to do on their shifts, and the DON is responsible to make sure the staff get those done. The DON said there is not assigned staff for showers on shifts. During an interview on 04/23/26 at 4:45 P.M., the administrator said residents should get showers twice a week per shower schedule. The administrator said he/she is aware the residents are not getting their scheduled showers, because of staffing. The administrator said the charge nurse is responsible to make sure residents get showers on their shifts. The administrator said shower sheets should be filled out when residents get their shower. The administrator said the CNA giving the shower, fills out shower sheet and gives charge nurse. The charge nurse puts all the shower sheets together and then the DON gets them. The administrator said the DON should review the shower sheets. The administrator said the DON is responsible for residents getting showers. 2787106, 2976653, 2989809

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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 observation, interview and record review, facility staff failed to document they provided the physician ordered wound treatment for one resident (Resident #2) and failed to ensure one resident (Resident #27) out of seven sampled residents received the necessary treatment and services in accordance with professional standards to promote the prevention of pressure ulcer/injury development when staff failed to provide pressure relief to the resident's heel which resulted in a new pressure ulcer/injury. The facility census was 50.1. Review of the National Pressure Injury Advisory Panels (NPIAP) showed a Stage 1 Pressure Injury is Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. 2. Review of the facility's policy titled Prevention of Pressure Injuries, dated April 2020, showed: -Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team;-Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines;-Provide support devices and assistance as needed;-Remind and encourage residents to change positions;-Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice;-Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device;-Monitor regularly for comfort and signs of pressure-related injury;-Evaluate, report and document potential changes in the skin;-Review the interventions and strategies for effectiveness on an ongoing basis. 3.Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the resident as: -Has pressure ulcer/injury, a scar over bony prominence;-Is at risk of developing pressure ulcers/injuries;-Has 1 or more unhealed pressure ulcer/injury;-One stage 1 (an early-stage, localized injury to intact skin, characterized by non-blanchable erythema (redness) that does not turn white when pressed) pressure injury;-Application of nonsurgical dressings, ointments/medications other than to feet.Review of resident's care plan, dated 03/12/26, showed staff documented resident has a stage three (a serious, full-thickness skin injury appearing as a deep, crater-like wound that exposes subcutaneous fat) pressure ulcer to sacrum and to administer treatments as ordered and monitor for effectiveness.Review of resident's Physician's Order Sheet (POS), dated March 2026, showed the physician directed staff to cleanse resident sacrum with wound cleanser, pat dry, apply skin prep to peri wound, cut a fit Calcium Alginate (a water-insoluble, gelatinous, cream-colored substance derived from brown seaweed, commonly used in advanced wound care and food thickening) to wound bed. Cover with bordered gauze dressing every day shift.Review of resident's Treatment Administration Record (TAR), dated March 2026, showed staff did not document they administered the treatment on 03/01/26 and 03/29/26.Review of resident's TAR, dated April 2026, showed staff did not document they administered the treatment on 04/2/26; 04/03/26; 04/06/26; 04/07/26; 04/15/26; and 04/21/26. 4. Review of Resident #27's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/06/26, showed staff assessed the resident as: -Severe cognitive impairment;-Range of Motion (ROM) to both sides of lower extremities (legs);-Dependent on staff for bed mobility and transfers;-At risk for pressure ulcers/injuries;-Turning/repositioning program.Review of the resident's care plan, dated 03/12/26, showed staff assessed the resident as:-Totally dependent on staff for Activities of Daily Living (ADL) and mobility;-Totally dependent on staff for repositioning and turning in bed;-Totally dependent, with mechanical lift for transferring;-At risk for impaired skin integrity;-Encourage resident to frequently shift weight;-Utilize pressure relieving devices on appropriate surfaces. Review of the resident's Physician Order Summary (POS), dated April 2026, showed an order directed staff to complete skin assessment upon admission and weekly and charge nurse to ensure resident is laid down after meals, if agreeable. Heel protectors and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioning wedges to be used for turning and repositioning. Review of the resident's Nurse Medication Administration Record (MAR), dated April 2026, showed the charge nurses documented they ensured the resident had been laid down after meals with heel protectors on, on 04/20/26, 04/22/2/26 and 04/23/26. The charge nurse did not sign for 04/21/26, after breakfast and lunch.Review of the residents' Weekly Skin Assessments showed: -04/18/26, foot evaluation completed, no skin issues identified;-04/20/26, no skin issues identified;-04/23/26, Issue: #001: New skin Issue. Location: Right heel. Issue type: Pressure ulcer/injury. Progress: New: new wound. Pressure ulcer staging: Stage 1 Pressure ulcer/injury: non-blanchable erythema of intact skin. Wound acquired in-house. Length centimeter (cm): 5 Width (cm): 1.2 Depth (cm): Epithelial: 100%. Surrounding tissue: Intact. New wound identified to right heel. Observation on 04/20/26 at 1:45 P.M., showed the resident sat in mechanical chair, in his/her room. The resident's heel protectors are not on and are in the corner of the resident's room. The resident's heels are pressed firmly against the footrest of the mechanical chair. The footrest is depressed where the resident's heels connect to the footrest. Resident did not have shoes on. Observation on 04/21/26 at 9:51 A.M. through 10:52 A.M., showed the resident in his/her room in his/her mechanical chair. The resident's heel protectors in the corner of room. Observation showed the residents did not have shoes on and his/her heels pressed firmly against the footrest of the mechanical chair. Observation on 04/21/26 at 4:34 P.M., showed resident in his/her room in his/her mechanical chair. The resident wore regular socks on his/her feet and both heels pressed into the footrest of the mechanical chair. Resident's heel protectors on a chair in the corner of room. Observation on 04/22/26 at 8:55 A.M.to 11:20 A.M., showed resident in his/her room in his/her mechanical chair. The resident's heels pressed into the footrest without his/her heel protectors on. Observation showed the heel protectors on a chair. Continuous observation through 11:20 A.M., showed the resident in the same position, unturned or repositioned by staff. Observation on 04/23/26 at 9:46 A.M., showed the Director of Nursing (DON) completed a skin assessment of the resident and observed the resident's right heel with a half dollar sized indention, and the skin over the indention loose from the heel tissue and wrinkled. During an interview on 04/23/26 at 9:51 A.M., the DON said he/she would call the area on the resident's right heel, soft to likely a stage 1. The DON said even if the resident gets agitated when he/she lays down sometimes, he/she sometimes does not, and the staff should at least try to lay the resident down after meals. During an interview on 04/23/26 at 2:01 P.M., Certified Nurse Aide (CNA) N said he/she did not know the resident had orders to lay down between meals, and place heel protectors. The CNA said he/she did know the resident had heel protectors, and they go on when he/she is in bed. The CNA said he/she didn't lay the resident down, because he/she and the other staff were busy and don't always get to do what they are supposed to do. During an interview on 04/23/26 at 2:13 P.M., CNA D said he/she did not know the resident has an order to lay down with heel protectors on between meals. The CNA said he/she did not know the resident is supposed to have heel protectors on, when he/she is in bed. The CNA said when the resident first got to the facility, he/she had heel protectors, to his/her knowledge the last year, staff have not used the heel protectors. The CNA said he/she tries to put a pillow under the resident's feet, to offload pressure, and so his/her feet are not directly on the bar of the chair. During an interview on 04/23/26 at 3:03 P.M., Registered Nurse (RN) K said he/she has assisted at the facility since January, but this is his/her 2nd shift on the floor. The RN said he/she is not aware the resident is supposed to be put in bed between meals. The RN said he/she is not aware the resident had heel protectors. The RN said the DON talked to him/her and said the resident now has an area on his/her heel and he/she will document. During an interview on 04/23/26 at 4:12 P.M., the DON said if something is ordered on the POS staff should complete the order, the aides should have been directed by the charge nurse to lay the resident down. The DON said to lay the resident down in bed between meals and place heel protectors is on the resident's MAR, and the nurses have signed they completed it. The DON said the POS not being followed could be the cause for the pressure ulcer/injury. The DON said he/she is ultimately responsible to make sure the physician's orders are followed. During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265866	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steelville Senior Living	311 N Spring Street Steelville, MO 65565

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/23/26 at 4:45 P.M., the administrator said if something is on the resident's POS, the aides need to know, and it should be communicated to the aides by the charge nurse. The administrator said the resident's feet dug into the footrest can cause pressure. The administrator said he/she is aware the resident has a pressure ulcer/injury now and that the wound is facility acquired. The administrator said he/she was not aware the staff did not know the resident is supposed to be placed in bed between meals. The administrator said he/she was not aware some of the staff did not know the resident has heel protectors. During an interview on 04/28/26 at 1:18 P.M., the Nurse Practitioner (NP) said the resident needs to have heel protectors on when in the mechanical chair, or in bed. The NP said not using heel protectors could cause what was seen. The NP said the orders were not followed, and the resident continued to be put in the same position, it would cause a pressure wound. The NP said if the order had been followed, it would have stopped the pressure wound from developing. 2976653