STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265871	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Springfield	4935 S National Ave Springfield, MO 65810

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported timely when staff failed to report an allegation of abuse involving one resident (Resident #3) to the state survey agency (Department of Health and Senior Services (DHSS)) within the required two hour time frame. The facility census was 36. Review of the facility's policy Abuse, Neglect and Exploitation, revised 06/2023, which showed the following: -Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations; -Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or other but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property; -The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies such as law enforcement when applicable within specified timeframes; -The facility reports immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or -The facility reports not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. Review of Resident #3's face sheet (admission information at a glance) showed the following: -admitted [DATE]; -Diagnoses that included left arm fracture, depression, and generalized anxiety disorder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265871	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/29/24, showed the resident was cognitively intact.

Review of the resident's progress note dated 07/24/24, at 8:41 A.M., showed the Social Services Director (SSD) met with the resident to discuss a complaint regarding two nurses in the facility. The resident wanted to leave the facility after being recently admitted . The resident responded, Two nurses came in here and absolutely humiliated me. They pulled down my pants, smacked my ass, and then ran both of their fingers up my ass. The SSD reiterated that it was a nurse's responsibility to check the buttocks area of residents. The resident responded, It's like they were on something, ya know? I couldn't smell nothin', like marijuana or [NAME]. But, they acted like they were on something.

During an interview on 08/01/24, at 10:52 A.M., the SSD said when he/she talked to the resident on 07/24/24, at 8:17 A.M., the resident kept bringing up his/her home situation. The home kept trying to reach a specified family member several times and when they talked to this family member, he/she said he/she would not come pick up the resident until 07/30/24. On 07/31/24, the resident said he/she was going home and this was when the SSD hotlined DHSS for adult protective services regarding concerns with him/her going home. The Administrator was responsible for making self reports of abuse and neglect.

Review of the resident's record showed staff did not document reporting the resident's allegation of abuse involving facility staff to DHSS.

Review of DHSS records showed the facility reported the allegation of abuse on 07/31/24 (seven days after the allegation was made).

During an interview on 08/01/24, at 11:33 A.M., Licensed Practical Nurse (LPN) A said he/she admitted the resident. Certified Nurse Aide (CNA) C assisted LPN during the assessment process. The resident did not make an allegation of abuse at that time. Staff were to report any allegation of abuse/neglect within two hours to the on-call nurse first. Then the on-call nurse was to report to the Director of Nursing (DON) who reported to the Administrator. The Administrator was to report to the state.

During an interview on 08/01/24, at 1:14 P.M., CNA C said the resident was in the recliner in the room when he/she and LPN A went in to check the resident's skin. The resident was already agitated. Both he/she and LPN A explained that they were going to do a skin assessment on the resident. The resident did not make any allegation of abuse during or right after the skin assessment. CNA C knew to report any allegation of abuse to the charge nurse and said they were to do this right away and staff were to report any allegation of abuse to the state within two hours of incident.

During an interview on 08/01/24, at 10:35 A.M., the Assistant Director of Nursing (ADON) said the Administrator called him/her at the facility on 07/24/24, about 7:00 A.M., and asked him/her to talk to the resident regarding the allegation. He/She asked the resident if he/she had any care concerns. The resident said, when two nurses came in and did assessment they pulled up his/her gown, pulled his/her underwear down, and one of them patted his/her butt and said It's a cute butt and then put their finger in his/her butt. The resident knew who he/she was and where he/she was but seemed off. He/She talked to LPN A and CNA C and got their statements. The Administrator was to call the state for abuse and neglect.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 08/01/24, at 10:05 A.M. and 5:12 P.M., the DON said the resident had concerns with LPN A who admitted the resident. The resident said LPN A had the resident drop his/her pants, swatted him/her on the butt, and said he/she had a nice butt, and stuck his/her finger in it. At first, the resident seemed lucid (thinking clearly), but when speaking more with the resident, the story grew. When the admitting nurse does the initial skin assessment, they try to have two staff go into the room to do the assessment. If the nurse had been the only one to go do the initial skin assessment on the resident and they felt it was possible abuse, they would have reported this to the state. They thought with two staff in the room who described what they did, that there was no abuse. The resident did not make any allegation of abuse then. During interviews on 08/01/24, at 10:10 A.M. and 11:20 A.M., the Administrator said the night shift nurse called him/her at 6:11 A.M. on 07/24/24 and said the resident asked the night CNA if it was normal for a nurse to stick her finger in his butt. The Administrator called the ADON to start an investigation to talk to the resident. The resident did not report this until hours later to the night CNA. The staff that did the skin assessment were LPN A and CNA C. The resident never said he/she was abused, neglected, or harmed or she would have reported this to DHSS within the two hour time frame. She was on the fence about calling the state. She had two witnesses in the room at the time (the nurse and the aide), but she should have made a self report to the DHSS state survey agency. MO00239812

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17193 Based on observation, interview, and record review, the facility failed to provide care per professional standards related to pressure ulcers when staff failed to document a full assessment of wounds upon admission; failed to document on-going full assessments of wound to assist with monitoring and possible decline of wound; failed to obtain physician's orders for treatment and failed to follow ordered treatments of pressure ulcers; and failed to care plan and update care plans regarding actual skin breakdown and intervention changes for two residents (Residents #1 and #2) of six sampled residents. The facility census was 36. Review of the facility policy Skin Assessment, revised 7/2024, showed the following: -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter; -The assessment may also be performed after a change of condition or after any newly identified pressure injury; -Procedure included begin head to toe and thoroughly examining the resident's skin for conditions. Pay close attention to pressure points, bony prominences, and underneath of medical devices; -Remove any dressings, unless contraindicated ordered to remain in place, and note findings; -Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions; -Consider the general status of the resident's skin such as color, temperature, moisture status, sensory perception, and skin texture/turgor (firmness); -Documentation included observations of the skin conditions, type of wound, wound measurements, color, type of tissue in wound bed, drainage, odor, and pain. Review of the facility policy Wound Care Best Practice Guidelines, undated, showed the following: -Upon admission and readmission (during 24 hour chart check) all new admissions will be carefully examined for any wounds. It is very important that any wounds received prior to admission are documented as such. Additionally, any factors which contribute to a wound such as boggy heels, non-blanchable areas, etc should be documented also; -Each time a new wound is found, it should be assessed by the nurse designated for wound management. The Wound Nurse will add each wound to resident Wound Management Documentation or the facility wound report. The Wound Nurse will complete a new Braden assessment (scale developed to identify patients at risk for forming pressure sores) and update the at risk for skin impairment care plan; -Every wound will be measured and assessed weekly in the facility. This included resident receiving hospice or palliative care (comfort measures); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The assessment will be documented in electronic medical record Wound Management and will include date of assessment, measurements, description of wound and peri-wound, wound bed, current treatments/interventions, pain, wound status, and physician notification, etc.; -Any time a wound is not improving or worsening, showing signs and symptoms of infection, or has uncontrolled pain associated with it, the physician will be notified, and new orders obtained; -The care plan will be updated as needed with assessment/new orders for the wound, and interventions. 1. Review of Resident #1's face sheet (admission information at a glance) showed the following: -admitted [DATE]; -Diagnoses included right femur (lower leg) fracture, atrial fibrillation (abnormal heart rhythm), peripheral vascular disease (PVD - reduced circulation of blood to a body part due to a narrowed or blocked blood vessel), chronic obstructive pulmonary disease (COPD - lung disease that blocks air flow and makes it difficult to breathe), high blood pressure, history of abnormal weight loss, and pain. Review of the resident's care plan, dated 07/19/24, showed the following: -At risk for alteration to skin integrity secondary to surgical wounds as well as other open area to skin, thin fragile skin, and decreased meal intake due to poor appetite. Patient frequently refuses protein supplement or meal alternatives; -Approaches included air mattress applied to bed, dietitian/nutritional evaluation as needed, provide skin and incontinence care assistance as needed, weekly skin check per facility schedule, and notify physician of alterations for prompt/proper intervention. Review of the resident's admission assessment, dated 07/20/24, showed the following: -Right knee and leg fracture; -Lifted manually; -Limitation on one side; -Occasionally incontinent of bladder and usually continent of bowel; -Mild pain daily; -DTI (deep tissue injury - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. The injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface) to resident's coccyx (tailbone). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Staff did not document a description or complete assessment of the DTI.) Review of the resident's Braden scale (a risk assessment tool that helps identify residents at risk of developing pressure ulcers or injuries), dated 07/20/24, showed staff assessed the resident as at mild risk for developing pressure ulcers. Review of the resident's physician's orders, dated 07/20/24, showed a treatment order for the DTI to coccyx. Staff to cleanse with vashe (a wound cleanser), pat dry, and apply calmoseptine (a moisture barrier ointment) every shift on the DTI to coccyx. Review of the resident's progress note, dated 07/20/24, showed a DTI to coccyx with dark purple/black and open area. Staff obtained treatment orders. (Staff did not document a full and complete assessment of the area.) Review of the resident's current care plan, last reviewed 07/19/24, showed staff did not address the resident's DTI on the care plan. Review of the resident's daily skilled charting, dated 07/21/24, showed the resident had moisture associated skin damage (MASD) on the resident's buttocks. (Staff did not document regarding the resident's DTI to the coccyx.) Review of the resident's daily skilled charting, dated 07/22/24, showed the resident had multiple skin tears on his/her bottom. (Staff did not document regarding the resident's DTI to the coccyx.) Review of the resident's weekly skin assessment, dated 07/22/24, and completed by the wound nurse showed the following: -Skin turgor was fair, warm, dry, and pale; -Open lesions; -DTI to coccyx; -New skin tears over weekend were measured, and treatment put in place. (The wound nurse did not document a full and complete assessment of the resident's DTI on the coccyx.) Review of the facility's wound report, dated 07/24/24, showed the wound nurse measurements as follows: -The wound nurse documented measurements of three skin tears on the resident's left buttock, the right buttock, and the right rear thigh; -The unspecified ulcer on the top of the coccyx was 4 cm (centimeters) by 4 cm width by 4 cm length by 0.1 cm depth (depth would indicate this area was open). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(The wound nurse did not document any further description of the open area or the DTI on the coccyx) Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 7/25/24, showed the following: -Cognitively intact; -Required substantial/maximum assistance to shower, toilet, and dress, transfer, and change position in bed; -Occasionally incontinent of urine and bowel; -admitted for fracture and malnutrition; -At risk for developing pressure ulcers/injuries; -Has one or more unhealed pressure ulcers/injuries; -One unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured) pressure injury present upon admission. During an interview on 07/30/24, at 9:05 A.M., the resident said he/she had an open sore on his/her behind and staff put ointment on it. He/she said his/her skin was sensitive and he/she had lymphedema (swelling in the tissues). Observation on 07/30/24, at 9:28 A.M., showed the resident told Licensed Practical Nurse (LPN) B that his/her pain level was 10 (10 is severe pain on a level from 1 to 10). The resident told LPN B that the crack in his/her butt was hurting. Observation on 07/30/24, at 12:15 P.M., showed the following: -The resident was in bed and said his/her bottom was hurting and kept trying to raise up off his/her bottom and his/her hand underneath his/her right leg; -The Director of Nursing (DON) and Certified Nurse Aide (CNA) C assisted the resident to his/her side. There was a dressing on the sacrum (the large triangular bone at the base of the spine) at the top of the buttocks on the coccyx with a darker color drainage beneath the dressing. The DON removed the undated mepilex foam dressing (foam dressing to treat pressure ulcers) and the pressure ulcer was red, open, with a scant to moderate amount of darker color drainage with a slight odor. The DON measured the pressure ulcer as 3.5 cm by 6 cm by 0.2 cm depth. She removed a small piece of calcium alginate (dressing for moderate to heavy drainage) from the wound bed on the upper coccyx/sacrum. (The resident's physician's order did not address use of a dressing.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 07/30/24, at 1:30 P.M. and 4:04 P.M., LPN A said for the resident the physician's order was to cleanse and put calmoseptine ointment over the pressure wound on the coccyx. The physician's order did not say to put a dressing over this. During interviews on 07/30/24, at 2:10 P.M. and 4:06 P.M., LPN B said for the resident, LPN A notified the physician to put the resident on antibiotics for the wound. When he/she changed the resident's dressing on the coccyx, he/she just followed the order to put calmoseptine ointment on the wound. He/she did not cover the wound with a dressing. Review of the resident's physician's order, dated 07/30/24, showed the following: -Cephalexin (antibiotic for skin infection) 500 mg (milligrams) three times a day for wound to coccyx and leg; -Staff to cleanse wound to coccyx with vashe, pat dry, and cover wound with bordered optifoam (an absorbant foam dressing) dressing or equivalent once a day. Review of the resident's wound care companys progress notes, dated 7/31/24, showed the resident had very fragile skin exacerbated by fluid overload which made his/her skin susceptible to tearing and once an opening was there. H e/she may weep heavily from the wound because of the fluid. They cleansed the open pressure ulcer injury and applied santyl (debrides the skin) to wound bed with dressing changes. During an interview on 08/01/24, at 2:33 P.M., LPN E (wound nurse) said the resident had calmoseptine ointment for his/her bottom which wasn't too bad. Calmoseptine can be used for for reddened skin and when the wound is not real deep like sheering. The resident wanted to sit in bed and the wound physician told him/her to get up for one hour a day. The wound physician debrided the coccyx and other areas on the resident and then gave orders for the foam dressing with calcium alginate (absorbs wound fluid). 2. Review of Resident #2's hospital progress note, dated 07/01/24, showed the following: -Deep tissue pressure injury (DTI), unstageable pressure ulcer, on the left buttock; -Non-blanchable purple, red appearance that measured 1.5 cm length by 4.5 cm width. Review of the resident's face sheet showed the following: -admitted [DATE] from the hospital; -Diagnoses included surgical wound/colostomy (a piece of colon is diverted to an artificial opening in the abdominal wall to bypass a damaged part of the colon) with colostomy complication and peritoneal abscess (a collection of pus or infected fluid within the abdomen). Review of the resident's care plan, dated 07/05/24, showed the following: -At risk for infection secondary to multiple wounds. Staff to use universal precautions and notify physician of signs and symptoms of infection; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At risk for alteration to skin integrity secondary to moisture. Staff to provide skin and incontinence care assistance as needed, dietitian/nutritional evaluation as needed, standard facility pressure reduction mattress, weekly skin check per facility schedule, and notify physician of alterations for prompt/proper intervention; -Resident has actual skin impairment/wound to midline abdomen and left buttock. In house wound care provider to assess and treat, followed by outside wound care provider, enhanced barrier precautions, supplements to promote wound healing as prescribed, and treatments as prescribed. Review of the resident's nursing admission assessment, dated 07/05/24, showed a small area to buttock noted. Staff cleansed area and applied a dressing. (Staff did not document a full and complete description of the wound.) Review of the resident's Braden scale, dated 07/05/24, showed staff assessed the resident as not at risk for developing pressure ulcers. Review of the resident's skin assessment, dated 7/5/24, showed left buttock shearing and MASD. (Staff did not document a full and complete description of the wound.) Review of the resident's physician's orders showed no documented treatment orders put in place on 07/05/24 for the shearing and MASD. Review of the resident's admission MDS, dated [DATE], showed the following: -Cognitively intact; -Supervision for activities of daily living such as toileting, dressing, transfers, rolling left to right in bed; -At risk for developing pressure ulcers; -Had a surgical wound. Review of the resident's skin assessment, dated 07/08/24, showed the following: -A pressure ulcer to the left buttock, pale in color with fair skin turgor and cool to touch. Dry skin and area on left buttock measured 5.5 cm width by 2 cm length and depth 0.4 cm. Resident reports as painful. Large amount of drainage without dressing (soaked through patient's pants); -Cleaned with wound cleanser, pat dry, and cover with foam dressing. Nurse notified the wound care nurse. Resident reported pain with touch or pressure. Nurse recommended pressure cushion in chair. (There was no order in the record for this treatment.) Review of the resident's physician's orders, dated 07/05/24, showed no treatment ordered for the resident's left buttock. (There was a delay in treatment from the resident's admission on 07/5/24 to when a treatment was ordered on 7/10/24) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's daily skilled charting, dated 07/10/24 and 07/12/24, showed open lesions, MASD, and other with wound to left buttocks and inner buttocks MASD. (Staff did not document any further description of the wound.) Review of the facility wound report for the resident, dated 7/17/24, showed unspecified ulcer on left buttock, present on admission. Staff identified on 07/10/24, the wound measured 1.2 cm length by 1.8 cm width by 0. 1 cm depth. Review of the resident's physician orders, dated 07/10/24, showed a treatment order for the left buttock . Staff to wash with vashe, pat dry, santyl (an enzymatic debridement ointment) to eschar (dark dead tissue on wound), calcium alginate (absorbs wound fluid), border mepilex (a protective foam dressing) once a day every other day and as needed if soiled. (This was the first ordered treatment after admission on 07/05/24.) Review of the resident's current care plan showed the staff did not update the resident's care plan with new or change in interventions for prevention and treatment of pressure ulcers. Review of the resident's daily skilled charting, dated 07/14/24, showed open areas to buttocks. (Staff did not document any further description.) Review of the resident's weekly skin assessment, dated 07/15/24, showed an ulcer to the left buttock, MASD and the wound care company to see the resident on Wednesday (07/17/24). (Staff did not document any further description.) Review of the resident's daily skilled charting, dated 07/17/24, showed an ulcer to left buttock. (Staff did not document any further description.) Review of the resident's wound management charting, dated 07/17/24, showed the following: -Unspecified ulcer identified on 07/10/24 on left buttock 1.2 cm by 1.8 cm ; -Unspecified ulcer identified on 07/17/24, sacrum both sides, present on admission, 7.2 cm X 10 cm . During interview on 08/07/24, at 2:23 P.M., LPN E said the following; -He/she did assess the resident's skin day the resident was admitted on [DATE]. He/she observed the left buttock which was black with red around it like it was a big bruise. It was blackish/purple DTI in the middle. He/she measured it as 4.2 cm length by 4 cm width, but it was not open and had no depth. The resident would not lie down, but stayed up in the recliner because he/she said it was hard to breathe lying down. -He/she does measurements on Wednesdays and measured the resident's wounds on 07/10/24. The left buttock measured 6.3 cm length by 4.5 cm width by 0.1 cm depth with pinhole drainage. He/she called the physician and the wound care physician to see this resident. He/she did put a dressing of calcium alginate with Santyl on the left buttock; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The wound care physician saw the resident on 07/17/24 and the left wound pressure injury measured 7.2 cm length by 10 cm width by 0.2 cm depth and had opened up. The wound care physician debrided the wound and then the resident went to the hospital that night. 3. During interviews on 07/30/24, at 1:30 P.M. and 4:04 P.M., LPN A said when they have a new admission to the facility, the admitting nurse does the skin assessment from head to toe. The former DON, did not want them to measure wounds, but just say what it looked like in the documentation. They recently found out from the DON that they were to measure any wound, describe the appearance, location, drainage, and any odor. They have a full time wound nurse who works Monday, Wednesday, and Friday. The wound nurse does the weekly skin assessments. They were to notify the physician for any wound treatments. 4. During interviews on 07/30/24, at 2:10 P.M. and 4:06 P.M., LPN B said when they admit a new resident to the facility, they were to do a head to toe skin assessment and look for wounds and pressure areas. He/she did not measure any wounds, but was taught like quarter size and dime size as describing sizes and would describe its appearance. The wound nurse comes in on Monday, Wednesday, and Friday and they were to look at wounds and document any changes. 5. During an interview on 08/01/24, at 12:55 P.M., Registered Nurse (RN) D said when they admitted a new resident, they were to do a head to toe skin assessment which included their bottom, for redness and breakdown. If the wound nurse was here that day, he/she would go with him/her to catch anything he/she might miss. They look at the size and appearance of wounds, but since there was a discrepancy with measuring wounds, they would just document drainage, odor, color, how much drainage, temperature, and would notify the physician. They have training for staging pressure wounds, but they were to describe them. Calmoseptine is a barrier cream and they do use a foam dressing when needed. DTI-coccyx is not a skin assessment. The wound nurse does the weekly skin assessments. 6. During interviews on 08/01/24, at 2:33 P.M., and on 08/07/24, at 2:23 P.M., LPN E said the following: -He/she worked at the facility on Monday, Wednesday, and Friday and usually worked 7:30 A.M. to 5:30 P. M. He/she did not work on his/her days off or weekends; -He/she does all wound measurements on Wednesdays at the facility and documents all measurements in a wound book kept at the nurses' station; -He/she will try to get all this documentation in the residents' wound management in their electronic medical record, but it takes a long time; -He/she has the wound book to check if something was missed in the resident's electronic medical record for wounds; -Staff were to assess any wounds and leave a note for him/her. They were to call the wound physician for treatment orders. LPN A was the only nurse who calls him/her about residents' wounds; -He/she expected staff to measure any open area, bruise, and pressure and see what was going on with this; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265871	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2024
NAME OF PROVIDER OR SUPPLIER Sunterra Springs Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE 4935 S National Ave Springfield, MO 65810	

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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	-Staff were to do daily treatments on wounds, but not always getting done; -They did stage wounds and the physician was to measure and/or stage wounds for him/her. He/she will let the physician and the wound physician know when the resident's wounds have changed in condition; -For the wound description of Coccyx-DTI, this could be an area that was badly bruised and could be open but would need more description of this; -He/she would expect staff to daily look at the residents' coccyx, heels, and when staff do daily cares and showers/baths. During interviews on 07/30/24, at 10:55 A.M., and on 08/01/24, at 12:06 P.M., the DON said the following: -The nurses were not describing or measuring wounds upon admission. They were dependent on the wound nurse to do the skin assessments; -Nurses were to measure all wounds and observe for odor, signs and symptoms of infection, appearance of the wound but were not to stage any wounds; -They were to call the physician or the physician's nurse practitioner for wound orders; -Calmoseptine was a barrier cream; -There were no standing orders for wound treatments and dressings; -If a small wound was stable and had a treatment and they were on supplements, they would not contact the wound company physician unless interventions were not working and the wounds became worse; -They were to update the care plan with any changes and new interventions. During an interview on 08/06/24, at 1:37 P.M., the Administrator said the following: -Staff were to do a full skin assessment on a resident and document this assessment; -They were to describe, measure all pressure injuries and wounds and notify physician of open areas for treatment; -If there was no dressing on an open pressure injury or wound, he/she would expect staff to call the physician and ask what was best for this; -She would expect staff to update the care plan with new interventions for any new pressure injuries and wounds with changes. During an interview on 08/05/24, at 3:38 P.M., the Medical Director said the following: -Prevention is the biggest factor for skin breakdown; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265871	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Springfield	4935 S National Ave Springfield, MO 65810

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A resident's skin can have breakdown within three hours due to being partially immobile, too weak, and incapacitated. Healing wounds were difficult and staff need to prevent wounds developing and getting worse; -When a resident comes in the door, staff need to identify issues with skin breakdown and what factors could cause skin breakdown and attempt to prevent them. MO00239551 and MO00240004