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	03/04/2025

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 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** 50185 Based on observation, interview, and record review, the facility failed to provide care per professional standards related to pressure ulcers (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) when the facility staff failed to document a full assessment of wounds upon admission, failed to obtain physician's orders for treatment and interventions of wounds, and failed to update the care plan regarding skin breakdown intervention changes for one resident (Resident #1) out of 7 sampled residents. The facility census was 37. Review of the facility's policy titled, Skin Assessment, dated 07/21, showed the following information: -A full body, or head to toe skin assessment will be conducted by a licensed or registered nurse (RN) upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury; -The following should be documented: date and time of the assessment, staff members name and position title, observations, type of wound, measurements, if the resident refused the assessment and why; and any other information as indicated or appropriate. Review of the facility's policy titled, Wound Treatment Management, dated 07/21, showed the following information: -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; -Treatment decisions will be based on the following: etiology of the wound, characteristics of the wound, and location of the wound, and goals and preferences of the resident; -Treatments will be documented on the Treatment Administration Record (TAR) inside the resident's Electronic Medical Record (EMR); (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The effectiveness of treatments will be monitored through ongoing assessment of the wound; -Considerations for needed modifications include lack of progression towards healing, changes in the characteristics of the wound. And changes in the resident's goals and preferences. 1. Review of the Resident #1's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included malignant neoplasm of the spinal cord (a cancer containing tumor within the spinal cord), severe protein-calorie malnutrition (a condition that occurs when an adult doesn't get enough protein, calories, and other nutrients), and diabetes. Review of the resident's care plan, initiated on 02/17/25, showed the following information: -Staff to encourage and assist with frequent repositioning to alleviate areas of pressure; -Staff to provide skin and incontinence care as needed; -Standard facility pressure reduction mattress; -Staff to complete weekly skin checks per facility schedule and notify physician of alterations for prompt/proper intervention; -Wound to the sacrum (a large, triangular bone at the base of the spine that forms the back wall of the pelvis). Staff to use enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes); -In house wound care provider to assess and treat; -Treatments as prescribed. Review of the resident's admission orders from the discharging hospital, dated 02/17/25, showed the following information: -Coccyx (a small triangular bone at the base of the spinal column) and gluteal (buttock) wounds; Cleanse wounds with normal saline and pat dry. Apply Mepilex border (a foam dressing used for treating low to medium exudating (draining) wounds). Change every three days and as needed per soiling. If the resident is frequently incontinent, discontinue using Mepilex and apply barrier cream instead; -Low loss air mattress with repositioning every two hours; -Float heels off the bed with pillows. Review of the resident's February 2025 Physician Order Sheet (POS) showed the following: -An order, dated 02/17/25, for pressure relieving cushion to wheelchair; (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 02/17/25, for pressure reduction mattress; -An order, dated 02/17/25, for outside wound clinic to evaluate and treat. (staff did not transcribe the hospital orders for wound treatment or floating heels on 02/17/25.) Review of the residents admission assessment, dated 02/17/25, showed the following: -Wound to sacrum with type documented as other; -Staff did not document a description and measurements; -Staff did not indicate the resident had wounds to the buttocks as noted on the hospital summary; -Staff did not note any current treatment orders. Review of the resident's progress notes, dated 02/17/25, showed staff did not document regarding the resident's wounds and or treatment. Review of the resident's Braden Scale assessment (an assessment filled out by facility staff to determine a resident's likely hood of developing pressure ulcers), dated 02/17/25, showed staff assessed the resident at moderate risk for developing pressure ulcers. Review of the resident's February 2025 POS showed an order, dated 02/18/25, for wound to sacrum. Staff to cleanse with vashe (a wound cleanser that contains hypochlorous acid, which helps remove debris and microorganisms) , pat dry, apply calcium alginate (a highly absorbent wound dressing made from alginate, a natural polymer derived from the cell walls of brown seaweed), and cover with bordered dressing every day shift. (Staff did not document treatment orders for the resident's buttock wounds.) Review of the resident's February 2025 Treatment Administration Record (TAR) showed the following information: -An order, dated 02/18/25, for sacrum. Staff to wash with vashe, pat dry, apply calcium alginate and Mepilex daily; -Staff did not document completion of the treatment on 02/18/25. Review of the resident's progress notes, dated 02/18/25 through 02/21/25, showed staff did not document regarding the resident's wounds and/or treatment. Review of the resident's wound assessment, dated 02/21/25, showed the following: -Pressure ulcer to the right buttock measuring 1.8 centimeters (cm) by 1 cm with a depth of 0.1 cm; -Pressure ulcer to the left buttock measuring 1.5 cm by 1.2 cm with a depth of 0.1 cm; -Pressure ulcer to left buttock measuring 2.6 cm by 1.9 cm with a depth of 0.1 cm; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wounds were worsening and have outside wound clinic to evaluate and treat; -Supplementary healing included, air mattress, offloading, cushion in wheelchair, and supplements. Review of the resident's progress note, dated 02/23/25, showed the resident utilized the call light frequently, did not participate in self-cares, and refused to assist staff. The resident's buttocks wounds were extensive and causing pain to the resident despite frequent repositioning by staff. Review of the resident's February 2025 TAR showed the following information: -Staff did not document completion of the ordered treatment to the sacrum wound on 02/24/25 through 02/26/25; -An order, dated 02/24/25, for buttocks. Staff to wash with vashe, pat dry, apply calcium alginate and Mepilex on Monday, Wednesday, Friday, and as needed. Staff did not document completion of the ordered treatment on 02/24/25 and 02/26/25. Review of the resident's care plan, initiated on 02/17/25, showed staff did not update the care plan to reflect the resident's additional identified wounds and/or treatments. Review of the resident's progress notes, dated 02/24/25 through 02/26/25, showed staff did not document regarding the residents' wounds, treatments, or why treatments were not completed. The resident discharged from the facility on 02/26/25. Review showed the facility did not provide shower sheets for the resident from 02/17/25 through 02/26/25. During an interview on 02/28/25, at 1:38 P.M., Certified Nursing Assistant (CNA) A said the following: -If he/she noticed a new area of concern on a resident's skin, he/she reported it to the charge nurse; -Areas of concern are also found during showers, documented on shower sheets, and turned into the charge nurse; -The charge nurse will assess and measure the wound and decide on an appropriate treatment if the wound nurse was not on shift that day. The wound nurse works Monday, Wednesday, and Friday; -The charge nurse would notify the wound nurse of the new area of concern. During an interview on 02/28/25, at 2:23 P.M., Certified Medication Technician (CMT) B said the following: -If he/she noticed a new area of concern on a resident's skin, he/she reports it to the wound nurse, if the wound nurse was not here that day, he/she would notify the charge nurse; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse that was at the facility, will assess and measure the wound, notify the physician, and obtain orders for treatment; -The resident did have wounds upon admission;. During an interview on 02/28/25, at 2:37 P.M., Licensed Practical Nurse (LPN) C said the following: -The resident was admitted to the facility with really bad wounds to both buttocks and the sacrum; -He/she was the resident's nurse the day after he/she admitted to the facility. On that day, 02/18/25, the resident's wound beds had slough (a non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed) and eschar (a dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.); -He/she spoke with the facility wound nurse regarding the residents' wounds, the wound nurse then completed her own assessment of the wounds; -The admission skin assessment should be completed within 48 hours of the resident's admission to the facility; -Wound treatment should be initiated immediately upon discovering of the wounds, and should be documented in the progress notes, and care planned; -There should be documentation of the wounds and treatment in the progress notes and care plan. During an interview on 03/24/25, at 10:24 A.M., Registered Nurse (RN) D said the following: -The admitting nurse should do a full head to toe assessment of the resident. If the wound nurse is on shift during the admission, she can do the skin assessment; -If concerns are found during the head-to-toe assessment, the nurse on staff gets into contact with the wound nurse and initiates an appropriate treatment; there are standing orders that can be used until the wound nurse assesses the wound herself; -Floor nurses were responsible for looking at the resident's skin weekly and the wound nurse does weekly wound documentation as well; -The resident had wounds upon admission, and he/she believes the hospital he transferred from sent orders for wound treatment; -Wound care was not due on any of the shifts he/she worked. He/she did see a Mepilex pad on the wounds during repositioning; -Wounds and treatment of wounds should be documented in the progress notes, notifications should be made to the physician, and the resident's responsible parties, and should also be care planned. (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 03/04/25, at 12:36 P.M., LPN E said the following: -He/she was the admitting nurse for the resident; -The resident had open wounds on both buttocks, and a reddened sacrum upon admission; -The resident admitted to the facility with treatment orders from the discharging hospital; -Nurses should perform skin assessments daily and should document their findings in the progress notes. Findings should also be reported to the wound nurse; -The wound nurse does wound assessments weekly. During an interview on 03/04/25, at 10:45 A.M., the Wound Nurse said the following: -The admitting nurse should do a full head to toe assessment of the resident as well as initiate a treatment, if she is not there that day; -She does wound assessments on Mondays and measures wounds on Wednesdays or Fridays; -She documents her wound assessments in the EMR, under assessments; -Aides will bring her their shower sheets if there is a concern with skin, and she also has a book on her desk that staff can fill out when she is not on shift; -The resident admitted with a reddened sacrum and stage two (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) wounds to both buttocks; -A couple days after the resident admitted , a nurse had reported to her that the wounds appeared to be worsening, initially the staff were applying barrier cream; -During her assessment of the wounds, on 02/21/25, she noticed the wounds needed more attention and ordered an air mattress, an outside wound clinic to evaluate and treat, and initiated a new treatment; -When an area of concern is found or is found to be worsening, the finding nurse should notify her, as well as document that in the progress notes, and the care plan. During an interview on 03/24/25, at 11:09 A.M., the Director of Nursing (DON) said the following: -She expected staff that find new and/or worsening wounds to notify the nurse. The nurse would then go and assess the wound, decide an appropriate treatment, and document in the progress notes, update the care plan, and notify the Wound Nurse; -The admitting nurse is responsible for obtaining a full head to toe assessment on the residents, if areas of concern are found they should also initiate treatment, the wound nurse should complete the measurements of the wounds and document her assessment; (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 had wounds to his/her sacrum and both buttocks; -The resident refused repositioning and care often, which should also be documented. During an interview on 03/04/25, at 11:57 A.M., the Administrator said the following: -She expected head to toe assessments to be completed upon admission; -She expected all staff members who notice a area of concern or worsening of the skin to notify the nurse on duty and the wound nurse. The nurse should assess the wound and initiate a treatment; -Nurses should be laying eyes on resident's skin daily and should be documenting and care planning any concerns. MO00250192