| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 265875 | A. Building<br>B. Wing | 04/04/2025 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct weekly skin assessments per their policy and complete a Braden Scale (a tool used to identify if a resident is at risk for the development of Pressure Ulcers (PU) for four residents (Resident #1, #2, #3 and #8) out of eight sampled residents who developed PU. Resident #1 admitted to the facility from a local hospital with a pressure ulcer to the coccyx. The facility failed to complete an admission skin assessment indicating that the resident had the PU, or document the size and characteristics of the PU. The facility failed to complete weekly skin assessments on the resident and the PU to the coccyx deteriorated to a Stage III PU (full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue, extending down to but not through underlying fascia, presenting as a deep crater with or without undermining). The resident was readmitted to the hospital. The facility failed to do weekly skin assessments and complete a Braden Scale for Resident #2 and the resident developed a Stage II PU (a partial-thickness skin loss involving the dermis and epidermis, presenting as a shallow, open ulcer with a red or pink wound bed, without slough or eschar) which progressed to a Stage III PU with no skin assessments or documentation of the characteristics of the wound. The facility failed to do weekly skin assessments for Resident #3, the resident had wounds on his/her feet, the facility had no documentation of the wounds or skin assessments. Resident #8 had no weekly skin assessments or Braden Score completed. The resident was receiving Hospice benefits, and Hospice documented that the resident had open areas on the coccyx/buttock area; the facility failed to document the characteristics of the wounds, there were no measurements of the wounds and no physician notification, or weekly skin assessments completed. The resident also had an unstageable PU to the right heel that was not identified by the facility. The facility census was 47.<br><br>Review of the facility policy for Admissions dated 8/1/2023 showed the following:<br><br>-The charge nurse will assume responsibility for the admission;<br><br>-Receive report and the name of the physician from the discharging facility;<br><br>-Perform a comprehensive nursing assessment of the resident that includes: skin assessment (Braden, a tool used to predict the risk of developing pressure ulcers or injuries, with scores ranging from 6 to 23, where lower scores indicate a higher risk. );<br><br>-Findings of the assessment will be documented in the electronic health record (EHR);<br><br>-Contact the resident's physician and verify the admission/readmission orders including all needed medications including as needed (PRN) medication;<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Complete the admission nurse's notes including: a summarized comprehensive assessment, vital signs, height and weight;<br><br>-Initiate admission 48-hour care plan.<br><br>Review of the facility policy for Skin assessment dated [DATE] showed the following:<br><br>-The facility will ensure that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition demonstrates that they are unavoidable;<br><br>-The charge nurse will perform a skin assessment upon admission, weekly times four, monthly and when the resident has a change of condition;<br><br>-Implement care planning for any resident at risk for pressure ulcers;<br><br>-Complete a comprehensive head to toe assessment of the resident's skin with each scheduled assessment and with any significant change of condition, that includes evaluating risk factors such as: poor positioning in a chair, dementia, co-morbidities such as diabetes, end stage renal disease or thyroid disease, drugs like steroids that impair wound healing, friction and shearing ( friction is the force of rubbing two surfaces against each other, while shear is a force that causes tissues to move in opposite directions, often leading to deeper tissue damage), history of skin breakdown/pressure ulcers; impaired blood floor; impaired/decreased mobility; exposure of skin to urinary and/or fecal incontinence, nutrition or hydration deficit; skin desensitized to pain or pressure;<br><br>-Supervise the Certified Nurse Aides (CNA) to ensure that each resident's skin is assessed for signs of breakdown with daily care and bathing;<br><br>-Instruct CNA's to identify and report signs of skin breakdown such as: purple or dark area, edema, hardening of the skin (induration; redness (erythema), bogginess (refers to a soft, spongy, or wet texture of the skin that may feel like a sponge or a wet cloth);<br><br>-Document the status of the resident's skin in the resident's electronic health record (HER) once per week and in the resident's monthly summary.<br><br>Review of the facility policy for Pressure Ulcers: Prevention, Identification, Evaluation and Interventions dated 8/21/2025 showed:<br><br>-Definition: a pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer (PU) will present as an open ulcer the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may be affected by skin temperature and moisture, nutrition, perfusion, comorbidities and condition of soft tissue;<br><br>-The facility will ensure that a resident who enters the facility without PU does not develop PU unless the resident's clinical condition indicates that they were unavoidable;<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -If the resident has a clinical condition that makes a PU unavoidable, this must be defined by the resident's physician and must be documented in the resident's chart;<br><br>-The facility will ensure that all residents at risk for PU are identified and be given care to prevent the development of PU. Identification includes previous PU or pressure injury history. A Braden Scale will be completed upon admission/readmission, weekly for four weeks and with the quarterly, annual and significant change of condition assessments;<br><br>-The facility will ensure that a resident with PU receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing;<br><br>-The charge nurse will: Instruct and supervise CNA's to ensure that care and interventions are implemented to prevent skin breakdown including:<br><br>-review of documentation of skin issues identified during the resident's shower;<br><br>-application of creams/ointments with the provision of incontinent care;<br><br>-monitor to ensue pressure relieving devices: mattresses, cushions and/or wedges, etc Are in place;<br><br>-positioning protocols are followed to prevent skin breakdown;<br><br>-Provide wound care as prescribed by the physician; mark each dressing with date and initials after treatment has been administered; document in the resident's EHR/Treatment Administration record (eTAR) that wound care was administered as prescribed;<br><br>-The charge nurse will track the healing progress of PU and alter the plan of care and treatment when needed;<br><br>-Completing skin integrity documentation for each resident with skin breakdown that includes: type of wound, location, shape, measurements in centimeters: width, length, depth; stage ( refers to a classification system used to categorize the depth and severity of skin and tissue damage, aiding in determining appropriate treatment and monitoring); color, redness, warmth, swelling; granulation (formation of new tissue), surrounding tissue, ulcer edges; exudate (drainage) bleeding; treatments, dressing changes, medication; presence of infection or other complications; pain;<br><br>-Evaluating PU treatment weekly for effectiveness and inform the resident's physician of PU states;<br><br>-Working with the care plan team to alter the PU care plan and implement new intervention(s) when healing is not adequate;<br><br>-The Director of Nursing/Designee will monitor the weekly wound report: wounds present upon admission or acquired in the facility; wounds improving or worsening; wound types; proper documentation completed in the nurses' notes, treatment records, weekly skin sheets, care plans.<br><br>Review of the facility's Wound Care Policy and Procedure with a review date of 8/2024 showed the following:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Purpose: to provide a standardized approach in the prevention, assessment, and treatment of wounds in our residents;<br><br>-Policy Statement: Our facility is dedicated to delivering high-quality, evidence-based wound care to prevent the occurrence of pressure injuries and other wounds. We commit to comprehensive assessment, timely treatment, proper documentation, and continuous education. All wound care will be delivered in accordance with federal regulations and state agency standards;<br><br>-This policy applies to all clinical staff, including licensed nurses, certified nursing assistants (CNA's), wound care specialists, and members of the interdisciplinary team involved in resident care at the facility;<br><br>-Wound care team: the interdisciplinary group may include the Director of Nursing (DON), physicians, wound care nurses, dietitians, physical therapists, and specialists in wound management;<br><br>-Wound Care Procedure: assessment and documentation: conduct a comprehensive head-to-toe skin inspection on admission, readmission, and with any significant change in condition;<br><br>-Assess all wounds for location, type, size, stage, exudate, tissue type, and periwound (refers to the skin and tissues surrounding a wound) condition;<br><br>-Reassess wounds at least weekly and document changes immediately;<br><br>-Take photos of wounds with consent and per facility policy;<br><br>-Risk identification and prevention: use the Braden Scale or another validated tool on admission, weekly, and with changes in health status; turn and reposition residents every two hours or as indicated; use pressure-reliving devices and provide prompt incontinence care;<br><br>-Treatment and care planning: obtain specific wound care orders from the physician; use advanced therapies if ordered, coordinate with therapy services as needed;<br><br>-Physician notification and orders; notify physician of new wounds, deterioration, infection or lack of healing, update and verify all treatment changes with physician orders;<br><br>-Education: ensure staff complete training on wound care procedures and documentation; provide resident and family education and document it in the medical record.<br><br>1. Review of Resident #1's referral information to the facility from the resident's discharging local hospital dated 2/24/25 showed the following:<br><br>-Discharge diagnosis of endocarditis (an infection of the inner lining of the heart chambers and heart valves, known as the endocardium. It is typically caused by bacteria that enter the bloodstream and settle on the heart valves, causing inflammation and damage;<br><br>-Active wounds to the anterior (front) of the left and right knee, wounds on the left and right dorsal (back) knee; lower right arm and elbow and medial sacrum (middle of the sacrum, which is located at the base of the spine above the tailbone);<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Utilize a low air loss mattress while in bed and a seat cushion while in a chair. Reposition frequently. Do not raise the foot of the bed, use off loading heel boots (reducing or redistributing pressure, force, or weight from a specific area of the body, particularly a wound or area prone to pressure injuries, to promote healing and prevent further complications.<br><br>Review of the discharge orders from the local hospital dated 3/4/25 at 12:40 P.M. showed the following:<br><br>-Mupirocin (medication commonly used to treat some skin infections) 2%, apply to affected area once daily with a start date of 3/5/25;<br><br>-Zinc oxide (used to protect skin from being irritated and wet ) 40% paste, apply to affected area two times daily.<br><br>Review of the resident's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of endocarditis, sepsis (a life-threatening condition that occurs when the body's response to an infection damages its own tissues and organs, potentially leading to organ failure and death), acute kidney failure, type II diabetes, cognitive communication deficit and a history of falls.<br><br>Review of the resident's Physician Order Sheet (POS) dated 3/4/25 showed no order for mupirocin or zinc oxide ointment.<br><br>Review of the resident's admission nursing assessment completed on 3/4/25 at 2:25 P.M., and signed by Licensed Practical Nurse (LPN) B showed the following:<br><br>-admitted to the facility on [DATE] via ambulance;<br><br>-Generalized pain at a level 10 (one being minor or no pain to 10 being excruciating pain);<br><br>-Alert and oriented to person, place and time;<br><br>-No edema. Skin warm and dry, skin color within normal limits, turgor (refers to the elasticity and firmness of the skin. It indicates the body's hydration status) normal;<br><br>-Area for skin issues was left blank.<br><br>Review of the resident's assessments in the electronic medical record (EMR) dated 3/4/25 showed no skin assessment, or Braden Scale completed.<br><br>Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review (a tool used by the CNA's to document any issues with a resident's skin when giving a bath/shower) dated 3/4/25 and signed by LPN B, showed the following:<br><br>-Admission. Picture of the body front facing: PICC (peripherally inserted central catheter -a long, thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart, used for long-term intravenous access for medications, fluids, blood draws, or other treatments) noted in the right upper arm;<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Picture of the body rear facing with a circle around the coccyx (tailbone) area and with Red written to the side. Heels circled with slightly red written to the side.<br><br>Review of the resident's nursing notes dated 3/4/25, showed no documentation of any open areas, pressure ulcers, skin tears, or bruised areas.<br><br>Review of the resident's undated baseline care plan showed the area for Skin Risk was left blank with no current skin issues marked and no interventions for the prevention of skin breakdown documented.<br><br>During an interview on 4/3/25 at 3:40 P.M. CNA D said the following:<br><br>-He/She was on duty when the resident was first admitted ;<br><br>-He/She remembered the resident had sores on his/her knees, the sacrum had a small deep crack like area and his/her left heel was soft feeling.<br><br>-LPN J was aware of the wounds, he/she was the admitting nurse and completed a skin assessment;<br><br>-The resident refused to wear heel protectors and he/she did not have a low air loss mattress;<br><br>-The CNA's complete a skin assessment when a shower was given, once completed it goes to the nurse.<br><br>During an interview on 4/4/25 at 10:19 A.M. LPN J said the following:<br><br>-He/She admitted the resident on 3/4/25. He/She did not complete the skin assessment in the medical record, he/she documented the resident's skin assessment on the Skin Monitoring Comprehensive CNA Shower Review sheet;<br><br>-The resident's sacrum/coccyx area was red; he/she did not remember if the area was open;<br><br>-He/She did not remember if the resident's heels were open, but had documented on the Shower Review sheet that they were red;<br><br>-The resident did not have a low air loss mattress on the bed and did not have heel protectors;<br><br>-The resident did not want to be turned, he/she was in a lot of pain;<br><br>-He/She should have documented the condition of the resident's skin in the skilled admission nurses notes, but did not document anything;<br><br>-Skin assessments should be done upon admission and with any issues noted with skin; the physician should be notified for a treatment order.<br><br>During an interview on 4/3/25 at 3:30 P.M. LPN A said the following:<br><br>-The resident admitted with endocarditis and reportedly had laid on the floor for over 30 hours before someone called the ambulance;<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The resident had a foam dressing on his/her sacrum upon admission;<br><br>-An admission skin assessment was not completed;<br><br>-There were no skin assessments completed for the resident;<br><br>-A skin assessment should have been completed upon admission;<br><br>-In his/her review of the resident's medical record, he/she could not find any skin assessment completed.<br><br>During an interview on 4/7/25 at 1:30 P.M. Registered Nurse (RN) E said the following:<br><br>-He/She remembered the resident had a dressing to the sacrum/coccyx area and the wound nurse was aware;<br><br>-The night shift would have changed the dressing, so he/she did not see the resident's skin;<br><br>-A skin assessment should be done upon admission and documented in the resident's EMR under the assessment tab.<br><br>Review of the resident's progress notes dated 3/5/25, signed by Nurse Practitioner (NP) A showed the following:<br><br>-Nursing home visit for post hospitalization. The resident had skin breakdown to the coccyx that was present upon admission. Consulted with wound nurse;<br><br>-Review of medications showed mupirocin and zinc oxide as discontinued.<br><br>During an interview on 4/4/25 at 10:17 A.M. NP B said the following:<br><br>-He/She saw the resident a couple of times;<br><br>-He/She was aware of the wound on the resident's sacrum from the local/discharging hospital's documentation from the discharging hospital, but did not remember discontinuing any medications or treatments;<br><br>-The facility had a wound nurse and a contracted outside wound care provider; residents who have wounds are referred to them for orders and treatments;<br><br>-He/She did not see a skin assessment for the resident;<br><br>-He/She had noticed that skin assessments were not always completed on the residents at the facility.<br><br>Review of the resident's skilled nursing notes dated 3/6/25, showed no documentation of any skin breakdown on the resident's coccyx.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the resident's EMR for 3/6/25, showed no skin assessment or Braden Score completed.<br><br>Review of the resident's progress note dated 3/6/25, and signed by Nurse Practitioner (NP) B showed the following:<br><br>-While sitting on the end of the bed, the resident yelled out in pain (buttocks);<br><br>-Medications: no mupirocin or zinc oxide noted as a current order;<br><br>-Sacral wound/multiple abrasions, continue wound care.<br><br>During an interview on 4/10/25 at 10:15 A.M. NP C said the following:<br><br>-He/She had seen the resident several times, but had never seen the resident's skin;<br><br>-He/She was aware that the resident had a wound on the sacrum/coccyx area from the documentation that was received from the hospital with a treatment order in place;<br><br>-The facility had a treatment nurse that took care of all of the wounds.<br><br>Review of the resident's Skin Monitoring: Comprehensive CNA (Certified Nurse Aide) Shower Review dated 3/7/25 showed a bed bath given, no skin issues noted.<br><br>Review of the resident's EMR for 3/7/25 through 3/9/25 showed the following:<br><br>-No documentation of the resident's skin in the skilled nursing notes, or in the progress notes;<br><br>-No skin assessments completed, and no Braden Score completed.<br><br>Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 3/10/25, showed the following:<br><br>-Able to make self understood and able to understand others;<br><br>-Alert and oriented and able to make decisions;<br><br>-Dependent upon staff for Activities of Daily Living (ADL's), bed mobility and transfers;<br><br>-Incontinent of bowel and bladder;<br><br>-At risk for pressure ulcers with one Stage III (full-thickness skin loss, where subcutaneous fat is visible, but bone, tendon, or muscle is not exposed. The ulcer may include undermining and tunneling) PU present.<br><br>Review of the resident's Skin Monitoring: Comprehensive CNA Shower Review dated 3/11/25, showed the resident refused a shower, gave a bed bath as best that could be done; no skin issues noted.<br><br>During an interview on 4/4/25 at 4:15 P.M. the Registered Nurse/Wound Nurse said the following:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -He/She was aware that the resident was going to be admitted with wounds from the discharging hospital documentation;<br><br>-The admitting nurse should have completed a skin assessment and documented any wounds;<br><br>-He/She called the resident's primary physician and got an order for the contracted wound care provider to come in to assess the resident;<br><br>-He/She did not see the resident's skin until 3/10/25 when the contracted wound care provider/Nurse Practitioner assessed the resident.<br><br>Review of the resident's Initial Visit Case Report completed by the contracted wound care provider dated 3/10/25, showed the following:<br><br>-Abrasions to left knee, right knee, skin tear to right and left forearms;<br><br>-Review of systems: Integumentary (skin): wounds to left and right knee, left and right forearm; sacrum;<br><br>-General Assessment and Plan: pressure injury to sacrum: cleanse wound, apply mupirocin 2% ointment and alginate (a highly absorbent wound care products that form a gel when exposed to wound fluid, maintaining a moist environment crucial for healing and managing moderate to heavy exudate) to wound bed, cover with a bordered foam dressing three times per week and as needed;<br><br>-Wound location: sacrum, pressure, Stage III 3.0 centimeters (cm) long by 0.30 cm wide, 0.20 deep with mild pain, serosanguinous drainage (a fluid that contains both serum (clear, watery fluid) and blood. It typically appears as a pinkish-red or pale yellow discharge), with yellow slough (fibrous, dead tissue that can impede healing and harbor bacteria, often appearing as a yellowish, tan, or white, stringy material).<br><br>During an interview on 4/10/25 at 10:00 A.M. NP A for the contracted outside wound care provider said the following:<br><br>-When a resident admitted to the facility with skin issues or concerns, the wound nurse will get an order for consultation from him/her;<br><br>-He/She received an order from the facility on 3/7/25 for a consultation for a wound on the sacrum/coccyx area;<br><br>-He/She saw the resident at the facility on 3/10/25;<br><br>-The wound to the coccyx was a Stage III PU and he/she ordered a treatment for the PU;<br><br>-If a resident admitted with a PU or wound, the facility should notify the physician and get a treatment started until he/she could evaluate the wound.<br><br>Review of the resident's Multidisciplinary Care Conference note dated 3/11/25 showed the following:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Attendees included the dietary manager, activity director, therapy director, nursing administration, family and administration:<br><br>-Problems: the resident entered the facility with a wound on his/her coccyx and multiple areas in the lower extremities with an IV (intravenous, a needle inserted in a vein for medication/fluids to be administered) that was working well for endocarditis. However, the resident still seemed to be in a quite a bit of pain with these injuries.<br><br>-No goals established for wounds, and no interventions indicated for the wounds, no treatments indicated for the wounds.<br><br>Review of the resident's Medication Administration Record dated March 2025 showed mupirocin ointment 2%, apply to sacrum topically every day shift on Monday, Wednesday, and Friday, for wound care with alginate to wound and cover with a bordered foam gauze with a start date of 3/12/25.<br><br>Review of the resident's medical record from 3/11/25 to 3/16/25 showed the following:<br><br>-No skin assessments completed;<br><br>-No documentation of the wound on the sacrum other than the contracted wound care provider note from 3/10/25.<br><br>Review of the resident's nurses notes dated 3/16/25 and signed by LPN B, showed the following:<br><br>-On 03/16/25 07:59 A.M., during resident care early this morning, CNA and this nurse observed a 2 1/2 inch purple area on resident's right heel and a red/purple area on the left hip (ischium) that was non-blanchable. Staff floated the resident's heels with two pillows and used Skin Prep ( used to create a protective barrier on the skin that forms a film to protect the skin by reducing friction on the right heel;<br><br>-Staff put a pillow under resident's left hip area to help with the pressure. Notified the on-call physician of findings and on-call said the resident should have a low air loss mattress.<br><br>Review of the resident's nurses note dated 3/16/25 at 6:20 P.M. and signed by LPN A, showed the resident refused all medications and meals during day shift. Resident observed as lethargic, blood pressure (BP) of 93/53 (normal BP 120/80), oxygen level of 94% on room air (normal oxygen level in an adult 95-100%), pulse of 88 (normal pulse range between 60 to 100), respirations 18 (normal respirations between 12 and 20 respirations), temperature 100.1 (normal temperature 98.6). No urine output during shift. Call placed to primary physician with an order to send the resident to the emergency room for evaluation due to change in condition.<br><br>During an interview on 4/8/25 at 2:50 P.M. CNA F said the following:<br><br>-He/She took care of the resident a couple of times while the resident was at the facility;<br><br>-The resident's bottom was red when the resident admitted and he/she put barrier cream on the resident's bottom;<br><br>(continued on next page) |

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|---|---|---|---|
| | 265875 | A. Building<br>B. Wing | 04/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| McClay Senior Care | 3801 McClay Road<br>Saint Peters, MO 63376 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -He/She last saw the resident the day before he/she went to the hospital , he/she did not look at the resident's heels;<br><br>-The resident would lay on his/her left side and frequently refused to turn. On 3/16/25, before the resident went to the hospital he/she had a dark red round area on his/her left side;<br><br>-He/she notified the nurse of the area on the left hip;<br><br>During an interview on 4/8/25 at 9:30 A.M. LPN B said the following:<br><br>-He/She had taken care of the resident and was off for a few days, when he/she came back to the facility, the resident was much weaker;<br><br>-On 3/16/25 before the resident was sent to the hospital, he/she found a dark non-blanchable (a discoloration of the skin that does not turn white when pressed) on the resident's right heel and a dark round spot on his/her left hip;<br><br>-He/She used skin prep to the heel and tried to position the resident on the right side, but the resident did not like to be turned;<br><br>-The resident did not have a low air loss mattress, so he/she got an order for one;<br><br>-He/She did not remember if the resident had an open are on the sacrum/coccyx area.<br><br>During an interview on 4/3/25 at 1:05 P.M. Registered Nurse/Wound Nurse from the discharging hospital said the following:<br><br>-When the resident discharged from the hospital on 3/4/25 the wound on his/her coccyx was in the final stages of healing and no longer open; the resident had no wounds on the heels;<br><br>-When the resident readmitted to the hospital on [DATE], the resident had an area on the left mid back 3 centimeters (cm) by 3 cm that was a deep tissue injury (DTI-is a type of pressure ulcer where damage occurs to the underlying soft tissues, like muscles and fat, before the skin shows visible signs of injury. It often presents as a purple or maroon discolored area of intact skin or a blood-filled blister, and can be mistaken for a bruise. DTIs can develop rapidly and may lead to the formation of a pressure ulcer if not addressed promptly), two areas on the right heel; one measured 2 cm by 2 cm that was an intact blister and another area that measured 4 cm by 4 cm that was a DTI. The wound on the resident's coccyx/sacral area (tailbone) measured 12 cm by 3 cm and extended from the coccyx to the peri-rectal area (the area surrounding the rectum) also DTI;<br><br>-When the areas opened, the wounds would be deep and extensive.<br><br>During an interview on 4/4/25 at 1:30 P.M. the Director of Nursing said the following:<br><br>-Skin assessments should be done upon admission and weekly thereafter;<br><br>-The admitting nurse should be doing a full body skin assessment and documenting the findings in the admission assessment;<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -If the resident had wounds, these should have been documented upon admission and treatment orders obtained and if needed a referral to the contracted outside wound care provider for assessment and treatments;<br><br>-She was aware that the resident had wounds from the discharging hospital documentation;<br><br>-She did not see the resident's skin.<br><br>2. Review of Resident #8's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of dementia and stroke.<br><br>Review of the resident's care plans with a revision date of 1/11/25 showed no care plan for skin issues or prevention of PU.<br><br>Review of the skin assessment dated [DATE] showed right medial thigh bruising, acquired in house.<br><br>Review of the resident's EMR dated 1/17/25 showed no further documentation of the bruising to the thigh or any Braden Score completed.<br><br>Review of the medical record dated 1/18/25 through 3/4/25 showed no skin assessments completed.<br><br>Review of the resident's contracted hospice provider notes dated 1/21/25 through 3/4/25 showed no documentation of any skin alterations or PU's.<br><br>Review of the quarterly MDS dated [DATE] showed:<br><br>-Able to make self understood and usually able to understand others;<br><br>-Unable to make decisions;<br><br>-Dependent upon staff for all ADL's, turning and repositioning and transfers;<br><br>-Incontinent of bowel and bladder;<br><br>-At risk for PU, with no PU present.<br><br>Review of the resident's POS dated March 2025 showed an order for weekly skin assessments with a start date of 3/4/25<br><br>Review of the resident's medical record dated 3/4/25 through 3/28/25 showed no skin assessments completed.<br><br>Review of the contracted hospice provider notes dated 3/4/25 through 3/28/25 showed no documentation of any skin alterations or PU's.<br><br>Review of the skin assessment completed 3/28/25 showed:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Skin issue - right medial thigh bruising and wound to coccyx area with treatment order in pace, house acquired;<br><br>-No previous documentation of the wound to the coccyx;<br><br>-There were no measurements or description of the wound.<br><br>Review of the residents EMR dated 3/28/25 showed no documentation of physician notification of the wound to the coccyx or bruising to the right medial thigh.<br><br>Review of the resident's POS dated March 2025 showed an order for mupirocin to coccyx Monday-Wednesday-Friday for wound care with a foam dressing with an order date of 3/28/25.<br><br>Review of the resident's medical record dated 3/28/25 through 4/1/25 showed the following:<br><br>-No skin assessments completed;<br><br>-No description of the wound to the coccyx with no measurements.<br><br>Review of the resident's contracted hospice provider notes dated 4/1/25 showed the following:<br><br>-The resident currently has three PU's, two Stage II (a partial thickness loss of dermis, presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. It can also manifest as an intact or open/ruptured blister) on the coccyx/buttock area and one Stage I (an area of intact skin with non-blanchable redness, usually over a bony prominence) to the heal. All are being treated by the facility staff.<br><br>Observation on 4/4/25 at 2:11 P.M. showed the following:<br><br>-CNA I and LPN A transferred the resident from a wheelchair to the bed via a mechanical lift;<br><br>-CNA I said the resident had an open are on the coccyx;<br><br>-The resident's right heel had a large area of discoloration on the bottom that was red in color;<br><br>-A foam dressing was on the coccyx with no date or initials to indicate when or who applied the dressing;<br><br>-LPN A removed the dressing; under the dressing was an oblong shape open area that was approximately 2-3 inches long with pink tissue surrounded by white, macerated tissue (tissue that has had prolonged exposure to moisture, Signs of Maceration: Skin that appears soggy, soft, or whiter than usual. A white ring around the wound, especially in areas with excessive moisture or drainage).<br><br>During an interview on 4/4/25 at 2:30 P.M. RN/Wound Nurse said the following:<br><br>-The resident recently acquired the PU to the coccyx and the heel;<br><br>-The contracted hospice provider measured and documented the wound in their notes;<br><br>(continued on next page) |

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