STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265876	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arrowhead Senior Living Community	6100 Arrowhead Drive Osage Beach, MO 65065

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to follow appropriate infection control practices during perineal care for one resident (Resident #39) out of 18 sampled residents and during wound care for three residents (Resident #27, #28 and #1) of four sampled residents with wounds. Facility staff also failed to develop and implement complete policies and procedures for the inspection, testing and maintenance of the facility's water systems to inhibit the growth of waterborne pathogens and reduce the risk of an outbreak of Legionnaire's Disease, a serious type of pneumonia (lung infection) caused by Legionella bacteria. This failure has the potential for the failure of staff to identify and mitigate the presence of waterborne pathogens, which places all residents of the facility at risk of exposure which could lead to illness. The facility census was 51. 1. Review of the facility policies showed facility staff did not provide a policy for when to change gloves during perineal care or wound care. Review of the facility's Competency Checklist titled Hand Hygiene and Glove use, undated, showed facility staff are to wash or sanitize hands before applying gloves and gloves should be removed when completing a task, when leaving the room, or when handling objects such as drawers, call light, etc., dispose of gloves in a waste container and sanitize hands immediately after removing gloves. Review of the facility's Competency Checklist titled Wound Care, undated, showed facility staff are to: -Cleanse hands and put on gloves; -Remove soiled dressings and dispose in trash can; -Cleanse hands and put on clean gloves; -Cleanse wound. 2. Observation on 04/08/26 at 2:02 P.M., showed the Infection Preventionist (IP) provided wound care to Resident #27's right foot. The IP put on a gown, washed hands, put on gloves, removed the resident's sock, removed the soiled dressing to the resident's right foot, and with the same gloves, cleansed the resident's wound with sterile gauze. 3. Observation on 04/09/26 at 9:12 A.M., the IP provided wound care to Resident #28's left leg. The IP put on a gown, washed hands, put on gloves, removed drainage stained tubi-grips (sleeves to provide compression) from the resident's leg, removed rolled gauze, and with the same soiled gloves cleansed multiple wounds to the resident's right leg. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 04/09/26 at 10:08 A.M., showed Certified Nurse Aide (CNA) A and Certified Medication Technician (CMT) G entered resident #39's room to provide perineal care. CNA A and CMT G washed hands, applied gloves, and transferred the resident to the toilet with a sit to stand lift. CNA A pulled down the resident's pants and brief, removed the resident's urine saturated brief, rolled the brief, placed the brief in the trash can and with the same soiled gloves on put a clean brief on the resident. Observation showed the CNA touched the sit to stand lift, the resident's clean pants, and the resident's shirt with the same gloves on. During an interview on 04/09/26 at 10:24 A.M., CNA A said he/she should have changed his/her gloves and washed hands after he/she touched the resident's urine saturated brief and before he/she touched the resident's clean brief, pants, lift and the resident's shirt. The CNA said he/she did not think about it at the time. During an interview on 04/10/26 at 12:36 P.M., LPN E said staff are expected to wash hands and change gloves from dirty to clean tasks. The LPN said staff should have changed gloves and washed hands between touching the resident's urine saturated brief and then touching the clean brief and other clean items. 5. Observation on 04/09/26 at 10:31 A.M., showed the IP and Licensed Practical Nurse (LPN) E provided wound care to Resident #1. Observation showed the IP put on a gown, washed hands, put on gloves, removed the soiled dressing to the resident's left heel, and with the same soiled gloves on cleansed the left heel wound, removed his/her gloves, washed hands and then performed the treatment. Observation showed the IP removed his/her gloves, washed hands, applied clean gloves, removed the soiled dressing from the resident's right heel, and with same gloves on cleansed the right heel wound. The IP removed his/her gloves, washed hands and performed the right heel treatment. Observation showed the IP removed his/her gloves, washed hands, removed the dressing to the resident's left great toe, and cleansed the wound with the same gloves on. During an interview on 04/09/26 at 11:22 P.M., the IP said he/she has been taught to remove the soiled dressing, cleanse the wound and then change gloves and wash hands. The IP said that is what he/she did. 6. During an interview on 04/10/26 at 12:36 P.M., LPN E said staff are expected to wash hands and change gloves from dirty to clean tasks. During an interview on 04/10/26 at 12:30 P.M., the Director of Nursing (DON) said staff should change gloves and wash hands after removing a soiled dressing during wound care. He/She said the reason you change gloves and wash hands is because the dressing is dirty. The DON said during perineal care staff should wash hands and change gloves from dirty to clean tasks and anytime the gloves become soiled. 7. Review of the Centers for Medicare and Medicaid Services (CMS), QSO-17-30, dated 06/02/17 and revised 07/06/18, showed CMS expects Medicare and Medicare/Medicaid certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mycobacteria, and fungi) could grow and spread in the facility water system; -Develops and implements a water management program that considers the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) industry standard and the Centers for Disease Control and Prevention (CDC) toolkit; -Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions taken when control limits are not maintained; -Maintains compliance with other applicable Federal, State and local requirements; -Note: CMS does not require water cultures for Legionella or other opportunistic water borne pathogens. Testing protocols are at the discretion of the provider. Review of the facility's Water Management Program (WMP): Legionella, undated, showed a Water Management Team (WMT) has been established which includes the administrator, Plant Operations Director, Safety Officer, Water Treatment Contractor, Director of Nursing (DON), Medical Director and Quality Assurance Director. Review showed: -With initiation of this WMP in February 2019, samples of water will be taken and tested through a contracted vendor. This testing will be done annually through various points throughout the water system; -The WMT understands the water systems, monitors and documents program performance annually; -Control measures have been established and corrective actions will be utilized if controls are not within limits; -The Plant Operations Director will oversee control locations and limits and report outliers to the team; -WMP will be documented and all activities will be communicated in safety and quality assurance meetings quarterly -Verification of water management within building will be done by the Plant Operations Director. Review of the facility's WMP, showed the records did not contain: -A written description of the building's water system; -A facility specific risk assessment; -Control measures related to identified risk areas; -Corrective actions to take if control measures are not within specified ranges; -Complete documentation of annual water system testing. Review of the facility's inspection, testing and maintenance records showed the Plant Operations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Director documented all locations were tested on [DATE] and passed using Legionella test kits. Reviewed showed the records did not contain a list of sampled locations. Observations on 04/08/26 during the Life Safety Code tour showed the facility equipped with three ice machines and multiple resident room showers throughout the facility. Observation showed the kitchen ice machine drainpipe ended below a white plastic cover on the floor drain and did not contain an air gap. Observation showed the drains on two ice machines located in resident dining areas were connected directly to sink p-traps and did not contain air gaps. Observation showed shower heads were hung in a manner which created a U in the shower hose, and many were not in regular use. During an interview on 04/10/2026 at 12:52 P.M., the Infection Preventionist (IP) said he/she monitored residents for respiratory symptoms as part of the IP program and if he/she noticed any resident trends in respiratory illness he/she would report the issue to the administrator. The IP said he/she did not do anything building related as part of the IP program. During an interview on 04/09/26 at 10:55 A.M., the Plant Operations Director said he/she and the administrator reviewed the plan in January 2026 and he/she signed off as the reviewer. The director said he/she did not know the specifics of what the plan requirements were and the plan had not changed since he/she started in November of 2020. The director said he/she did not know the plan should include control measures and corrective actions for all identified risk areas. The director said facility risk areas would include spas, water fountains, ice machines. The director said he/she monitored risk areas by testing for Legionella in water heaters and spas once a year. The director said he/she never tested ice machines or resident rooms and he/she did not know if he/she should document Legionella testing locations. The director said he/she did not know of any facility control measures beyond annual water testing. The director said the facility water system has ultraviolet (UV) devices to reduce bacteria growth and he/she checks the UV devices weekly but does not document the checks. The director said as long as the UV devices were plugged in they were working and he/she did not have any other way to ensure the devices worked correctly. The director said he/she flushed water in resident rooms and water heaters but did not document the flushes because there was no policy to document the flushes. The director said the water management team met monthly and reviewed any issues that would indicate a need for Legionella testing as a part of the facility safety meeting. The director said issues that could prompt additional testing would include issues with water heaters, spas, city water or facility water temperatures out of range. During an interview on 04/09/26 12:06 P.M. the administrator said the facility's water management plan contained a water system description and risk areas which included water heaters, ice machines, stagnant water areas and low use resident room water fixtures. The administrator said annual plan review, Legionella testing and monitoring for resident infections would be control measures. The administrator said he/she did not know control measures were required for all identified risk areas. The administrator said the director flushes water fixtures in vacant resident rooms, but he/she did not know how often, how long or if the flushes were documented. The administrator said he/she did not expect the water flushes to be documented if the director said they were done. The administrator said the director completes Legionella testing annually, but he/she did not know how many tests or locations the director completed. The administrator said he/she would expect the director to document water sample locations. The administrator said the plan should include corrective actions.

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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** Based on observation, interview and record review, facility staff failed to ensure two residents (Resident #1 and #39) out of four sampled residents with wounds, received the necessary treatment and services in accordance with professional standards when staff failed to ensure pressure wounds were identified, assessed appropriately and provided adequate pressure relief. The facility census was 51. 1. Review of the National Pressure Injury Advisory Panels (NPIAP) definitions of staging showed: -Stage 1 Pressure Injury: 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. -Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. 2. Review of the facility's policy titled Wound Assessment, Prevention and Treatment, dated 11/28/17, showed a care plan will be developed for a resident with a skin issue which details the specific wound healing interventions which have been determined appropriate. This will include an individualized turning/repositioning schedule as indicated when in bed attempt to float heels.The resident should also be assessed for risk factors that increase susceptibility to develop a pressure ulcer. Examples of these risk factors include, but are not limited to:-Impaired/decreased mobility and decreased functional ability;-Co-morbid conditions, such as end-stage renal disease, thyroid disease or diabetes mellitus.Review of the facility's Wound Care Competency Checklist, undated, showed staff are directed to cleanse hands, apply gloves, remove soiled dressings, cleanse hands, apply clean gloves, and cleanse wounds. 3. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 11/19/25, showed staff assessed the resident as: -admitted on [DATE];-Cognitively intact;-Did not reject care or evaluation;-Had four Stage 2 pressure ulcers/injuries and one Stage 3 pressure ulcer/injury;-Diagnoses of Diabetes Mellitus, Non-Alzheimer's Dementia, and kidney insufficiency. Review of the resident's Braden Scale (Scale used to determine pressure ulcer/injury risk), dated 12/03/25, showed staff scored mild risk for developing a pressure ulcer/injury. Review of the resident's Quarterly MDS, dated [DATE], showed: -Cognitive;-Did not reject care or evaluation;-Dependent on staff for upper and lower body dressing and bed mobility;-Had a pressure ulcer/injury;-At risk of developing pressure ulcers/injuries;-Had one stage 2 pressure ulcer/injury present on admission. -Diagnoses of Diabetes Mellitus and Non-Alzheimer's Dementia;-Received hospice care.Review of the resident's Physician Order Summary (POS), dated April 2026 , showed: -04/03/26: Wound Care to Right Heel: Cleanse with wound cleanser, pat dry, apply xeroform gauze (petroleum-impregnated dressing) to wound bed and secure with kerlix (rolled gauze);-04/03/26: Would Care to Left Heel: Cleanse wound bed with wound cleanser, pat dry, apply Medihoney (wound material used to draw fluid from the wound to the surface and liquify non-viable tissue) to wound bed and secure with kerlix; -04/9/26: Skin-prep to Great Right toe tip, once daily for Stage I pressure ulcer care. Review of the resident's care plan, dated 04/10/26, showed: -12/16/25: Maximum assistance required for upper and lower body dressing;-01/21/26: Apply Gaymar boots (pressure relief boots) to both feet as tolerated; may float heels with pillow if patient refuses boots;-04/03/26: Low Air Loss mattress to bed;-04/09/26: Maintain pressure reducing pad to the foot of the bed;-04/09/26: Stage 1 right great toe ulcer will resolve;-04/09/26: Skin prep to right great toe as ordered. Review of the residents' progress notes showed staff documented: -On 04/07/26- The wound nurse documented: Seen today for ongoing cares of admission toe(s) injuries. Left heel and Right heel Diabetic (DM) Ulcer development. Continues to refuse (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure reducing boots in bed but accepts heels floated onto pillows; -On 04/08/26- The wound nurse documented during wound cares noted when repositioning up toward head of bed foot touched the footboard. Pillow placed at footboard to prevent recurrence. Treatment initiated and care plan adjusted. Review of the residents' Left Heel Weekly Wound Assessments showed: -On 03/10/26, the IP/Wound Nurse documented the left heel, Date acquired 11/12/25, Stage 2, Improving. Tissues: Epithelial, granulation, necrotic and moist;-On 03/18/26, the MDS Coordinator documented the left heel, Date acquired 11/12/25, Stage 2, Improving. Tissues: Epithelial, granulation, necrotic and moist;-On 03/24/26, the IP/Wound Nurse documented the left heel, Date acquired 11/12/25, Stage 3, Worsening. Tissues: Granulation, necrotic, and moist;-On 03/31/26, the IP/Wound Nurse documented the left heel, Date acquired 11/12/25, Stage 3, Improving. Tissues: Granulation, necrotic, and moist; -On 04/07/26, the IP/Wound Nurse documented the left heel, Date acquired 11/12/25, Stage 3, Worsening. Tissues: Granulation, Necrotic, moist. Review of the resident's Right Heel Weekly Wound Assessment, dated 04/07/26, showed the IP/Wound documented wound to right heel, Date acquired 04/03/26, Type: Diabetic Ulcer (DM); First observation, no reference; Tissues: Granulation and Slough (yellow, tan, white, stringy); Moist; Measurements Length (L) 6 centimeters (cm) by Width (W) 2 cm by Depth (D) 0.2 cm. Observation on 04/07/26 at 10:21 A.M., showed the resident in bed with both heels wrapped in gauze. The resident's right and left heels rested directly on a pillow. Heel protector boot on the floor, with three other heel protector boots in a chair in the room. Observation on 04/07/26 at 3:23 P.M., showed the resident in bed with both legs propped up on a pillow. The resident's right and left heels sat directly on the air mattress. Heel protector boots in a chair in the room. Observation on 04/08/26 at 8:49 A.M., showed the resident in bed with heels dug into air mattress. Observation on 04/08/26 at 3:41 P.M., showed the resident in bed with heels dug into air mattress. Dressings to bilateral heels. Observation on 04/09/26 at 9:01 A.M., showed the resident in bed with tip of right great toe pressed directly into wooden footboard. The ball of the resident's left foot is covered in a dressing and pressed directly into the wooden footboard. Both heels are dug into the air mattress. Certified Nurse Aide (CNA) F entered the resident's room and positioned the resident in bed. The CNA did not float the resident's feet on a pillow. The resident's feet remained pressed against the footboard and his/her heels dug into the mattress. Observation on 04/09/26 at 10:31 A.M., showed the resident in bed with tip of right great toe and ball of left foot pressed directly into the wooden footboard of the bed. The Infection Preventionist (IP)/Wound Nurse and Licensed Practical Nurse (LPN) E entered the resident's room to provide wound care. The IP placed an incontinence pad under the resident's feet and when he/she lifted the resident's right foot a 3 cm dark purple indented area could be seen on the tip of the resident's right great toe. LPN E said the wound is new and the indention from the footboard is seen. The IP removed the dressing to the resident's left heel and revealed a pressure injury with granulation tissue, eschar and slough with a red peri-wound (area around the wound bed). The IP/Wound nurse with the same gloves on that he/she removed the soiled dressing with cleansed the resident's wound. The IP/Wound Nurse and LPN removed their gloves, washed hands, applied new gloves and the IP/Wound nurse completed the treatment to the resident's left heel wound. While staff performed treatment and hand hygiene the resident's right great toe remained pressed against the footboard. Observation showed the IP/Wound nurse removed the soiled dressing to the resident's right heel, cleansed a dime sized wound with beefy red granulation tissue and a purple, maroon nickel sized wound above the dime sized wound with the same gloves on. During an interview on 04/09/26 at 10:31 A.M., the Wound Nurse/IP said the resident admitted to the facility with a Stage 3 pressure ulcer/injury to his/her left heel. He/She said the left heel wound is a Stage 2 with epithelial tissue and is shallow, so it has improved. The IP/Wound nurse said the right heel wound is a diabetic ulcer, so he/she has not staged the wound. He/She said the resident cannot position himself/herself in bed at all and that is why he/she has an air mattress. The IP/Wound nurse said the tip of the right great toe is indented, and he/she would expect staff to reposition the resident if they saw his/her feet resting against the footboard. The IP/Wound Nurse said the resident has a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	new Stage 1 pressure ulcer/injury. During an interview on 04/10/26 at 8:01 A.M., the Director of Nursing (DON) said the resident has reduced mobility and has had a recent decline. He/She said a dark purple/maroon wound could be considered a suspected deep tissue injury. During an interview on 04/10/26 at 8:22 A.M., CNA F said he/she does not believe the resident could lift his/her legs off the bed. The CNA said if he/she saw the resident's feet resting on the footboard and his/her heels dug into the mattress he/she would get another staff member to help him/her reposition the resident. The CNA said the resident really needs a bed that fits him/her because the resident scoots his/her bottom down in the bed, and that's how his/her feet end up on the footboard and dug in the mattress. During an interview on 04/10/26 at 11:07 A.M, the IP/Wound Nurse said the wound to the resident's right heel is a diabetic ulcer because he/she does not have observations of the resident's right heel not floated or without pressure relief. He/She said the resident has a new Stage I pressure ulcer to his/her right great toe and described the wound as red with some darkness, bruised looking. He/She said if staff are not utilizing pressure relief interventions the wounds could become worse. The IP/Wound nurse said he/she stages the wound according to guidelines. During an interview on 04/15/26 at 1:15 P.M., Physician M said he/she knew about the wounds to the resident's heels. He/She said staff notified him/her of the worsening wound to the left heel, facility staff obtained an x-ray, and the x-ray showed osteomyelitis (bone infection). The physician said the wounds to both the resident's heels are from pressure as they are over bony prominences, and the resident has decreased mobility and stays in bed. He/She said staff should ensure pressure relief interventions are in place and utilized. He/She said if staff are not providing pressure relief that could make the residents wounds worse and keep the wounds from improving. He/She said staff should follow the facility policy for wound care. 4. Review of Resident #39's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:-Intact cognition;-Required maximal assistance from a staff member for bed mobility, personal hygiene, dressing, bathing and transfers;-At-risk for developing pressure ulcers/injuries;-Application of dressings to feet;-Diagnosis of Coronary Artery Disease and Diabetes.Review of the resident's Braden Scale for predicting pressure sore risk, dated 12/09/25, showed staff assessed the resident as a moderate risk for developing pressure sores.Review of the resident's care plan, dated 03/24/26, showed staff documented the resident's right heel has a diabetic ulcer on 11/18/2025. Bilateral heel boots as resident allows. Required maximum assistance with bed mobility. Review of the resident's POS, dated April 2026, showed an ordered dated 02/02/26 to cleanse right heel would with wound cleanser, apply xeroform gauze to wound bed, cover with gauze and secure every shift. Review of the resident's right heel Weekly Wound assessments showed staff documented:-On 03/03/26: right heel, Stasis Ulcer, Tissue: Epithelial, Granulation;-On 03/10/26: right heel, Stage II, Tissue: Granulation, 1 cm L by 1.1 cm W by 0.1 cm D. Much improved with no eschar; new dermis;-On 03/18/26: right heel, Stage II, Tissue: Granulation; -On 04/07/26: right heel, Improving, Tissue: Epithelial, Granulation and Slough; Slowly resolving. Observation on 04/09/26 at 3:11 P.M., showed resident in his/her recliner. The resident's right heel pressed into the footrest of the recliner. The fabric of the footrest depressed from the resident's right heel. The resident did not have heel protector on right heel.During an interview on 04/09/26 at 3:13 P.M., the resident said his/her wound is on the heel of his/her right foot. Observation on 04/09/26 at 3:20 P.M., showed the resident in a recliner in his/her room with his/her right heel dug into the footrest of the recliner. LPN E asked the resident if he/she could lift his/her leg up so a barrier could be placed on the footrest. The resident attempted to lift his/her right leg and could not. LPN E placed a pillow under the resident's right leg. LPN E removed the dressing to the resident's right heel and revealed a dime sized wound with pink/red granulation tissue. During an interview on 04/09/26 at 3:20 P.M., LPN E said he/she thinks the wound to the resident's right heel is from pressure. He/She said the wound bed is pink and top layers of skin are not present. During an interview on 04/09/26 at 3:20 P.M., the resident said the wound to his/her right heel is from laying in bed. He/She said the wound started before he/she got booties to wear. During an interview on 04/10/26 at 11:52 A.M., the IP/Wound Nurse said (continued on next page)

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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	the resident has a diabetic ulcer to his/her right heel, and he/she determined that by direct observations, interview and medical history. During an interview on 04/10/26 at 8:01 A.M., the DON said the IP/Wound Nurse determines if wounds are pressure injuries versus diabetic ulcers. He/She said the nurses do not stage the wounds, that is the IP/Wound Nurses responsibility, as well as all assessments and measurements. He/She said staff should follow certain criteria to describe and assess wounds. He/She said he/she expects the IP/Wound Nurse to follow guidelines including the facility protocol and reference material. During an interview on 04/10/26 at 11:07 A.M., the DON said if staff are not utilizing pressure relief interventions the wounds could become worse. He/She would expect staff to reposition residents. During an interview on 04/10/26 at 12:30 P.M., the Director of Nursing (DON) said staff should change gloves and wash hands after removing soiled dressing during wound care. He/She said the reason you change gloves and wash hands is because the dressing is dirty.