STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265877	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate	3130 John Duffy Dr Joplin, MO 64804

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care to promote the prevention and healing of skin breakdown when staff failed to timely and accurately assess and document related to Moisture Associated Skin Damage (MASD-inflammation and skin erosion caused by prolonged exposure to bodily fluids such as urine and feces) for one resident (Resident #3) in a selected sample of 10 residents. The facility's census was 100 residents. Review of the facility's Wound and Skin Care Protocol, revised November 2024, showed the following information:-Purpose to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. This protocol serves as a tool for treatment options for the staff member to utilize;-The Director of Nursing (DON) at each facility is responsible for informing and educating the attending physicians and the facility's Medical Director regarding facility wound care protocols. It will also be the responsibility of the facility DON to ensure that the wound care protocols are instituted and followed for all residents needing wound treatment and have orders for wound care protocol;-The DON will be responsible for reviewing the weekly wound report and monitoring progress/decline of any wound and assuring compliance with current standards of wound care practice;-The Resident Assessment Instrument (RAI - a standardized, federally mandated system used by Medicare and Medicaid-certified nursing homes and long-term care facilities to evaluate the health, functional capacity, and individualized care needs of every resident) process to be used for ongoing risk assessment;-The interdisciplinary plan of care will address problems, goals, and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure injury. 1. Review of Resident #3's face sheet showed the following: -admission date of 12/18/24;-Diagnoses included congestive heart failure (CHF - impaired heart function) and pneumonia (infection and inflammation of the lung). Review of the resident's care plan, initiated on 08/29/24, showed the following:-The resident was at risk for impaired skin integrity related to limited mobility and bowel incontinence;-Staff should evaluate the resident's skin integrity. Review of the resident's May 2026 Physician Orders (POS) showed an order, dated 03/25/26, for staff to apply barrier cream to buttocks/perineal area (surface area between the thighs, extending from the pubic bone to tail bone), as needed for incontinence care/skin integrity. Review of the resident's 5-day Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 03/27/26, showed the following information: -Moderate cognitive impairment;-Required substantial/maximum assistance with toileting hygiene-Dependent on staff for bathing;-Occasionally incontinent of bowel and bladder;-The resident had MASD.Review of the resident's shower sheets, dated 05/19/26 and 05/22/26, showed staff documented no new skin issues. Review of the resident's skilled evaluation dated 05/26/26, at 11:34 A.M., showed staff did not document an assessment of the resident's buttocks. Review of the resident's skin check assessment dated [DATE], at 3:44 P.M., showed the following: -New skin issue to right gluteus (buttock);-MASD. Review of the resident electronic medical record (EMR) showed the nurse did not document a skin issue assessment of the MASD including size, description/appearance, cause, and implemented interventions. During an interview on 06/04/26, at 3:40 P.M., Licensed Practical Nurse (LPN) H said the following: -On 05/26/26, one of the (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse managers asked him/her to conduct a skin check (the assessment form used for residents with no skin issues) on the resident. He/she did not know the resident had any skin issues;-When the nurse found the resident had MASD to his/her buttocks, he/she noted it on the skin check form but did not go back and enter a skin issue assessment. Review of the resident's skilled evaluation dated 05/27/26, at 5:12 P.M., showed staff did not document an assessment of the resident's right gluteal MASD. Review of the resident's skilled evaluations dated 05/28/26, at 10:43 P.M., and 05/29/26, at 3:38 A.M., showed a nurse documented MASD, incontinence associated dermatitis (IAD-a painful, irritant contact dermatitis (an itchy rash caused by direct contact with a specific irritant) caused by prolonged skin exposure to urine and/or feces.Review of the resident's skin issue assessment dated [DATE], at 8:38 A.M., showed the following: -Skin issue to buttocks;-MASD, Type IAD that measured 11.74 centimeters (cm) x 8.41 cm;-Primary dressing Triad Paste (a zinc oxide-based paste that creates a protective barrier and moist environment).During an interview on 06/03/26, at 3:47 P.M., LPN H said the following:-The resident had a history of MASD on his/her buttocks;-Staff applied Triad paste to his/her buttocks;-Staff found the reddened MASD on the resident's buttocks a few weeks ago.During an interview on 06/03/26, at 6:43 P.M., the DON said the resident had a history of MASD, but she did not know if the resident currently had any skin concerns on his/her buttocks. Review of the resident's shower sheet, dated 06/03/26, found by Registered Nurse (RN) F on 06/04/26, showed CNA C left the visual assessment of the resident's skin blank. During an interview on 06/04/26, at 4:31 P.M., CNA C said the following: -He/she documented in the EMR when he/she assisted a resident with a shower; -He/she completed the resident's shower sheet on 06/03/26;-He/she forgot to document the resident had a skin issue on his/her buttocks, on the shower sheet. Observation on 06/04/26, at 10:45 A.M., showed the following:-The resident laid in bed on his/her right side with a wedge supporting his/her back and pressure relieving boots on both feet;-The Assistant Director of Nursing (ADON) and current wound nurse (LPN K) entered the resident's room to apply a barrier cream to his/her buttocks;-The ADON removed the resident's disposable brief which showed a softball-sized area of red and flaky skin on the resident's bilateral buttocks.During an interview on 06/03/26, at 3:24 P.M., Nurse Aide (NA) B said the following:-When he/she completed a shower sheet on a resident, he/she documented any abnormal bruising, skin tears, and bleeding;-NA B would also tell the nurse in person if the skin issue looked bad;-Upper management told NA B a couple of days ago that staff should document all skin issues, old or new, on the resident's shower sheet. During interviews on 06/03/26, at 3:50 P. M. and 5:22 P.M., and on 06/04/26, at 4:31 P.M., Certified Nurse Aide (CNA) C said the following: -He/she documented abrasions, skin tears, redness, and bruising on the resident's shower sheets then gave the sheets to the nurse;-Recently management staff told him/her to document all skin issues, old and new, on the resident's shower sheet;-He/she would notify the nurse of any new skin issues. During interviews on 06/03/26, at 3:47 P.M., and 06/04/26, at 3:40 P.M., LPN H said the following:-MASD appeared as redness or galling (a painful skin condition caused by a combination of friction, heat, and moisture) which could lead to open areas due to moisture;-If the nurses noticed a resident had MASD, they would clean the area, pat dry, and apply a moisture barrier cream, and anti-fungal powder if needed;-The nurse also completed a full assessment of the MASD, completed a risk management report and skin issue assessment, and notified the wound nurse, family and physician;-If the resident had orders for preventative treatments such as moisture barrier cream or skin prep, those orders were listed on the nurse medication administration record. If the treatment included medication such as nystatin (a prescription antifungal medication), it was listed on the nurse treatment administration record;-The CNAs completed shower sheets when they assisted a resident with a shower. The aides documented current and new skin issues on the sheet, then gave the sheets to the nurse to review and sign. The nurse then gave the shower sheets to the wound nurse to review;-If the aide documented a skin issue the nurse did not know about, the nurse addressed the issue; -The nurse addressed the new skin issue by assessing the area which included measuring the area and contacting the provider for orders;-The nurse also completed a skin issue assessment and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk management documentation (incident report) in the EMR;-The night shift nurses completed the weekly skin check assessment for residents who were not at high risk for developing pressure ulcers;-The wound nurse completed the skin issue assessments for residents with existing wounds and for residents at high risk for developing pressure ulcers. During an interview on 06/03/26, at 5:45 P.M., LPN L said the following:-If a CNA found a new skin issue, the CNA told the nurse and immediately the nurse assessed the wound, completed a skin issue assessment and incident report (risk management) in the electronic medical record, contacted the physician/provider for treatment orders.-When the nurses enter a new order into the electronic medical record, it alerts the wound nurse and nurse management of the new order;-The CNAs rarely shower residents on the nurse's shift, but when they did, they completed a shower sheet, gave the sheets to the charge nurse who reviewed and signed the sheet. If the CNA documented a new skin issue, the nurse assessed the resident, then placed the completed shower sheets in the wound nurse's office; -The CNAs documented all skin issues on the shower sheet. If the nurse did not know of a skin issue marked on the shower sheet, the nurse reviewed the resident's chart. During an interview on 06/03/26, at 5: 53 P.M., RN E said the following:-If a CNA reported a new skin issue to the nurse or if a nurse found a new wound, that nurse would complete the initial assessment, apply a simple dressing to cover the wound, document the skin assessment, and complete a risk assessment (incident) report, if the wound nurse or management did not complete one for the new wound;-The nurse would then contact the on-call provider for treatment orders;-When a CNA completed the shower sheet, he/she should document all skin issues they observed, not just the new skin issues;-The CNAs should notify the nurse about any skin issues, every time. During an interview on 06/04/26, at 11:05 A.M., Hospice Nurse (HN) G said the following: -When the hospice aides (HA) assisted a resident with a shower, they completed a shower sheet documenting any skin issues on the sheet, then gave the sheet to the charge nurse;-The HA also documented the find in the secured messaging system which the HN reviewed;-The HN assessed the wound then talked to the charge nurse about the assessment. The HN did not know if the charge nurses talked to the wound nurse for orders. During an interview on 06/03/26, at 4:27 P.M., the ADON said the following:-If a CNA found a new wound on a resident when he/she assisted the resident with care, he/she notified the nurse of the new wound, and waited for the nurse to assess the wound before transferring the resident out of bed;-The nurse immediately assessed the resident's wound and followed the treatment protocol approved by the physician;-The wound assessment included the type of wound (pressure injury, skin tear, and other types of wounds), location, wound bed and peri-wound appearance, size, drainage, any signs of infection, treatment, and who the nurse notified;-The nurse documented the wound assessment on the risk management (incident) report which linked to a nurses/progress note;-The nurse also contacted the physician or provider, investigated how the wound developed, implemented interventions for that specific wound, and completed the skin issue assessment in the electronic medical record;-When the nurse obtained specific treatment orders from the physician/provider, the nurse entered the order into the EMR;-The wound nurse also assessed the new wound and its cause, entered the wound treatment order in the EMR, and documented it all in the skin issue assessment;-The CNAs completed a shower sheet after each residents' shower and they documented all skin issues on the shower sheet;-The CNAs gave the completed shower sheets to the nurses to review, and the nurses either gave the reviewed shower sheets to the wound nurse or placed the shower sheets in the wound nurse's office. The wound nurse then reviewed the shower sheets and reported any new skin issues to the DON and ADON during the morning clinical meeting;-The wound nurse completed a skin assessment on each resident weekly, including residents with newly identified wounds;-The former wound nurse (LPN J) should have been able to complete all of the skin assessments including newly identified wounds, as she (the ADON) and the new wound nurse who she was training, had no issues completing the assessments; -In order to assess every resident, the wound nurse had to complete about 20 residents' skin assessments every day;-She and the wound nurse reviewed the risk management (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reports completed by the nurses the previous day, at the daily (Monday-Friday) morning clinical meeting;-During the morning meeting, the wound nurse gave the DON and ADON updates on residents' skin assessments he/she completed the previous day which included new admits, newly identified wounds, and wounds that had deteriorated;-The facility utilized a mobile wound care company to manage all residents' wounds including pressure ulcers;-When a resident developed a new wound, the nurse contacted the family for consent. Once they received consent, they notified the physician/provider who gave an order for the mobile wound Nurse Practitioner (NP) to see the resident. During interviews on 06/04/26, at 5:00 P.M. and on 06/05/26, at 5:00 P.M., the DON said the following: -MASD was caused by moisture sitting on the skin and the skin would appear moist and red;-The staff member who assisted the resident with a shower was responsible for completing the shower sheet, documenting all skin issues, old and new;-Staff then give the shower sheets to the charge nurse to review;-If the shower sheet showed a new wound, the charge nurse was responsible for assessing the new skin issues. During an interview on 06/03/26, at 6:43 P.M., the DON, Administrator and Corporate Nurse said the following:-The DON said if a CNA found a new wound on a resident, the CNA notified the charge nurse who assessed the wound, followed the wound protocol, completed a risk management report, and contacted the physician. -The DON said the charge nurse also notified the wound nurse. The charge nurse documented the wound assessment including the size, appearance of the wound, the treatment per the wound protocol, family and physician notifications, preventative measures, and how the wound occurred, on the risk management report;-The DON said the charge nurse was ultimately responsible for the initial wound assessment. If the wound nurse was available, he/she could go with the charge nurse to assess the wound, but the charge nurse documented the assessment, completed the risk assessment, and contacted the physician and family;-The DON said the CNAs completed a shower sheet after each residents' shower. The CNA who showered the resident completed the form;-The administrator said the CNAs gave the completed shower sheets to the charge nurse;-The DON said the charge nurse reviewed and signed the shower sheet then gave the sheets to the wound nurse. The nurse who reviewed and signed the sheet should follow up on any new skin concerns;-The Administrator said the wound nurse reviewed the shower sheets and reported any new or deteriorating wounds to nurse management during the morning clinical meeting; -The Administrator said the former wound nurse was supposed to print the weekly wound report and give the report to the Administrator and Corporate Nurse to review, but the former wound nurse did not do this consistently. If the wound nurse did not give the weekly report to her, she asked the wound nurse for the report although the wound nurse did not always comply with her request. The Administrator did not print the weekly wound report if the (former) wound nurse did not give it to her;-The Administrator said the wound nurse reviewed and discussed issues with the DON, ADON, and Administrator every day in the clinical meeting; -The DON said the electronic medical record program generated the wound report, but she did not print the weekly wound report when the wound nurse did not give it to the Administrator, and until recently, she did not know how to generate that report;-The Corporate Nurse said she thought the wound NP assessed and monitored all wounds at the facility. Complaint #3030519

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety 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, the facility failed to provide care to promote the prevention and healing of pressure ulcers when staff failed to assess, monitor, document, and notify the physician for at least 17 days of a newly acquired Stage 4 (full thickness tissue loss with exposed bone) pressure ulcer that developed on one resident's (Resident #1) sacrum (the triangular bone located above the tailbone) which resulted in the resident requiring prolonged antibiotic treatment for probable osteomyelitis (an infection and inflammation of the bone typically caused by bacteria or fungi) and when staff failed to complete a wound treatment per physician order, and timely assess, document and notify the physician of five newly acquired pressure ulcers for one resident (Resident #2) in a selected sample of 10 residents. The facility's census was 100 residents.The Administrator was notified on 06/03/26, at 7:23 P.M., of an Immediate Jeopardy (IJ) which began on 05/05/26. The IJ was removed on 06/04/26, as confirmed by surveyor on-site verification. Review of the facility's Wound and Skin Care Protocol, revised November 2024 showed the following information:-Purpose to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. This protocol serves as a tool for treatment options for the staff member to utilize;-Purpose to prevent pressure injury formation by identifying those residents who are at risk for pressure injury and to develop appropriate interventions;-Purpose to promote healing of pressure injuries in a cost efficient and timely manner;-The Director of Nursing (DON) at each facility is responsible for informing and educating the attending physicians and the facility's Medical Director regarding facility wound care protocols. It will also be the responsibility of the facility DON to ensure that the wound care protocols are instituted and followed for all residents/patients needing wound treatment and have orders for wound care protocol;-The DON will be responsible for reviewing the weekly wound report and monitoring progress/decline of any wound and assuring compliance with current standards of wound care practice;-All residents will be assessed by the charge nurse for risk of skin breakdown using the Braden Scale (a widely used, evidence-based assessment tool used by healthcare professionals to predict a patient's risk of developing pressure injuries) on admission, re-admission, and with any major change in condition. The Resident Assessment Instrument (RAI - a standardized, federally mandated system used by Medicare and Medicaid-certified nursing homes and long-term care facilities to evaluate the health, functional capacity, and individualized care needs of every resident) process to be used for ongoing risk assessment;-The interdisciplinary plan of care will address problems, goals and interventions directed toward the prevention and/or treatment of impaired skin integrity/pressure injury. 1. Review of Resident #1's face sheet (a standardized document that provides a quick, high-level summary of important information) showed the following:-admission date of 03/08/23;-Diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life) and systemic lupus (a chronic autoimmune disease in which the immune system mistakenly attacks healthy tissues throughout the body, causing widespread inflammation and potential damage to the joints, skin, kidneys, heart, lungs, and brain). Review of the resident's current care plan showed on 12/09/24 staff added the following:-The resident was at risk for impaired skin integrity related to limited mobility and incontinence;-Evaluate skin. Review of the resident's Physician Order Summary (POS) showed an order, dated 09/15/25, to apply barrier cream to the resident's groin/perineal area every shift and as needed for incontinence care and skin integrity. Review of the resident's current care plan showed on 01/04/26, staff added the intervention to frequently turn/reposition and offload (reducing or removing pressure from an area of the body to help a wound heal or to prevent one from developing) both feet. Review of the resident's Braden Scale evaluation, dated 03/10/26, showed the resident was at moderate risk for developing pressure ulcers. Review of the resident's significant change Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 04/06/26 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	showed the following information:-Severe cognitive impairment;-Functional limitation in range of motion: Lower extremity impairment on both sides;-Used a wheelchair for mobility;-Required maximum assistance for bathing, personal hygiene, and rolling left and right in bed;-Dependent on staff for toileting hygiene, lower body dressing, transfers;-Always incontinent of bowel and bladder;-The resident was at risk of developing pressure ulcers;-One Stage 3 pressure ulcer (full thickness tissue loss);-One unstageable pressure ulcer (a severe wound where the base is completely covered by dead tissue making it impossible to determine the true depth or severity until the wound bed is exposed);-Pressure reducing device for bed and chair;-Nutrition or hydration intervention to manage skin problem;-Pressure ulcer care;-Received hospice services. Review of the resident's hospice clinical note, dated 05/05/26, showed Hospice Nurse (HN) G documented the following:-The HN changed the resident's dressing to his/her sacrum;-This was a new pressure sore since the weekend;-The facility's wound care nurse (Licensed Practical Nurse (LPN) J), and the HN coordinated the dressing changes to include calcium alginate (wound dressing made from natural fibers that absorbs heavy fluid, promotes healing, and stops minor bleeding) to the wound bed, sacral mepilex (soft silicone foam dressing), change every other day and as needed for soilage, integrity, and/or excess drainage; -The pressure areas measured 4 centimeters (cm) x 5 cm and 1.5 cm x 2 cm;-Wound order added for sacrum dressing of clean with wound cleanser, pat dry, apply calcium alginate to wound bed and cover with a sacral mepilex, change every other day and as needed for soilage, integrity;-A reportable wound event was identified on 05/04/26. The pressure ulcer was not acquired during hospice care. The pressure ulcer was Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed). The pressure ulcer was found by facility nurse on Monday (05/04/26) and some investigation was done by this nurse and facility wound care nurse (LPN J) on the onset of this wound. LPN J had already applied a dressing to the wound, and the resident was up in chair for lunch at the time (on 05/04/26). Today (05/05/26) the HN assessed the wound. The event was reported to the appropriate provider (hospice physician). Review of the resident's shower sheet, dated 05/05/26, showed the following:-The certified nurse aide (CNA) documented the resident's left big toe was red;-The CNA circled the buttocks on the human diagram and noted open; -The nurse (Registered Nurse (RN) E) signed the form which indicated he/she reviewed the form. During an interview on 06/03/26, at 5:53 P.M., RN E reviewed the resident's shower sheet, dated 05/05/26, and said the following:-The skin on the resident's sacrum was not open like it is now; -He/She did not assess the resident's skin on 05/05/26 as he/she thought the former wound nurse (LPN J) assessed the resident's skin and applied barrier cream to his/her sacrum. Review of the resident's skin issue assessment, completed by the former wound nurse, dated 05/12/26, showed the following:-Reinforced teaching on proper positioning in bed to offload pressure (reducing or removing pressure from an area of the body to help a wound heal or to prevent one from developing) and use of pressure relieving boots when up to prevent further breakdown; -No additional skin concerns at this time.(The wound nurse did not document an assessment of the resident's sacral wound.) Review of the resident's hospice clinical note, dated 05/12/26, showed HN G documented the following:-Upon arrival, the resident was in his/her wheelchair at the dining room table;-There was no wheelchair cushion in the resident's Broda chair (a specialized, highly adjustable medical wheelchair or recliner) and it did not appear that he/she has one available to use; -A wheelchair cushion was ordered at this visit related to wounds on her bottom (sacrum); -A skin assessment could not be completed to the posterior (the back or rear of the body) skin related to the resident positioned in his/her chair;-The resident had a pressure wound on her bottom. Review of the resident's hospice clinical note, dated 05/14/26, showed HN G documented the following:-Wound care provided by this nurse as the facility's wound care nurse was off today. -Pressure area to coccyx (tailbone), tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound), has brownish drainage, yellow slough (necrotic (dead) tissue) to wound bed. The resident had a necrotic area next to deep area of wound;-Wound cleanser applied with calcium (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alginate to wound bed and covered with Mepilex;-The HN told the charge nurse he/she completed the treatment. Review of the resident's shower sheet, dated 05/19/26, showed the following:-The hospice CNA circled the buttocks on the human diagram and noted opening; -The nurse (RN E) signed the form which indicated he/she reviewed the form. During an interview on 06/03/26, at 5:53 P.M., RN E reviewed the resident's shower sheet, dated 05/19/26, and said the following:-He/She did not assess the resident's skin on 05/19/26 as he/she thought the former wound nurse talked to the hospice nurse about the resident's sacral wound;-The hospice nurses talked to the charge nurse about anything going on with the resident;-If the hospice nurse had concerns related to wounds, the RN referred the hospice nurse to the wound nurse, if he/she was at the facility. Review of the resident's shower sheet, dated 05/22/26, showed the following:-The hospice CNA circled the buttocks on human diagram and noted opening; -The nurse (RN E) signed the form which indicated he/she reviewed the form. During an interview on 06/03/26, at 5:53 P.M., RN E reviewed the resident's shower sheet, dated 05/22/26, and said the following:-On 05/22/26, one of the hospice aides asked the nurse to go to the resident's room, which he/she did;-The hospice aide showed the nurse the pressure ulcer on the resident's sacrum;-The wound had no dressing;-No facility CNAs told him/her of the resident's sacral wound;-Since the former wound nurse was not working, the RN asked the Assistant Director of Nursing (ADON) for assistance. During an interview on 06/03/26, at 3:25 P.M., RN E said the following: -He/she observed the resident's skin off and on when he/she assisted with the resident's incontinent care and transfers;-On 5/22/26, one of the hospice aides told RN E of the resident's sacral wound. He/She found the ADON and they assessed the resident's wound;-No one told RN E about the resident's wound prior to 05/22/26.(RN E signed shower sheets dated 05/05/26 and 05/19/26.) Review of the resident's hospice clinical note, dated 05/22/26, showed HN G documented the following:-Facility nurse (RN E) reported the resident had a new wound;-The facility nurse also requested a low air loss mattress (a mattress that provided a constant flow of air in the mattress to help prevent pressure ulcers) and bolsters (long, narrow and often firm cushion of pillow) for the resident;-The resident had the wound on his/her buttock (sacrum) since 05/05/26;-The facility nurse (RN E) claimed to have no knowledge of the wound;-Facility wound care nurse (LPN J) had changed this wound with this nurse (HN G) at least once, probably twice, and they had talked about it a few times. This was not a new wound;-The HN remembered the wound care nurse (LPN J) asking about documentation on the wound; -Hospice had no documentation of the wound prior to 05/05/26, -Orders given to wound care nurse that day (05/05/26). During an interview on 06/04/26, at 11:05 A.M., HN G said the following: -The resident was dependent on staff for all care including bed mobility; -He/she had contractures of both knees and required a mechanical lift for transfers;-On 05/05/26, the former wound nurse told HN G the resident had a wound on his/her sacrum;-The HN observed two pressure ulcers on the resident's bottom area, one on the resident's sacrum and another to the side of the sacral wound. Both wounds were opened with white slough (non-viable yellow, tan, gray, green or brown tissue) covering the wound bed;-The former wound nurse discussed the treatment with the HN and told the HN he/she did not have an order to treat the wound. The HN applied calcium alginate to the wound bed and covered the wound with a silicone dressing, then entered the treatment orders for hospice;-After the HN reviewed his/her note, he/she said that he/she guessed he/she noticed the dressing on the resident's buttocks and changed the dressing. The HN thought he/she entered the order for the treatment on 05/05/26.-When the HN visited the resident, he/she changed the dressing when the resident was in bed but sometimes when the HN visited the resident, the resident sat in his/her wheelchair and the HN could not observe the resident's skin. Review of the resident's progress note dated 05/22/26, at 12:04 P.M., showed RN E documented the following:-Called to the room by the hospice CNAs about an open area on the resident's sacral area;-Upon examination, RN E noted an open area on the resident's sacrum and asked the ADON for assistance; -The open area measured 7.5 cm x 5.5 cm x 3.0 cm and the wound bed was 100% covered with slough; -Notified the hospice physician who ordered treatment for the sacral wound;-Staff educated to turn/reposition the (continued on next page)

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	265877	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate	3130 John Duffy Dr Joplin, MO 64804

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident every two hours or more frequently; -Hospice asked to provide an air mattress (a low loss air mattress) and the facility awaited delivery of the mattress at that time. Review of the resident's skin issue assessment, completed by the ADON, dated 05/22/26, showed the following:-New skin issue: An unstageable pressure ulcer due to slough and/or eschar (dead or devitalized tissue that is hard or soft in texture) to the resident's sacrum with an onset date 05/05/26 that measured 7.14 cm x 5.53 cm x 3 cm with no undermining (wound open underneath the border of the wound). The wound had a moderate amount of serosanguinous drainage (yellowish drainage with small amounts of blood) with a moderate odor after cleansing;-Additional care (interventions) of mattress with pump. Staff did not mark any other interventions used;-Nursing notified by hospice of new skin concerns. The charge nurse assessed the area and notified the ADON. The pressure ulcer was unstageable due to 100% slough covering the wound bed. Treatment orders received. Hospice provided an air mattress for pressure reduction. Staff educated on turning/positioning frequently. The resident was already seen by the mobile wound Nurse Practitioner (NP) (for his/her other pressure ulcers) and the wound NP would assess the resident's new wound on her next visit. Review of the resident's physician order summary, dated 05/22/26, showed an order for the sacral wound-cleanse with wound cleanser, apply calcium alginate, cover with silicone bordered foam every day and as needed if soiled or missing. Review of the resident's care plan showed staff added the following interventions:-On 05/22/26, hospice to provide air mattress to help with off-loading;-On 05/26/26, provide wound care to coccyx (sacrum) as ordered. Review of the resident's wound assessment, completed by the mobile wound NP, dated 05/26/26 showed the following:-New Stage 4 pressure ulcer on the resident's sacrum acquired on 05/05/26;-The wound measured 7.10 cm x 8.0 cm x 4.20 cm;-The wound bed was 100% covered with slough with exposed bone;-The wound had heavy seropurulent (wound discharge that is a mixture of serum (a clear, thin, watery fluid) and pus (a thick, cloudy fluid containing white blood cells, dead tissue, and bacteria) drainage with a mild odor after cleansing. Review of the resident's progress note dated 05/26/26, at 5:29 P.M., the wound NP documented the following:-New stage 4 pressure ulcer to the resident's sacrum which was initially observed by hospice on 05/05/26;-The first documented assessment in the resident's EMR was on 05/22/26;-Extensive wound with palpable bone with slough and necrotic tissue to the wound base;-Sacral wound had a depth of 4.2 cm with large amount of palpable bone. Epibole (edges of the skin roll inward and curl under instead of migrating across the wound bed) and erythema to wound margins; -Culture taken via facility. Debridement performed, but unable to remove much tissue as the resident displayed signs of pain during procedure;-The resident had frequent incontinence of bowel and bladder; -The resident used an air-fluidized mattress;-Reinforced teaching on a strict turn every 2 two-hour regimen to prevent further tissue breakdown;-Resident up for less than one hour at a time when up to wheelchair for meals. Review of the resident's POS showed the following:-An order, dated 05/26/26, to obtain a wound culture and sensitivity of the sacral wound;-An order, dated 05/26/26, for Meropenem (a potent, broad-spectrum antibiotic), 1 gram intravenously (a needle into the vein to infuse medication) three times a day for wound infection;-An order, dated 05/26/26, for Pro-stat (a ready-to-drink concentrated liquid protein) oral liquid, 30 milliliter (ml) three times a day for wound healing;-An order, dated 05/27/26, to cleanse the sacral pressure ulcer with wound cleanser or normal saline, pat dry, apply skin prep (protective barrier wipes) to the periwound, gently pack with sterile gauze moistened with hypochlorous acid (a weak, naturally occurring acid that your immune system produces to fight off bacteria and viruses) to the wound bed and cover with a silicone bordered dressing. Change every day and as needed for missing or soiled dressing. Review of the resident's progress note dated 05/27/26, at 7:39 A.M., the ADON documented the following:-Stage 4 pressure ulcer to the resident's sacrum that measured length 6.28 cm, width 6.72 cm, depth 3 cm;-Stable, previously deteriorating wound characteristics plateaued; -Wound acquired at the facility on 05/05/26. Review of the resident's sacral culture, dated 05/28/26, showed heavy growth of proteus mirabilis (bacterium found in the human intestines), escherichia coli (a group of bacteria normally found in the intestines) and (continued on next page)

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