STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265881	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Dardenne Prairie	7275 State Highway N Dardenne Prairie, MO 63368

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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 - 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** 34003 Based on interview and record review, the facility failed to complete weekly skin assessments per facility policy for two residents, (Resident #1 and #2), of five sampled residents. Resident #1 admitted to the facility with no pressure ulcers (a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Staff failed to identify any issue with the resident's skin before the resident presented with a Stage III pressure ulcer on the resident's buttocks on 1/19/25 (Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). Resident #2 was at risk for pressure ulcers and admitted to the facility without pressure ulcers. The resident was dependent on staff for cares, was not consistent in keeping pressure off his\her heels, and would slide down in bed so his/her feet touched the footboard. The facility had not addressed the resident's heels in his/her care plan and did not complete weekly skin assessments. According to staff, therapy discovered the wounds on the resident's feet on 2/28/25. The wounds included an unstageable pressure ulcer (wound is unstageable due to a covering of slough or eschar (dead tissue) to the right heel, an unstageable pressure ulcer on the left Achilles (ankle) area, and a suspected deep tissue injury (a localized area of discolored intact skin or a blood-filled blister caused by damage to underlying soft tissue from pressure and/or shear often appearing as a purple or maroon discoloration) on the right great toe. The facility census was 33. Review of the facility policy for Skin Assessment with a revision date of 1/2024 showed the following: -It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management; -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury; -Documentation of skin assessment includes date and time of the assessment, your name and position title, document observations (e.g. skin condition, how the resident tolerated the procedure, etc); document type of wound; document wound (measurements, color, type of tissue in wound bed, drainage, odor, pain); document if resident refused assessment and why; document other information related as indicated or appropriate. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Actual harm Residents Affected - Few	Review of the facility's Pressure Injury Prevention and Management policy with a revision date of 7/2024 showed the following: -This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries; -Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device; -Avoidable means the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice, monitor and evaluate the impact of the interventions; or revise the interventions as appropriate; -The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate; -Assessment of Pressure Injury Risk: licensed nurses conduct a pressure injury risk assessment, using the (fill in blank for designated tool) on all residents upon admission/re-admission, weekly for four weeks, then quarterly or whenever the resident's condition changes significantly; the tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of 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; -Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be document in the medical record; -Nursing assistants will inspect skin during a bath and will report any concerns to the resident's nurse immediately after the task; -Interventions for Prevention and to Promote Healing; after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions; -Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: redistribute pressure (such as repositioning, protecting and /or offloading heels, etc.); minimize exposure to moisture and keep skin clean, especially of fecal contamination; provide appropriate, pressure-redistributing, support surfaces; provide non-irritating surfaces; and maintain or improve nutrition and hydration status, where feasible; -Interventions will be documented in the care plan and communicated to all relevant staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of parainfluenza virus with pneumonia, Parkinson's disease (a movement disorder of the nervous system that worsens over time), diabetes, heart disease, and generalized weakness. Review of the admission skilled nurses note dated 12/6/24 showed the resident's skin was clean and dry with no alterations in skin integrity. Review of the resident's comprehensive Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 12/12/24, showed the following: -Able to make self understood and able to understand others; -Alert and oriented with some difficulty making decisions; -Dependent upon staff for activities of daily living (ADLs), transfers and walking; -Occasional incontinent of bowel and bladder; -At risk for pressure ulcers. Review of the resident's Care Plan for skin integrity dated 12/8/24 showed the following: The resident was at risk for alteration to skin integrity secondary to mobility deficits; -Goal: the resident will have no unaddressed alteration of skin integrity; -Approaches: provide skin and incontinence care assistance as needed; standard facility pressure reduction mattress; weekly skin checks per facility schedule; notify the physician for prompt/proper interventions. Review of the resident's weekly skilled charting nurses notes showed the following: -On 1/9/25 the area for assessment of the skin was blank with no documentation; -On 1/16/25 the area for assessment of the skin was blank with no documentation; Review of the resident's Weekly Wound Rounds dated 1/19/25 signed by Registered Nurse (RN) D showed the resident had an open area to the left buttock, that measured 2 cm by 1.5 cm by 0.2 depth, Stage III, found upon assessment. During an interview on 3/24/25 at 2:45 P.M. RN D said the following: -He/She was working as the RN supervisor when a staff member asked him/her look at Resident #2's bottom on 1/19/25; -He/She assessed the area, the area was open and deep. He/She documented the findings on the weekly wound rounds and notified management. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/24/25 at 1:04 P.M. RN B said the following: -He/She was the wound nurse and measured the wounds when found and then weekly; -Staff found the resident with a Stage III pressure ulcer on his/her left buttock on 1/19/25; -He/She had not assessed the resident's skin prior to 1/19/25; -The resident was seen by the contracted wound care company on 1/22/25. During an interview on 3/19/25 at 2:00 P.M. the Director of Nurses (DON) said the following: -Resident #1 did not have any identified issues with his/her skin until 1/19/25; -The resident had a toilet riser and may have developed the ulcer due to sitting on the toilet for a long period of time; -Staff did not find the area until it was open and at a Stage III level. During an interview on 3/24/25 at 2:00 P.M. the Nurse Practitioner for the contracted wound care company said the following: -The resident had been referred to him/her on 1/22/25 for a wound on his/her left buttock; -He/She assessed the wound to be quarter size, open with slough and was a Stage III pressure ulcer; -This was the first time he/she had seen the resident's skin. Review of the resident's weekly skilled charting nurses notes showed the following: -On 1/23/25 the area for assessment of the skin was blank with no documentation; -On 1/30/25 the area for assessment of the skin was blank with no documentation; -On 1/31/25 the area for assessment of the skin was blank with no documentation. (The resident had a pressure ulcer on his/her buttock that was identified on 1/19/25) 2. Review of Resident #2's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of low back pain, weakness, pneumonia, and diabetes. Review of the resident's admission skin assessment dated [DATE], showed no skin issues, buttocks red but not open. Review of the resident's Care Plan for Alteration in Skin Integrity Risk dated 1/24/25, showed the following: -Resident was at risk for skin alteration due to incontinence of bladder; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Encourage and assist with frequent repositioning to alleviate areas of pressure; provide skin and incontinence care assistance as needed. -The care plan did not address any interventions to address pressure relief specific to the resident's heels, including refusals to use devices for pressure relief or or sliding down in the bed. Review of the resident's Care Plan for Actual Skin Impairment/Wound dated 1/28/25 showed the following: -The resident had a skin tear to the right upper extremity; -Enhanced barrier precautions (a type of isolation to prevent the spread of multi resistant organisms); in house wound care provider to assess and treat; registered dietician to evaluate as needed; treatments as prescribed; resident was being followed by outside wound care provider; -The care plan did not address any interventions to address pressure relief or wounds on the resident's heels. Review of the resident's comprehensive MDS dated [DATE], showed the following: -Able to make self understood and able to understand others; -Alert and oriented able to make some decisions; -Dependent upon staff for Activities of Daily Living (ADLs), dependent upon staff to come from a sitting to a standing position and standing to sitting position, dependent upon staff for toileting transfers; -Incontinent of bowel and bladder; -At risk for the development of pressure ulcers, no pressure ulcers present. Review of the resident's Treatment Administration Record dated 2/1/25 through 2/28/25 showed no treatment orders or interventions to the resident's heels including pressure relieving boots or application of skin prep. Review of the resident's skilled nursing notes dated 1/26/25, 2/6/25, 2/14/25, 2/15/25, 2/19/25, 2/25/25 and 2/26/25 showed the section in the notes for skin assessment was left blank, with no documentation of an assessment. Review of the resident's daily skilled nursing notes dated 2/28/25 showed the following: -Right heel Issue type: Pressure ulcer/injury. Length 2.5 centimeters(cm): Width 2.5 (cm): Depth 0.003 (cm): , skin issue had not been evaluated. Location: Left Achilles (heel bone) scabbed over area. Length 2.5 (cm): Width 1.25 (cm): Depth 0 (cm). Skin note: soft boots to bilateral feet, heels floated. Review of the resident's Wound Rounds dated 2/28/25 showed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound acquired in house. Right heel, pressure ulcer 3.3 cm by 3.0 cm. Depth unable to determine, unstageable (a full-thickness skin and tissue loss where the base of the ulcer was obscured by slough (dead fibrous tissue usually yellow in color), and eschar (dead tissue forming a crust on the surface making it impossible to determine the true depth or stage of the ulcer); -Left Achilles, pressure, 0.7 cm by 1.5 cm, unable to determine depth, unstageable; -Right great toe, pressure, 0.7 by 0.7 by 1.3, suspected deep tissue injury (a localized area of discolored intact skin or a blood-filled blister caused by damage to underlying soft tissue from pressure and/or shear often appearing as a purple or maroon discoloration). Review of the resident's care plans dated 2/28/25 showed no care plan to address the resident's pressure ulcers to the resident's heel, Achilles area, or right great toe. Review of the resident's nurses notes dated 3/2/25, showed the resident started having acute on chronic left knee pain. The resident had called Family Member (FM) A several times throughout the night after 4:00 A.M. regarding the pain; family demanded 911 be called for evaluation. Resident sent out (to the hospital) per request. During an interview on 3/21/25 at 11:18 A.M., the resident's FM A said the following: -The resident would complain about pain in his/her feet and legs; -The night before the resident was sent to the hospital, the resident called him/her crying with the pain in his/her feet and legs; -On 3/1/25 when he/she went to the facility, he/she took pictures of the sore/open area on the resident's right foot. Review of photographs supplied by FM A (photographs taken on 3/1/25), on 3/21/25, showed a wound to the resident's right heel the size of a quarter that had yellow slough with dried, flaky skin around the wound. During an interview on 3/19/25 at 3:55 P.M. Certified Nurse Aide (CNA) A said the following: -The resident spent a lot of time in bed and was incontinent of bladder; -The resident had complained about heel pain since admission and the resident's heels felt a little soft and were red; -The nurses put skin prep (a medication that reduces friction, protecting sensitive skin) on the resident's heels; -The resident had protective boots, but refused to wear them; -The heels did open up to a sore; -He/She thought nurses were aware of the skin on the heels opening; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 3/1/25, the resident was in a lot of pain and the family requested that the resident be sent to the hospital. During an interview on 3/24/25 at 1:04 P.M. Registered Nurse (RN) B said the following: -He/She did weekly wound rounds with the contracted wound care nurse practitioner and measured wounds; -Nurses will notify him/her of any new wounds and he/she will measure the wounds and document in the electronic medical record in the weekly wound assessment; -The resident was not admitted with any skin issues on his/her feet, the resident did have a large skin tear on an arm that was being treated and followed by the contracted wound care nurse practitioner; -On 2/28/25, he/she was notified by therapy of the wounds on the bottom of the resident's right heel, the Achilles area of the left heel, and the right great toe; -The Achilles area of the left heel was open with slough with the wound bed was yellow, the bottom right heel was open and the wound bed covered with yellow slough and the right great toe was dark purple in color; -The resident spent a lot of time in bed with the head of the bed elevated and he/she would slide to the end of the bed with his/her feet pressed on the foot board. The resident had foot protectors, but he/she would not leave them on; -The resident went to the hospital before the outside contracted wound care provider could see the wounds. During an interview on 3/24/25 at 2:50 P.M. RN C said the following: -He/She was not aware of any wounds on the resident's feet; -He/She worked the day shift on 3/1/25 and sent the resident to the hospital due to extreme pain in his/her knee; -He/She did not look at the resident's feet before he/she sent the resident to the hospital; -The nurses would do skin checks and document the skin checks in the skilled nurses notes; -He/She did not remember any staff member telling him/her about any sores on the resident's feet. During an interview on 3/19/25 at 2:00 P.M. and 3:00 P.M. the Director of Nurses (DON) said the following: -Resident #2 was very sick upon admission; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Resident #2 had a low air loss mattress on his/her bed and had heel protectors on both heels that he/she would refuse to wear; -CNAs are to inspect the resident's skin with cares and bathing at least two times a week and inform the nurses of any concerns; -If the CNAs notice a problem with a resident's skin, they are to notify the nurses verbally of the concern and the nurses are to check the resident's skin; -Nurses should document on a wound assessment if there was a wound and notify the physician and responsible party; -The nurses are to assess the resident's skin weekly and document the results on their weekly skilled nursing note; -Resident #1 and Resident #2's weekly skilled nurses notes does not always address the resident's skin; -She would expect nurses to complete the weekly skin checks per the facility policy and thoroughly assess the resident's skin. During an interview on 3/19/25 at 3:00 P.M., the Administrator said he would expect the nursing staff to follow their policy for skin and pressure ulcers. During an interview on 3/24/25 at 9:00 A.M. facility Medical Director/Physician A said the following: -He would expect the facility nurses to follow their policy to assess the resident's skin at least weekly and document the results and if there are any skin issues or concerns to notify the physician and the contracted wound care company for orders and treatments; -The facility staff should have identified these pressure ulcers before they were a Stage III and the unstageable on the resident's heel; -Generally, the skin would have shown some type of changes, such as being discolored, reddened or a blister, before the wounds opened. MO249791 and MO250792