STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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 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. 37672 Based on observation, interview, and record review, the facility failed to provide services consistent with acceptable standards of practice for one resident when staff failed to accurately assess and document a wounds appearance, odors, the condition of the surrounding skin, resulting in the failure to timely identify the worsening of a left heel wound. The resident was sent to the hospital for evaluation of the wound. The hospital staff assessed the wound and identified the wound to have necrotic (dead) skin, very malodorous (very foul odor), and the surrounding skin erythematous (abnormally red and inflamed). The hospital diagnosed the wound as osteomyelitis (infection of the bone) and gangrene (a serious condition that occurs when tissue dies due to a lack of blood flow or a bacterial infection) (Resident #1). The sample size was four. The census was 38. Review of the facility's undated Wound Management policy, showed: -Purpose: to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure wounds; -Process: -all residents admitted to the facility will have a Braden scale (a tool used to predict the development of pressure wounds) observation completed at admission, in conjunction with each quarterly and annual assessment, with any significant change in assessment and as deemed necessary by the interdisciplinary team. The admitting nurse is responsible for completing the form. The admitting nurse will then be responsible for initiating the appropriate interventions such as ensuring treatment orders are in place, pressure reduction devices are ordered and/or requested, i.e. specialty mattress and wheelchair cushion, and that the interim/baseline care plan is initiated; -the admitting nurse will then initiate and complete the initial wound exam for each wound that has been identified; -the admitting nurse will be responsible for informing the unit manager or other designated supervisor of the wound so that the wound can be documented on the appropriate tracking log. The unit manager or other designated supervisor will be responsible for updating the log and every Thursday turning the completed tracking logs to the Director of Nursing (DON), the Minimum Data Set department and the dietary department; (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the unit managers will be responsible for the creation of the monthly cumulative report of all wounds on their individual unit and present this report at the monthly risk management/quality assurance meeting; -the facility utilizes an outside wound care specialist, to assist with wound management and treatment, who provides weekly visits to residents with wounds. The wound description information obtained from this provider will be scanned into the electronic medical record and maintained under the documents section; -the unit manager or designee with be responsible for completing the wound exam observation utilizing the information obtained during that week's visit. Review of Resident #1's significant change Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/28/24, showed: -Severe cognitive impairment; -Does not reject care; -Dependent on staff for hygiene, toileting, dressing, bathing, bed mobility and transfers; -Diagnoses included diabetes, seizures, anxiety and depression; -Used pressure reducing device for chair; -No pressure reducing device selected for the bed. Review of the resident's care plan, in use at the time of the investigation, showed: -Problem: Resident is at risk for impaired skin integrity related to incontinence of bowel and bladder, impaired mobility and function, and dependence on staff for activities of daily living, transfers, and mobility; -Goal: left heel wound will exhibit structural intactness and normal physiological function; -Approach: provide heel treatment as ordered, monitor wound and surrounding area for deterioration of skin and wound for redness, swelling, blanching and moisture, Review of the resident's podiatry visit note, dated 8/7/24, showed: -Patient presents for diabetic foot care and at risk foot care; -Thickened toe nails. Review of the resident's medical record, showed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/13/24 at 5:25 P.M., the resident readmitted to the facility. The resident alert and oriented to self and place (A&O 1-2), able to make needs known. Bruising noted to arms from intravenous sites; -No Braden assessment completed. Review of the resident's electronic physician order sheet (ePOS), showed: -An order, dated 8/13/24: wound care consult and treat as needed; -An order, dated 8/13/24: weekly skin assessment every Thursday day shift; -An order, dated 8/13/24: Apply skin prep (protective barrier wipe) to left heel twice a day. Leave open to air. Discontinued 9/25/24. Review of the resident's progress note, showed on 8/14/24 at 11:08 A.M., remains on new admission monitoring. Able to make needs known. Incontinent of bowel and bladder and moisture barrier cream applied. Skin prep applied to left heel. Heel noted with scabbed area. Review of the resident's skin assessment, dated 8/14/24 at 2:36 P.M., showed: -Skin impairments: left heel; -Skin color: within normal limits, pale; -Sign of infection: none; -Treatment: skin prep left heel. Review of the resident's wound care nurse practitioner visit note, dated 8/19/24, showed: -Wound: left foot, heel; -Status: open; -Reported wound cause: diabetic; -Measurements Length: 2.5 centimeter (cm); Width: 2.5 cm; Depth: 01 cm; -Preliminary impression: the ulcer is mixed etiology including pressure. Further workup will determine primary etiology; -Classification: full thickness; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Exudate (drainage): none, dry; -Recommendations: wipe the skin protectant (skin prep or similar product) to stable eschar (black, hard tissue). Ensure edges and surrounding skin are painted. Do not wash off skin protectant between applications. Review of the resident's progress notes, showed on 8/19/24 11:45 A.M., seen by wound care nurse practitioner. Left heel assessed with no changes in treatments. Review of the resident's medical record, showed no weekly skin assessment located for 8/21/24. Review of the resident's skin assessment, dated 8/29/24, showed: -Skin impairments: area to bilateral heels; -Skin color: within normal limits; -Sign of infection: none; -Continue current plan. Review of the resident's skin assessment, dated 9/5/24, showed: -Skin impairments: area to left heel; -Skin color: within normal limits and pale; -Sign of infection: none; -Current treatment: skin prep to left heel; -Continue current plan. Review of the resident's skin assessment, dated 9/12/24, showed: -Skin impairments: area to bilateral heels; -Skin color: within normal limits and pale; -Sign of infection: none; -Current treatment: lotion to dry skin; -Continue current plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's October 2024 ePOS and Treatment Administration Record (TAR), showed an order dated 9/25/24 and discontinued 10/14/24: Betadine (antiseptic cleansing solution) to left heel daily, leave open to air. Scheduled daily at 6:00 A.M. to 4:00 P.M. All days 10/1/24-10/11/24 documented as completed. The scheduled administration on 10/12 and 10/13/24 documented as not completed due to resident being in the hospital. Review of the resident's skin assessment, dated 9/26/24, showed: -Skin impairments: area to bilateral heels; -Skin color: within normal limits and pale; -Sign of infection: none; -Current treatment: lotion to dry skin, skin prep to heels; -Continue current plan. Review of the resident's skin assessment, dated 10/3/24, showed it did not address the heel. Review of the resident's progress notes, showed on 10/8/24 at 11:40 A.M., the left heel wound noted growth. Measured 6 cm wide x 7 cm length. Redness and warm to touch. Pain noted to area. Hospice provider ordered antibiotic twice a day for 10 days. Next of kin aware. Review of the wound infection event report, dated 10/8/24, showed: -admitted with infection: No; -Infection develop after admission: yes; -What date develop: 10/8/24; -Wound cultured: No; -Necessary to isolate: No; -Infection type: skin; -Orders: Doxycyxline (antibiotic) 100 milligram (mg). Take one capsule twice a day for 10 days for the left heel. Review of the resident's progress notes, showed on 10/8/24 at 8:29 P.M., the resident will begin antibiotic in the morning for left heel wound. Review of the resident's ePOS, showed an order, dated 10/9/24: Doxycycline 100 mg, take one capsule twice a day for six days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the October MAR, dated 10/1/24-10/31/24, showed Doxycycline 100 mg, take one capsule twice a day. Documented as administered as ordered until the resident sent to the hospital on 10/11/24. Review of the resident's skin assessment, dated 10/10/24, showed: -Skin impairments: left heel; -Skin color: within normal limits and pale; -Sign of infection: none; -Current treatment: lotion to dry skin, major wound to left heel and treatment in place; -Continue current plan. Review of the resident's progress note, showed: -On 10/10/24 at 1:18 P.M., resident on antibiotic to the left heel, denies pain but resistive to care provided; -On 10/10/24 at 11:20 P.M., the resident continues on antibiotic for left heel wound and yelled out help me. As needed morphine (narcotic pain medication) given for pain control with positive results. Review of the progress notes, showed on 10/11/24 at 11:17 A.M., facility assistant director of nursing (ADON) and writer, along with hospice nurse assessed the resident's left heel. A growth was noted from previous assessment and odor. The resident continuously complained of pain, and as needed morphine was administered. Family present and after observing the wound, requested the resident to be sent to the hospital. Review of the resident's ePOS, showed an order dated 10/11/24, transfer to local emergency department for left heel wound per family request. Review of the resident's hospital emergency room provider notes, dated 10/11/24 at 1:06 P.M., showed: -Patient presents with a wound to the left heel. Patient was on antibiotics at the nursing home and he/she was sent in due to worsening of the wound; -Medications administered: -Cefepime (antibiotic) 2,000 mg in 0.9% normal saline intravenous (IV) 50 milliliters (ml) IV; -Vancomycin (antibiotic) 1,500 mg in 530 ml IV; -Skin: dry, left heel with necrotic skin, very malodorous, surrounding skin erythematous; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left foot x-ray findings: demineralization and subtle permeative osteolysis (type of bone destruction characterized by a large number of small holes in the bone). Subtle cortical erosion (bony degeneration that occurs over time) and suspicious for osteomyelitis. Soft tissue thickening and perhaps some adjacent gas within the soft tissues; -Podiatry consult: family stated the left heel wound started a few weeks ago and had grown in size. The patient is on hospice services. The patient was started on Doxycycline at the facility and is presently on morphine for pain. Hospice provided wound care at the facility; -Dermatology: left heel ulceration measured 7.0 cm x 4.0 cm x 0.2 cm. significant surrounding erythema, plus malodor. Wound unable to be palpated or probed due to patient's mental status and pain. Review of the hospital wound nurse assessment, dated 10/15/24, showed: -Left heel: present on admission; -Wound bed: brown, eschar; -Exudate (drainage): scant; -Wound margin: undefined edges; -Length: 8 cm -Width: 6.5 cm; -Depth: 0 cm; -Assessment and plan: left heel osteomyelitis, left heel gangrene with sepsis (life-threatening medical emergency that occurs when the body has an extreme response to an infection). The patient is not a surgical candidate; -Recommendations: cleanse left heel ulcer with Vashe (wound cleanser) and gauze. Paint with betadine. Cover with abdominal pad (large, thick pad) and wrap with gauze daily. Apply bilateral heel boots. During an interview on 10/15/24 at 1:47 P.M., hospital Registered Nurse C said the resident admitted to the hospital a few days ago with a necrotic, infected left heel wound. The resident is not a surgical candidate due to his/her poor general health status. The resident revoked hospice services when admitted to the hospital, but family is considering re-admitting to hospice care. The resident is diagnosed with osteomyelitis and gangrene to the left heel. The resident will be discharged to a different facility with hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 10:43 A.M., Licensed Practical Nurse (LPN) A said he/she helped care for the resident. The resident had a wound to the left heel. The hospice nurse provided wound care on visits twice a week and the hospice aide provided baths. The other days of the week facility staff should administer the ordered treatments. The facility staff would initial in the TAR when hospice administered the treatments. The facility staff should report changes in a wound to the hospice provider, the physician and next of kin. During an interview on 10/16/24 at 3:04 P.M., the Director of Hospice services said the resident admitted to hospice services on 8/23/24. He/She admitted with a wound to the left heel. Hospice staff visited the resident twice a week and the nurse would provide wound care on visit days. The hospice nurse would obtain wound measurements weekly. The resident's family revoked hospice services and sent the resident to the hospital. During an interview on 10/16/24 at 3:33 P.M., the hospice LPN D said he/she had seen the resident with hospice services for several months. The resident had a wound to the left heel. The treatment was Betadine daily. He/She had administered wound care on visit days. The hospice aide notified him/her of a change in the heel wound around 10/7/24. LPN D ordered antibiotic. He/She visited the resident on 10/9/24 and the facility staff reported the antibiotic was started on 10/9/24. The heel wound appeared inflamed at the edges. He/She visited the resident again on 10/11/24 and the wound was odorous, inflamed, and painful to touch. The resident's family was present and elected to revoke hospice and sent the resident to the hospital. LPN D said he/she was going to order a stronger antibiotic on 10/11/24 and different wound care orders but the resident was sent to the ER. He/She expected staff to administer wound care orders when hospice was not at the facility and to notify hospice if wounds worsen. During an interview on 10/17/24 at 11:38 A.M., Certified Nurse Assistant (CNA) B said he/she took care of the resident occasionally and cared for him/her a few days before he/she went to the hospital. The resident received hospice services and the hospice aides provided bathing. The resident had a wound to his/her left heel. It was black and had some redness around the edge. CNA B did not recall if he/she notified the charge nurse of the wound appearance. The resident was later sent to the hospital. During an interview on 10/17/24 at 11:20 A.M., the DON and ADON said they expected staff to report worsening wounds to the charge nurse. All new wounds should be documented with measurements, a skin event, and wound care orders. Each wound should be documented separately with separate orders. Resident #2's heel wound worsened quickly but the facility staff should have observed it prior to the resident being sent to the hospital. Aides should report any changes in skin or changes in a wound to the charge nurse. The charge nurse should assess, document and notify the physician. Facility staff should provide treatments when hospice does not visit, including assessment of the wound at the time of treatment. The staff should conduct Braden assessments and document in the medical record, if the Braden assessments are not in the record, the assessments were not done. MO00243466

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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** 37672 Based on observation, interview, and record review the facility failed to ensure staff followed acceptable standards of nursing when staff failed to accurately assess open areas to the buttock and coccyx (tailbone) for one resident. When the wound was assessed by the wound care provider, the wounds were identified as stage III (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) pressure injuries. New treatment orders were given by the wound care provider, but not transcribed to the resident's physician orders or completed as ordered. (Resident #2). The sample size was four. The census was 38. Review of the facility's undated Treatment/Services to Prevent and Heal Pressure Ulcers policy, showed: -Intent: to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs; -Procedure: The facility will ensure that based on comprehensive assessment of the resident: -A resident received care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; -A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing; -Upon admission, the resident will receive a head-to-toe skin check to identify any skin issues; -Interventions will be implemented in the resident's plan of care to prevent pressure sore development, when the resident has no areas of concern; -When the resident is admitted with a pressure sore the admitting nurse will document the size, location, odor if any, drainage if any, and current treatment ordered; -Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure sore; -The admitting nurse will notify the attending physician as well as the resident and/or the resident's representative of the condition of the pressure sore on admission; -The pressure sore will be evaluated weekly and the nurse will document the size, location, odor, drainage and current treatment ordered; -The nurse will notify the physician anytime the pressure sore is showing signs of non-healing or infection and request treatment order changes; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse will notify the resident and/or the resident's representative of any changes related to the improvement, deterioration and/or treatment changes on an on-going basis. Review of the facility's undated Wound Management policy, showed: -Purpose: to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure wounds; -Process: -all residents admitted to the facility will have a Braden scale (a tool used to predict the development of pressure wounds) observation completed at admission, in conjunction with each quarterly and annual assessment, with any significant change in assessment and as deemed necessary by the interdisciplinary team. This includes the development of a newly identified pressure ulcer. The admitting nurse is responsible for completing the form. The admitting nurse will then be responsible for initiating the appropriate interventions such as ensuring treatment orders are in place, pressure reduction devices are ordered and/or requested, i.e. specialty mattress and wheelchair cushion, and that the interim/baseline care plan is initiated; -the admitting nurse will then initiate and complete the initial wound exam for each wound that has been identified; -the admitting nurse will be responsible for informing the unit manager or other designated supervisor of the wound so that the wound can be documented on the appropriate tracking log. The unit manager or other designated supervisor will be responsible for updating the log and every Thursday turning the completed tracking logs to the Director of Nursing (DON), the Minimum Data Set department and the dietary department; -the unit managers will be responsible for the creation of the monthly cumulative report of all wounds on their individual unit and present this report at the monthly risk management/quality assurance meeting; -the facility utilizes an outside wound care specialist, to assist with wound management and treatment, who provides weekly visits to residents with wounds. The wound description information obtained from this provider will be scanned into the electronic medical record and maintained under the documents section; -the unit manager or designee with be responsible for completing the wound exam observation utilizing the information obtained during that week's visit. Review of Resident #2's care plan, in use at the time of the investigation, showed: -Problem start date 10/17/22: pressure ulcer/injury; -Goal: skin will remain intact, without breakdown or pressure sores; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Approach: apply skin prep (protective barrier wipe) to both heels twice a day, provide incontinence care, turn and reposition every 2 hours, use barrier product to perineal area (the surface area between the thighs, extending from the pubic bone to tail bone), avoid shearing the skin, keep skin clean and dry, weekly skin assessments every Monday on night shift. Review of the resident's medical record, showed: -readmitted : 6/26/24; -Diagnoses included: protein-calorie malnutrition, history of pressure injury to the sacral region (tailbone, coccyx), cognitive impairment, anxiety, and chronic pain; -No Braden assessments documented. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument, completed by facility staff), dated 7/5/24, showed: -Moderate cognitive impairment; -No behavior concerns; -Used a wheelchair for mobility; -Dependent on staff for hygiene, dressing, bed mobility, and, transfers; -Always incontinent of bowel; -Uses an indwelling urinary catheter (a flexible tube inserted through the urinary tract and into the bladder to drain urine); -Pressure reducing device for chair; -Received applications of ointments/medications other than to feet. Review of the resident's skin assessment, dated 9/19/24 at 8:29 A.M., showed: -Skin impairments that require preventative care: redness to buttock; -Skin color: within normal limits and pale; -Type of wound or area of concern: moisture associated skin damage (MASD) to buttocks; -Current treatment: -Dry skin: lotion; -Incontinent care: Calmoseptine ([NAME], moisture barier) to the buttock; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Foley (a brand of indwelling urinary catheter) care; -Nystatin (antifungal) powder; -Plan: Continue current plan. Review of the resident's skin assessment, dated 9/21/24 at 3:12 P.M., showed: -Skin impairments that require preventative care: redness to buttocks, a concerned area to the coccyx, purple in color and inside the gluteal (buttock) folds; -Skin color: within normal limits, and pale; -Type of wound: pressure ulcer: stage I pressure ulcer (an observable, pressure-related alteration of intact skin, the ulcer may appear with persistent red, blue, or purple hues), purple in color and MASD; -Current treatment: -Dry skin: lotion; -Incontinent care; -Foley care; -Nystatin powder; -Plan: Continue current plan. Review of the resident's progress notes, dated 9/21/24 at 3:16 P.M., showed: The resident noted to have a stage I area on the inside of the gluteal folds, purple in color and also to the coccyx area. Informed the aides to keep the resident clean and apply barrier ointment to the area. Will notify the night shift nurse of the concerned area and to make sure the resident is rotated off his/her backside at night. Will continue to follow plan of care. Review of the resident's progress note, dated 9/23/24 at 2:35 P.M., showed: new order for [NAME] cream to coccyx/buttock area to prevent breakdown. Apply a quarter size amount to the reddened area on coccyx/buttock. Review of the facility's wound report, dated 9/23/24, showed the resident not listed on the report. Review of the resident's skin assessment, dated 9/26/24 at 9:09 A.M., showed: -Skin impairments that require preventative care: redness to the buttocks, concerned area to coccyx, purple in color, and inside the gluteal folds; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fieser Nursing Center	404 Main Street Fenton, MO 63026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin color: within normal limits, and pale; -Type of wound: Pressure ulcer, stage I-purple in color; -MASD; -Current treatment: -Dry skin: lotion -Incontinent care: apply Calmoseptine to buttocks; -Foley care; -Nystatin powder as needed; -Plan: Continue current plan. Review of the resident's progress note, dated 9/28/24 at 4:54 P.M., showed the resident transferred back to bed after meals for comfort and to prevent more breakdown to the coccyx. Staff positioned the resident on his/her side. Review of the facility's wound report, dated 9/30/24, showed the resident not listed on the report. Review of the resident's skin assessment, dated 10/3/24 at 10:24 A.M., showed: -Skin impairment that require preventative care: redness to coccyx, superficial area to coccyx; -Skin color: within normal limits and pale; -Type of wound: MASD; -Current treatment: -Dry skin: lotion; -Incontinent care: apply Calmoseptine; -Foley care; -Plan: Continue current plan. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note, dated 10/4/24 at 9:29 A.M., showed the resident noted to have four open areas to coccyx and right buttock. The right buttock 2 areas appeared to be shearing (occurs when tissue layers laterally shift in relation to each other) and current treatment of [NAME]. Distal (area furthest from the center of the body) wound roughly measured 1 centimeter (cm) x 1 cm. The proximal (area closest to the center of the body) area measured 2.0 cm x 2.0 cm. The coccyx has 2 open areas. The distal wound measured 2.5 cm x 1.5 cm with slough (moist dead tissue) noted to the wound bed. The proximal area measured 1 cm x 1 cm with a pink wound bed and continue current order of [NAME]. Physician notified and new orders received to cleanse the wound and apply Santyl (enzyme ointment used remove dead tissue and aide in healing) to distal coccyx wound and cover with dry dressing daily. Continue [NAME] to other areas and refer to the Wound Care providers. Next of kin notified. Review of the resident's physician visit note, dated 10/4/24 at 10:18 A.M., showed the resident identified with 4 open areas. The right buttock 2 open area appeared to be shearing with current treatment of [NAME]. Additional areas consult by wound care specialist. Consider surgery if areas do not improve. Review of the resident's electronic physician order sheet (ePOS), showed: -An order, dated 10/4/24: Calmoseptine ointment, apply to coccyx wound every day and night shift; -An order, dated 10/4/24: Cleanse distal coccyx wound with hypochlorous acid (used to kill bacteria and prevent infections), apply Santyl to the wound bed and cover with absorbent dressing daily and as needed; -An order, dated 10/4/24: Santyl 250 unit/gram. Apply nickel thick to distal coccyx wound, once daily. Scheduled daily at 6:00 A.M. to 10:00 A.M; -An order, dated 10/4/24: Wound care to evaluate and treat; -Weekly skin assessment every Thursday. Review of the resident's October treatment administration record (TAR), dated 10/1/24-10/31/24 and reviewed on 10/16/24 at 12:00 P.M., showed: -An order, dated 10/4/24: Calmoseptine topical every shift. Apply to proximal coccyx wound and right buttocks. Documented as completed as ordered; -An order, dated 10/4/24: Cleanse distal coccyx wound with hypochlorous acid. Apply Santyl to wound bed and cover with absorbent dressing. Change daily and as needed. Diagnosis: Pressure ulcer of sacral region, stage III. Not documented as completed on 10/8/24. Review of the resident's wound care visit note, dated 10/7/24, showed: -Wound 1: Coccyx: -Cause of origin: pressure; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Where was wound created: acquired at facility; -Length: 4.4 cm; -Width: 3.2 cm; -Depth: 0.2 cm; -Granulation (new tissue growth): 10 percent (%); -Slough: 70%; -Pressure injury: Stage III; -Exudate (drainage): moderate, wound is wet and drainage covers 25-75 % of the dressing; -Wound recommendations: Cleanse wound with soap and water. Pat dry. Scrub wound to mechanically debride (remove dead tissue). Apply skin protectant to peri-wound (skin on the edge of wound). Apply calcium alginate (absorbent dressing) to wound base. Cut to fit inside the wound edges, do not place on the skin. Cover with bordered gauze. Change dressing daily and as needed; -Procedure: debridement to remove unhealthy tissue to stimulate wound healing; -Wound 2: Right buttock; -Cause of origin: pressure; -Where was wound created: acquired at facility; -Length: 0.5cm; -Width: 0.5 cm; -Depth: 0.2 cm; -Granulation: 100 %; -Pressure injury: Stage III; -Exudate: moderate, wound is wet and drainage covers 25-75 % of the dressing; -Wound recommendations: Cleanse wound with soap and water. Pat dry. Scrub wound to mechanically debride. Apply skin protectant to peri-wound. Apply calcium alginate to wound base. Cut to fit inside the wound edges, do not place on the skin. Cover with bordered gauze. Change dressing daily and as needed. Review of the resident's skin assessment, dated 10/10/24 at 1:09 P.M., showed: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin impairment that required preventative care: coccyx with open area with treatment in place; -Skin color: within normal limits and pale; -Type of wound: pressure ulcer-stage I and MASD; -Current treatment: -Dry skin: lotion; -Incontinent care: calmoseptine; -Foley care; -Plan: continue current plan. Review of the resident's medical record, reviewed on 10/16/24, showed: -No documentation the physician was notified of the wound care provider's recommendation to change the treatment order; -The treatment recommended by the resident's wound care provider on 10/7/24 for the coccyx and right buttocks, cleanse wound with soap and water. Pat dry. Scrub wound to mechanically debride. Apply skin protectant to peri-wound. Apply calcium alginate to wound base. Cut to fit inside the wound edges, do not place on the skin. Cover with bordered gauze. Change dressing daily and as needed, not transcribed onto the TAR or ePOS. Review of the resident's wound care visit note, dated 10/14/24, showed: -Wound 1: Coccyx: -Cause of origin: pressure; -Where was wound created: acquired at facility; -Length: 3.5 cm; -Width: 3.0 cm; -Depth: 0.2 cm; -Granulation: 10%; -Slough: 70%; -Pressure injury: Stage III; -Exudate: moderate, wound is wet and drainage covers 25-75 % of the dressing; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound recommendations: Cleanse wound with soap and water. Pat dry. Scrub wound to mechanically debride. Apply skin protectant to peri-wound. Apply calcium alginate to wound base. Cut to fit inside the wound edges, do not place on the skin. Cover with bordered gauze. Change dressing daily and as needed; -Procedure: debridement to remove unhealthy tissue to stimulate wound healing; -Wound 2: Right buttock: resolved. Review of the resident's medical record, reviewed on 10/16/24, showed: -No documentation the physician was notified of the wound care provider's recommendation to change the treatment order; -The treatment recommended by the resident's wound care provider on 10/14/24 for the coccyx and right buttocks, cleanse wound with soap and water. Pat dry. Scrub wound to mechanically debride. Apply skin protectant to peri-wound. Apply calcium alginate to wound base. Cut to fit inside the wound edges, do not place on the skin. Cover with bordered gauze. Change dressing daily and as needed, not transcribed onto the TAR or ePOS. Observation on 10/16/24 at 9:30 A.M. and 10:23 A.M., showed the resident asleep and lay on his/her back in bed. During an observation and interview on 10/16/24 at 1:30 P.M., showed the resident sat upright in bed. His/Her lunch tray on the over bed table and food untouched. He/She said he/she had some sores on his/her buttocks. Staff had been changing the treatment. During an interview on 10/17/24 at 10:23 A.M., the Wound Care Nurse Practitioner (NP) said the resident had a wound to the right buttock that had healed and a current open area to the coccyx. His/Her initial assessment on 10/7/24 he/she determined both wounds were a stage III. The resident is incontinent of bowel and used a catheter that frequently leaked. The resident is dependent on staff for care needs and repositioning. Staff should notify the facility wound care nurse immediately for changes in skin condition, the physician should be notified so orders can be obtained quickly. During an observation and interview on 10/17/24 at 9:34 A.M., the Assistant Director of Nursing (ADON) said he/she is also the facility wound care nurse. The ADON entered the resident's room with wound care supplies. She assisted the resident onto his/her side and exposed the buttocks. The ADON said the resident is seen weekly by the wound care nurse practitioner. The wounds have been improving. An open area noted to the left buttock and to the coccyx. The ADON said the wound care plus NP had combined the left buttock wound and the coccyx wound into one wound. The ADON cleaned both wounds with hypochlorous, applied Santyl and applied cut to size Calcium Alginate to the wounds. She covered both wounds with absorbent pads, dated and labeled the dressings. During an interview on 10/17/24 at 11:48 A.M., the Wound Care NP said he/she was not aware of an open area to the resident's left buttock. All wounds are independent of each other unless the wounds expand into one. All wounds should have orders.