STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 36151 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when staff failed to follow a physician's order and send a resident (Resident #16) to the hospital for evaluation. The facility census was 88. Review of the facility Physician's Orders policy, reviewed on 1/5/21, showed: -Protocol: At the time each resident is admitted , the facility will have physician orders for their immediate care. Physician's orders will be verified by the attending physician at the facility. All physician orders will be dated and signed according to State and Federal regulations; -All clinicians may take verbal and/or telephone orders as permitted by their State licensure board; -Procedure: Obtain one of the following types of physician orders: -Verbal; -Telephone order; -Transmitted by facsimile machine; -Written by the physician; -Assure physician's orders include the drug/treatment and a correlating medical diagnosis or reason. Review of Resident #16's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 8/12/22, showed: -No cognitive impairment; -One staff person assist for bed mobility, dressing, toileting and personal hygiene; -Two staff person assist for transfers; (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No behaviors; -Open area other than lesions, ulcers, rashes, cuts: checked; -Pain management: On scheduled pain management regimen: no; -Limited day to day activities: yes; -Diagnoses included heart failure, high blood pressure, and kidney failure. Review of the resident's care plan, undated, showed: -Focus: admitted with wounds, right hip distal (a part of the body that is farther away from the center of the body than another part) abscess/post-surgical; -Interventions: Notify nurse if any wound dressings become soiled, loose or come off. Wound documentation weekly and as necessary; -Focus: The resident has an activities of daily living (self care) performance deficit due to overall decline in functioning ability; -Interventions: Bed mobility, the resident requires moderate assistance by one staff to turn and reposition. The resident requires max assistance by one staff with personal hygiene and oral care. Review of the resident's nurse's progress notes, dated 8/30/22 at 12:55 P.M., showed a Skin/Wound Note: resident was crying in pain during dressing change. Wound nurse spoke with resident's nurse who stated Tylenol was given for his/her pain. Nurse asked the resident to rate his/her pain on a scale of 1-10. Resident stated 3. Nurse contacted wound Dr and asked his opinion about the pain and he suggested resident go to the hospital. Physician was contacted and agreed resident needs to be evaluated at the hospital. Resident's nurse was notified and stated he/she will send him/her out. Review of the resident's physician's orders, dated 8/1/22 through 8/31/22, showed no order to send the resident to the hospital on 8/30/22. Review of the resident's nurse's progress notes, dated 8/31/2022 at 9:34 A.M., showed a Skin/Wound Note Note Text: Resident was not sent to hospital yesterday. Wound nurse called resident's family member to tell him/her would be going to the hospital. He/she was agreeable. During an interview on 9/8/22 at 12:06 P.M., the wound nurse said the resident was crying during wound care on 8/30/22. The resident had been given Tylenol, but would jump when the wound nurse would touch him/her. The resident had an abscess on his/her hip. When he/she was touched the resident, he/she would wince in pain. The resident said his/her pain level was a three when shown the pain scale of 1 through 10 (10 being the worst), but the resident was cognitively different that day, so the level of three was questionable, and his/her pain level had definitely increased. The resident had an increased pain level and the wound nurse said she had gotten orders to send the resident to the hospital because of the abscess and he/she needed to be evaluated. The wound nurse said she told the resident's nurse, LPN A, the resident needed to go to the hospital because of his/her wound, and it was not normal for him/her to react with pain like that during treatments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/13/22 at 8:50 A.M., LPN A said the wound nurse didn't get an order to send the resident to the hospital. The wound nurse said the resident had an abscess and the wound nurse didn't like the way it looked. LPN A said he/she told the wound nurse the resident was at a pain level of three, already had PRN pain medication, and was sleeping. LPN A said he/she didn't really see a need to send the resident to the hospital. It was expected the resident would be in pain during the wound treatment. LPN A said all of this happened after lunch and the resident was pretty much sleeping the rest of his/her shift. LPN A said he/she was gone after the resident woke up, so he/she didn't know what happened after he/she left. During an interview on 9/13/22, at 1:50 P.M., the wound nurse said the resident's pain was out of character, the resident was normally sensitive during the wound treatment, but he/she would say it was okay. This time he/she was crying in pain. The wound nurse said she called the resident's physician and she put the physician's order to send the resident to the hospital in a progress note. The wound nurse said she thought putting the order in the progress note was putting in the order. When the wound nurse returned the following day, on 8/31/22, she said she was very upset the resident had not been sent to the hospital. During an interview on 9/13/22 10:01 A.M., the resident's physician said she expected her order to send the resident to the hospital to be in the computer and for the resident to be sent out. She said it's not the nurse's decision to make, whether or not to send to the hospital, they are expected to follow the order. If the nurse felt they wanted to talk about their clinical evaluation, they could have called and discussed the situation. Not sending the resident to the hospital is going against a professional decision, and the decision is the physician's. During an interview on 9/14/22 at 11:50 A.M., the resident's physician said the resident had the wound for two years, it was chronic. The physician stated you cannot ignore a physician's order, as they make the decisions and are ultimately responsible for the resident's care. During an interview on 9/14/22 at 2:24 P.M., the administrator said the wound nurse was not aware she needed to put the order in the electronic record under Physician's Orders, as well as in a clinical note. She has been educated on the procedure and the expectation is all nursing staff are to enter orders in the electronic record, and document the order in a clinical note. All physician's orders should be followed.

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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** 34926 Based on observation, interview, and record review, the facility failed to ensure appropriate care and services were provided to residents to prevent the development of pressure ulcers and treat those residents with pressure ulcers. Facility staff failed to consistently ensure pressure ulcer treatments were completed as ordered and per acceptable nursing standards, ensure residents were turned and repositioned, thoroughly assess residents' skin and their pressure ulcers, and document assessments for three residents (Residents #19, #21, and #23) out of 3 sampled residents with pressure ulcers. The facility census was 88. Review of the facility's Pressure Ulcer Staging policy, dated revised on 5/28/19, showed: -Procedure: --Pressure ulcer is defined as ischemic (reduced blood flow) ulceration and/or necrosis (death) of tissues overlying a bony prominence (area) that has been subjected to pressure, friction, or shear; --This facility shall utilize pressure ulcer staging as defined by the anatomic depth of soft tissue damage. It is described as follows: -Suspected Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shearing. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or colder as compared to adjacent tissue; -Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk persons; -Stage II: Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed, without slough (dead tissue). May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicated suspected deep tissue injury). This stage should not be used to describe skin tears, tape bums, perineal dermatitis, maceration or excoriation; -Stage III: Full thickness tissue loss. Subcutaneous (the layer of tissue that underlies the skin) fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface) and tunneling (has progressed to form passageways underneath the surface of the skin). The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity (fat) can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable (able to be touched or felt); (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Stage IV: Full thickness deep tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, thick, leathery tissue over wound bed) may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis (inflammation of bone or bone marrow, usually due to infection) possible. Exposed bone/tendon is visible or directly palpable; -Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined. Stable, dry, adherent, intact without erythema or fluctuance (a tense area of skin with a wave-like or boggy feeling upon touch), eschar on the heels serves as the body's natural cover and should not be removed. Review of the facility's Pressure Ulcer Prevention policy, dated revised on 5/28/19, showed: - Any resident determined to be at risk for skin breakdown shall have the following interventions implemented as indicated; -Procedure: --Reposition at least every two hours; --Use pillows, foam wedges, etc. to keep bony prominences from direct contact; --Use devices that reduce pressure on the heels, if indicated; --Place on pressure redistribution mattress; --Inspect skin during care and report any changes. Review of the facility's Skin Program Policy and Procedure, dated revised on 5/10/21, showed: -Purpose: The purpose of the skin program is to ensure that every resident's skin condition is assessed on admission and a comprehensive and interdisciplinary care plan is developed and maintained to treat actual and/or prevent potential skin problems; -Policy: All residents are assessed upon admission and as needed (PRN) for actual and/or potential skin problems. All residents will receive an individualized preventative skin plan of care at the time of admission. All residents with skin problems will receive an active skin plan of care at admission. Skin Care team meetings will be held weekly to address all ulcers and any other pertinent skin problems. Performance Improvement/quality assurance (QA) tracking and monitoring are done according to the performance improvement/QA schedule. All Performance Improvement/QA Tracking & Monitoring are attorney/client privileged information; -Procedure: (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 assesses/evaluates all residents upon admission. The initial skin assessment is a full body audit and completion of the Braden Skin Risk Assessment. After admission the Braden Skin Risk Assessment will be completed weekly x 3 weeks and then a minimum of quarterly, a significant change of condition and annually; --A plan of care (POC) is initiated and individualized by the nurse on the day of admission; --Director of Nursing (DON)/designee to review all residents weekly with skin ulcers for condition of wound, treatment changes, and additional barriers to healing and will document weekly; --Certified nursing assistant (CNA) will complete the Bath/Shower Report Sheet with each resident's scheduled bath/shower. Each resident will be assessed/evaluated a minimum of weekly by the nurse. Bath and Shower sheets become part of QAPI; --If during care, the CNA notices that a dressing is off /soiled they should notify their charge nurse immediately. 1. Review of Resident #19's face sheet, showed he/she was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included: -Dementia without behaviors; -Severe protein calorie malnutrition (associated with low muscle mass and function, and increased prevalence of physical frailty); -Neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems); -Pressure ulcers (Injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction) of unspecified stage; -Osteomyelitis. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/8/22, showed: -Severely cognitively impaired; -Understood others and made his/her needs known; -Total dependence of one staff member for bed mobility, mobility on and off the unit, dressing, toileting, personal hygiene and bathing; -Total dependence of two staff members for transfers; -Required a wheelchair for mobility; -At risk for developing pressure ulcers; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Three unhealed Stage IV pressure ulcers; -Skin and pressure ulcer/injury treatments: --Pressure relieving device for chair; --Pressure relieving device for bed; --Turning/repositioning program; --Nutrition or hydration intervention to manage skin problems; --Pressure ulcer/injury care; --Application of nonsurgical dressing (with or without topical medications) other than feet; --Applications of ointments/medications other than feet. Review of the resident's care plan, revised on 2/18/22, showed: -Focus: the resident had an activities of daily living (ADL, the tasks of everyday life, including eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) self-care performance deficit related to overall decline in functioning ability and limited mobility; -Goal: the resident will improve current level of function in ADLs through next review date; -Interventions: --Get pillow between legs; --Bathing/showering: the resident is totally dependent on one staff to provide baths/showers two times weekly and as necessary; --Bed mobility: the resident is totally dependent on one staff for turning and repositioning in bed; --Personal hygiene/oral care: the resident is totally dependent on one staff for personal hygiene and oral care; --Toilet use: the resident is totally dependent on one staff with incontinence care; --Transfer: the resident is totally dependent with a Hoyer lift (a mechanical mobility tool used to help those with mobility challenges get in/out of bed and/or wheelchair and on/off the toilet) and two staff for transfers; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: the resident was admitted with one un-stageable sacrum (located at the bottom of the spine and lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone) pressure ulcer, one right hip Stage III pressure ulcer; 1/30/22, following new wounds added: sacrum Stage IV, right hip Stage IV pressure ulcer, left hip Stage IV pressure ulcer; 7/28/2022, following new wounds added: sacrum Stage IV pressure ulcer, right hip Stage IV pressure ulcer, left hip Stage IV pressure ulcer, right buttock Stage III; -Goal: Wound will show signs of improvement; -Interventions: --Encourage resident to frequently shift weight; --Evaluate skin for areas of blanching or redness; --Evaluate ulcer characteristics; --Low air loss (LAL) mattress with bolsters; --Monitor ulcer for signs of progression or decline; --Weekly wound documentation; --Continue weekly evaluation from wound physician; --Notify nurse if any dressing becomes loose, soiled, or comes off left or right hip, sacrum and/or right buttock. Review of the resident's electronic medical record (EMR), showed the following physician orders: -Braden skin assessment to be done on admission and quarterly, dated 6/29/22; -Weekly skin assessment, dated 6/29/22; -Wound care treatment to left hip: cleanse with wound cleanser (WC) or normal saline (NS), apply Santyl (removes dead tissue from wounds so they can start to heal) to wound bed, apply calcium alginate (dressing used on moderate to heavily exudative (draining) wounds during the transition from debridement (the removal of damaged tissue or foreign objects from a wound) to repair phase of wound healing), skin prep to peri wound (skin area around the wound), cover with border gauze. Change daily and if dressing becomes saturated, soiled or dislodged every day shift, dated 6/21/22; -Wound care: Cleanse right hip with WC and apply antifungal cream every day shift and as needed, dated 8/9/22; -Wound care: Cleanse sacrum with WC and apply antifungal cream to wound and peri wound every day shift and as needed, dated 8/9/22; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Santyl ointment 250 units per gram (unit/gm), apply topically to left hip wound every day shift, 8/22/22; Review of the resident's facility wound tracking showed: -Right hip Stage IV pressure ulcer, start date 9/10/21. No documentation if the resident was admitted with the pressure ulcer or if it was facility acquired. --8/1/22: 1.8 centimeters (cm) by 1.0 cm by 0.4 cm; --8/8/22: 1.4 cm by 1.0 cm by 0.4 cm, improved; --8/15/22: 1.4 cm by 0.8 cm by 0.4 cm; --8/22/22: 1.0 cm by 0.7 cm by 0.6 cm; --9/2/22: 1.8 cm by 1.0 cm; -Sacrum, start date 9/10/21, No documentation if the resident was admitted with the pressure ulcer or if it was facility acquired. No documentation of type of wound or stage noted: --8/1/22: 3.2 cm by 3.0 cm by 0.3 cm; --8/8/22: 3.0 cm by 2.2 cm by 0.3 cm; --8/15/22: 3.0 cm by 1.8 cm by 0.3 cm; --8/22/22: 2.4 cm by 1.2 cm by 0.1 cm; --9/2/22: 2.4 cm by 1.2 cm by 0.1 cm; -Left hip (facility acquired), start date 11/29/21, No documentation of the type of wound or stage noted: --8/1/22: 3.2 cm by 1.1 cm by 0.8 cm; --8/8/22: 3.5 cm by 2.1 cm by 1.2 cm; --8/15/22: 3.0 cm by 2.4 cm by 1.2 cm; --8/22/22: 2.5 cm by 1.8 cm by 1.0 cm; --9/2/22: 3.7 cm by 1.6 cm by 0.8 cm; -Right buttock (facility acquired), start date 7/11/22, No documentation of the type of wound this is. No pressure ulcer stage noted: --8/1/22: 2.2 cm by 0.6 cm by 0.2 cm; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--8/8/22: 1.2 cm by 0.8 cm by 0.2 cm; --8/15/22: 1.0 cm by 0.5 cm by 0.2 cm; --8/22/22: Healed 8/22/22. Review of the resident's Medication Administration Record (MAR), dated 9/1/22 to 9/30/22, showed: -Braden skin assessment to be done on admission and quarterly with an x marked in all dates until Wednesday September 14, indicating the activity was not due. Review of the resident's Treatment Administration Record (TAR), dated 9/1/22 to 9/30/22, showed: -Santyl ointment 250 unit/gm, apply topically to left hip wound every day shift with 4 out of 9 opportunities left blank with no signature to indicate the ointment was applied; -Weekly skin assessment every Thursday day shift with 2 out of 2 opportunities left blank with no signature to indicate the skin assessment was completed. No documented skin assessments for the month of September 2022 as of 9/9/22 noted; -Wound care treatment to left hip: cleanse with WC or NS, apply Santyl to wound bed, apply calcium alginate, skin prep to peri wound, cover with border gauze. Change daily and if dressing becomes saturated, soiled or dislodged every day shift with 1 out of 9 opportunities left blank with no signature to indicate the wound care was completed; -Wound care: Cleanse right hip with WC and apply antifungal cream every day shift and as needed with 1 out of 9 opportunities left blank with no signature to indicate the wound care was completed; -Wound care: Cleanse sacrum with WC and apply antifungal cream to wound and peri wound every day shift and as needed with 1 out of 9 opportunities left blank with no signature to indicate the wound care was completed. Observation on 9/9/22 at 7:45 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. Observation on 9/9/22 at 9:09 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 9/9/22 at 10:26 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The wound nurse turned the resident for wound care, and then placed the resident into the same position on his/her back as prior to wound care. This surveyor asked the wound nurse to obtain wound measurement at this time. The sacrum pressure ulcer measurements were 2.5 cm by 2.0 cm with no depth measurement taken. The wound appeared to have 100% granulation tissue with slight serous drainage. The sacrum pressure ulcer did not have a dressing in place when the treatment began. The left hip pressure ulcer measured 4.0 cm by 2.0 cm by 1.1 cm. The wound appeared to have approximately 10-15% slough, with a moderate amount of drainage on the dressing. The right hip pressure ulcer measurement was 1.5 cm by 1.0 cm by no depth measurement taken. 100% granulation tissue noted with scant serous drainage to dressing. His/her wounds become painful when lying in one position too long. Staff never comes in to reposition/turn him/her, even when asked. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. Observation and interview on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back with one pillow between his/her knees. He/she was uncomfortable and would like to be repositioned, but no one ever comes in to move or help him/her. No one ever comes into his/her room just to look at his/her entire skin. The nurse does not do a weekly skin assessment. 2. Review of Resident #21's face sheet, showed he/she was admitted to the facility on [DATE] with diagnoses that included: -Diabetes mellitus II; -Dementia without behaviors; -Stage IV pressure ulcer of the sacrum and hereditary; -Idiopathic (unknown cause) neuropathy (abnormality of the nervous system). Review of the resident's admission MDS, dated [DATE], showed: -Cognitively intact; -Understood others and made his/her needs known; -Required extensive assistance of one or two staff members for bed mobility, transfers, and dressing; -Total dependence with assistance of one staff member for toileting, personal hygiene, and bathing; -Required a wheelchair for mobility; -One unhealed Stage IV pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin and pressure ulcer/injury treatments: --Pressure relieving device for chair; --Pressure relieving device for bed; --Turning/repositioning program; --Pressure ulcer/injury care Review of the resident's care plan, initiated 9/8/22, showed: -Focus: admitted with a Stage IV pressure ulcer to the sacrum and decreased mobility; -Goal: The resident's pressure ulcer will show signs of healing and remain free from infection through review date; -Interventions: --Administer treatments as ordered and monitor for effectiveness; --Followed by wound physician; --If the resident refuses treatment, confer with the resident, IDT and family to LPN determine why and try alternative methods to gain compliance. Document alternative methods; --Monitor dressing, if dressing becomes soiled, loose or comes off notify nurse; --Monitor/document/report PRN any changes in skin status including appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), and stage; --The resident required LAL mattress on bed and cushion in wheelchair. The resident did not have a LAL mattress on his/her bed; --Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of the resident's EMR showed no order for a LAL mattress and no order for weekly skin assessments. Review of the resident's Braden scale for predicting pressure ulcer risk, dated 8/24/22, showed the resident score was 11, indicating high risk for developing pressure ulcers. Review of the resident's admission Skin Only Evaluation, dated 8/24/22, showed: -One stage IV pressure ulcer to the coccyx; -The pressure ulcer had no odor; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No other skin issues noted; -No other skin assessments noted in the resident's EHR. Record review of the resident's TAR, dated 8/24/22 to 8/31/22, showed: -Dakin's (bleach based solution) (full strength) solution 0.5 %, apply to coccyx wound topically one time daily for Stage IV wound, with no staff initials to document no wound care was performed for 3 out of 7 opportunities; -No order for weekly skin assessments. No documented skin assessments for the month of August 2022 noted. Record review of the resident's TAR, dated 9/1/22 to 9/30/22, showed: -Dakin's (full strength) solution 0.5 %, apply to coccyx wound topically one time daily for Stage IV wound, with no staff initials to document no wound care was performed for 2 out of 8 opportunities; -Weekly skin assessment every Wednesday day shift with an x marked in all dates until Wednesday September 14, indicating the activity was not due. The resident had no documented skin assessments for the month of September as of 9/9/22. Review of the resident's facility wound tracking, showed: -admitted with Stage IV sacrum, start date 8/24/22: --8/24/22: 12.0 cm by 12.0 cm by 1.0 cm; --9/2/22: 15.8 cm, by 9.8 cm by 2.2 cm. Review of the wound physician's Initial Wound Evaluation and Management Summary, dated 9/2/22, showed: -Stage IV pressure ulcer to sacrum; -Wound size (L x W x D): 15.8 cm by 9.8 cm by 2.2 cm; -Surface area: 254.84 cm^2; -Exudate: Moderate serous; -Thick adherent devitalized necrotic tissue: 10%; -Slough: 10%; -Granulation tissue: 80%; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Primary dressing: Gauze roll 4.5 inches, apply once daily for 16 days: soak in quarter strength Dakin's and pack entire cavity; -Secondary dressing: Gauze island with border, apply once daily for 16 days; -Recommendations: --Off-load wound; --Reposition per facility protocol; --Turn side to side and front to back in bed every 1-2 hours if able. Observation on 9/9/22 at 7:33 A.M., showed the resident lay on his/her back, in bed. Observation and interview on 9/9/22 at 10:44 A.M., showed the resident lay on his/her back, in bed. No LAL mattress noted to the bed. The resident said staff do not turn/reposition him/her unless asked to, and then sometimes they say they will be back to do it and they do not come back. Observation of wound care, showed the resident said ouch, this is where the wound care is painful, when she cleans the wound and applies the Dakin's soaked gauze. This surveyor requested wound measurements at this time. The sacrum pressure ulcer measurements were 13.0 cm by 10.0 cm by 1.6 cm. The pressure ulcer appeared red with approximately 10-15% slough and with approximately 10-15% necrotic tissue. A moderate amount of drainage was noted to the dressing. After wound care, the wound nurse positioned the resident into the same position on his/her back. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back, in bed. No LAL mattress noted to the bed. Observation and interview on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back in bed. No LAL mattress noted to the bed. The resident said staff had not attempted to reposition/turn him/her all shift. The resident said the nurse does not perform a weekly skin assessment. No one looks at his/her skin besides the wound nurse, who only looks at the wound during dressing changes. No one ever looks at the rest of his/her skin. 3. Review of Resident #23's face sheet, showed he/she was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included protein calorie malnutrition, dementia without behaviors, urinary incontinence and history of falling. Review of the resident's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Understood others and made his/her needs known; -Required extensive assistance of one staff member for bed mobility and eating; -Total dependence with assistance of one staff member for transfers, dressing, toileting, personal hygiene, and bathing; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required a wheelchair for mobility; -At risk for developing pressure ulcers; -No unhealed pressure ulcers; -Skin and pressure ulcer/injury treatments: --Pressure relieving device for chair; --Pressure relieving device for bed; --Applications of ointments/medications other than feet. Review of the resident's care plan, initiated 5/19/22, showed: -Focus: The resident has an ADL self-care performance deficit related to dementia and overall decline in functioning ability; -Goal: The resident will maintain current level of function in (SPECIFY) through the review date; -Interventions: --Bathing/showering: The resident is totally dependent on staff to provide bath/shower two times weekly and as necessary; --Bed mobility: The resident requires total assistance by one staff to turn and reposition in bed; --Dressing: The resident is totally dependent on one staff for dressing; --Eating: The resident is extensive to total dependent on one staff for eating. --Personal hygiene/oral care: The resident is totally dependent on one staff for personal hygiene and oral care; --Toilet use: The resident is totally dependent on one staff for toilet use; --Transfer: The resident is totally dependent on one staff for transferring; -Focus: The resident is at risk for skin breakdown related to protein calorie malnutrition and overall decline in functioning ability. Resident incontinent of bowel and bladder and dependent on staff. 8/18/2022 update: Unstageable pressure ulcer to left ischium (the lower and back sides of the hip bone); 8/22/2022 update: Unstageable DTI to sacrum; -Goal: The resident will have intact skin, free of redness, blisters or discoloration by/through review date; --Interventions: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Administer treatments as ordered and monitor for effectiveness; --Followed by wound physician, dated 9/8/22; --Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage; --Notify nurse if dressings on sacrum and left ischium become soiled, loose or comes off, dated 9/8/22; -- Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated; --Offer resident pain medication before skin treatments, dated 9/8/22. Review of the resident's EMR showed the following orders: -Weekly skin assessment every Friday, dated 5/7/22; -Wound care: cleanse left ischium and sacrum with WC and apply Santyl and pack with Dakin's soaked gauze and cover with foam dressing daily and as needed, dated 9/2/22. Review of the resident's TAR, dated 8/1/22 through 8/31/22, showed: -Santyl ointment 250 units/gm, apply to left ischium topically every day shift, start date 8/27/22, with 3 out of 5 opportunities left blank with no signature to indicate the ointment was applied. Review of the resident's facility wound tracking, showed: -Unstageable deep tissue injury to sacrum (facility acquired), start date 8/22/22: --8/22/22: 8.8 cm by 4.6 cm; --9/2/22: 7.8 cm, by 3.0 cm; -Unstageable left ischium pressure ulcer (facility acquired), start date 8/18/22: --8/15/22: 7.0 cm by 6.5 cm; --8/22/22: 6.0 cm by 4.5 cm by 1.3 cm; --9/2/24: 4.4 cm by 4.7 cm by 2.4 cm. Observation on 9/9/22 at 8:15 A.M., showed the resident lay on his/her back, in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 9/9/22 at 10:20 A.M., showed the resident lay on his/her back, in bed. The head of the bed was elevated and the resident had slid down in bed, and his/her feet where pushed against the end of the bed. The resident was lying at angle sideways in the bed with his/her head against the wall. Observation on 9/9/22 at 11:12 P.M., showed the resident lay on his/her back, in bed with the head of the bed elevated. The resident was still slid down in the bed. Left leg positioned over the right leg at the knee. The resident's head was no longer touching the wall. Observation and interview on 9/9/22 at 1:35 P.M., showed the resident lay on his/her back in bed with the head of the bed elevated. The resident was still slid down in the bed and his/her head was against the wall. The resident was positioned where his/her head was against the wall and his/her feet were at the other edge of the bed. Left leg was positioned over the right leg at the knee. The resident's brief appeared wet and ripped open in front. 4. During an interview on 9/9/22 at 12:06 P.M., the Wound Nurse said: -CNAs are supposed to document skin assessments on the shower sheets, but he/she does not believe they are doing it; -He/she does not see the shower sheets; -The regional nurse told him/her the skin assessments were the responsibility of the charge nurse, not the wound nurse; -He/she did not have the time to perform skin assessments, not even on the residents with wounds; -Resident #21 does not have a LAL mattress, but should; -LAL mattresses are requested through central supply and the maintenance man puts them on the bed; -He/she had never placed an order for a LAL mattress through central supply for Resident #21; -He/she had never contacted the physician to get an order for a LAL mattress for Resident #21; -Every time he/she goes into Resident #21's room, the resident was lying on his/her back and the resident had a really bad sacrum wound; -From observation, he/she does not believe the CNAs are turning and repositioning residents at all; -Resident #19 asks to be repositioned off his/her wound frequently, but staff does not do it as far as he/she can tell; -He/she started on May 5th and the wound nurse at that time just had him/her watch, because he/she just wanted to get it done fast and not take the time to teach him/her. He/she tried to watch and learn as much as he/she could; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she returned to work in the first part of June and the wound care nurse left as soon as he/she returned. He/she received no other training/orientation. During an interview on 9/9/22 at 2:10 P.M., Licensed Practical Nurse (LPN) B said: -Skin assessments should be performed weekly and documented in the chart. He/she was not aware of the exact protocol or who was responsible for skin assessments at this facility; -He/she would do a skin assessment if it was on the TAR; -Residents should be repositioned/turned every two hours and PRN; -It was not acceptable for a resident to lay in the same position all shift; -The wound nurse does all the wound dressings, so he/she was not sure about any of the resident's wounds; -He/she is not aware if Residents #19, #21 and #23 were turned/repositioned this shift. He/she just expected the CNA to do this since it is part of their job; -All treatments should be provided per physician order. During an interview on 9/9/22 at 2:36 P.M., CNA C said: -He/she was agency staff and new to the facility; -He/she was busy and did not get to check on the residents as often as he/she would have liked; -He/she was not aware residents were in the same position for several hours; -He/she does not remember if he/she turned/repositioned residents #19 or #21; -He/she would notify the nurse immediately if a new wound was found; -He/she said residents should be turned/repositioned every two hours and PRN. During an interview on 9/9/22 at 3:00 P.M., the Assistant Director of Nursing (ADON) said: -He/she expected CNAs to note weekly skin assessments on the resident shower sheets; -All residents in the facility should receive a weekly skin assessment; -He/she expected skin assessments to be performed per order; -The wound nurse is in charge of skin assessments. He/she can assign them to the charge nurse if desired, but it is ultimately his/her responsibility to ensure they are completed; -Weekly skin assessments should documented under the assessments tab in the EMR; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected staff to reposition/turn immobile residents every two hours and as needed; -Residents with wounds should be a priority for turning and repositioning; -If a resident has a wound, staff should try to keep the resident off the wound as much as possible to promote healing; -It is not acceptable for a resident with a wound on the sacrum to lay on his/her back all shift; -Resident #23 was repositioned at least once this shift because he/she noted the resident slid down in the bed and he/she pulled the resident up to the top of the bed. He/she left the resident on his/her back. He/she did not turn the resident, he/she just pulled the resident up; -If a residen

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on observation, interview, and record review, the facility failed to ensure staff maintained proper positioning and placement of catheter tubing and drainage bags on residents with a suprapubic catheter (a hollow flexible tube inserted into the bladder through a cut in the abdomen to drain urine) and failed to obtain and follow a complete detailed physician's order for type, care and monitoring of a suprapubic catheter for one resident (Resident #19) who was at risk for urinary tract infections (UTI, an infection of one or more structures in the urinary system), and also failed to obtain and follow a complete detailed physician's order for type, care and monitoring of an indwelling urinary catheter (a tube inserted into the urinary bladder to drain the bladder) for one resident (Resident #21) who was at risk for UTI out of three sampled residents with catheters. The census was 88. Review of the facility's policy, Foley Catheter Care, reviewed 1/2020, (the only policy provided) showed: -Procedure: --Assemble equipment; --Explain procedure to the resident; --Provide Privacy; --Wash Hands thoroughly; --Apply gloves; --Provide perineal care (peri care, involves washing the external genitalia and surrounding area) first prior to catheter care; --Female resident - Spread the labia and wash from front to back; --Male resident - Cleanse moving from the meatus to the base of the penis. If uncircumcised, retract the foreskin and clean thoroughly; --NOTE: if the resident is soiled with feces, take every precaution to keep feces away from the urinary meatus as bacteria found in the bowel will cause urinary tract infections; --Remove gloves; --Wash hands thoroughly; --Apply gloves; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Stabilize catheter at the insertion site, cleanse with warm soap and water and clean washcloth, starting at the site of insertion downward; --Check catheter to make sure positioning promotes proper flow of urine, no pulling is present, and catheter bag is below level of bladder. Bag should not be on floor; --Leave resident dry and comfortable; --Place dirty reusables in one plastic bag and place dirty disposables in another bag for proper disposal; --Remove gloves; --Wash hands thoroughly; --Notify MD of any concerns; --Document all changes. 1. Review of Resident #19's face sheet, showed he/she was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included: -Dementia without behaviors; -Neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems); -Pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction) of unspecified stage; -Osteomyelitis (inflammation of bone or bone marrow, usually due to infection). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/8/22, showed: -Severe cognitive impairment; -Understood others and made his/her needs known; -Total dependence of one staff member for bed mobility, mobility on and off the unit, dressing, toileting, personal hygiene and bathing; -Total dependence of two staff members for transfers; -Had an indwelling catheter. Review of the resident's care plan, revised on 2/18/22, showed: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: the resident had an activities of daily living (ADLs, the tasks of everyday life, include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) self-care performance deficit related to overall decline in functioning ability and limited mobility; -Goal: the resident will improve current level of function in ADLs through next review date; -Interventions: --Personal hygiene/oral care: the resident is totally dependent on one staff for personal hygiene and oral care; --Toilet use: the resident is totally dependent on one staff with incontinence care; --Transfer: the resident is totally dependent with a Hoyer lift (a mechanical mobility tool used to help those with mobility challenges get in/out of bed and/or wheelchair and on/off the toilet) and two staff for transfers; -No care plan noted for suprapubic catheter use, monitoring or care. Review of the resident's electronic medical record (EMR) showed the following physician orders: -Foley catheter care every day and night shift for Foley catheter, dated 6/29/22; -Monitor urinary output every shift for output, document on intake and output (I&O) sheet, dated 6/29/22; -Suprapubic catheter care every day and night shift for Foley catheter, dated 7/7/22; -No detailed order pertaining to the type and size of the catheter, or monitoring of the catheter insertion site noted. Review of the resident's Treatment Administration Record (TAR), dated 9/1/22 to 9/30/22, showed: -Monitor urinary output every shift at bedtime. Signed every day as done, with no place to document the output amount; --No documented urinary output noted; -Monitor urinary output every shift one time a day for output, document on I&O sheet. Two blanks were noted with no staff initials to document urinary output was performed for two out of nine opportunities. No documented urinary output noted; -Foley catheter care every day and night shift for Foley catheter with no staff initials to document catheter care was performed for two out of 17 opportunities; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor urinary output every shift, every day and night shift for urinary output, document on I&O sheet. Two blanks were noted with no staff initials to document urinary output was performed for two out of 17 opportunities. No documented urinary output noted; -Suprapubic (SP) catheter care every day and night shift for Foley catheter; -No staff initials to document suprapubic catheter care was performed for two out of 17 opportunities. No documented catheter care noted. Review of the resident's medical record showed no I&O sheets were documented. Observation on 9/9/22 at 7:45 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The resident's urine collection bag lay on the bed between the resident's feet, uncovered. The urine collection bag was half full. Observation on 9/9/22 at 9:09 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The resident's urine collection bag lay on the bed between the resident's feet, uncovered. The urine collection bag was full of urine and the urine was backed up into the tubing to under the resident's gown. Observation and interview on 9/9/22 at 10:26 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The resident's urine collection bag lay on the bed between the resident's feet, uncovered. The urine collection bag was full of urine and urine was backed up into the tubing to under the resident's gown. The wound nurse was in the resident's room at the same time and adjusted the resident's tubing when he/she turned the resident for wound care, but did not empty the urine collection bag or lower it below bladder level. The resident said staff never empty his/her urine collection bag and never clean the catheter insertion site. The wound nurse left the room without notifying the charge nurse or CNA the resident's urine collection bag was full and inappropriately placed. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The resident's urine collection bag lay on the bed between the resident's feet, uncovered. The urine collection bag was full of urine and urine was backed up into the tubing under the resident's gown. Observation on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back with one pillow between his/her knees. The resident's urine collection bag lay on the bed between the resident's feet, uncovered. The urine collection bag was full of urine and urine was backed up into the tubing under the resident's gown. He/she said staff had not performed catheter care nor looked at his/her catheter insertion site that shift. He/she said his/her catheter had not been emptied since sometime in the middle of the night. (continued on next page)

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	265130	A. Building B. Wing	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #21's face sheet, showed he/she was admitted to the facility on [DATE] with diagnoses of diabetes mellitus II, dementia without behaviors, stage IV pressure ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.) of the sacrum (triangular bone located above the coccyx) and hereditary and idiopathic (unknown cause) neuropathy (abnormality of the nervous system). Review of the resident's admission MDS, dated [DATE], showed: -Cognitively intact; -Understood others and made his/her needs known; -Required extensive assistance of one or two staff members for bed mobility, transfers and dressing; -Total dependence with assistance of one staff member for toileting, personal hygiene and bathing; -Required a wheelchair for mobility; -Had an indwelling catheter. Review of the resident's care plan, initiated 9/8/22, showed: -Focus: the resident admitted with indwelling catheter; -Goal: the resident will be/remain free from catheter related trauma through next review; -Interventions: --Catheter: 16 French (size). Change the catheter on the 15th day of each month; --Check tubing for kinks each shift; --Monitor and document intake and output as per facility protocol; --Monitor, record and report to the resident's physician, any signs or symptoms of a UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status and change in behavior. Review of the resident's EMR showed: -Foley catheter care every day and night shift for Foley catheter; -No physician's order for a catheter, including the type or size of catheter and how often to change the catheter tubing and collection bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's TAR, dated 8/24/22 to 8/31/22, showed: -Foley catheter care every day and night shift for Foley catheter, with no staff initials to document catheter care was performed for two out of 17 opportunities. Review of the resident's TAR, dated 9/1/22 to 9/30/22, showed: -Foley catheter care every day and night shift for Foley catheter, with no staff initials to document catheter care was performed for four out of 17 opportunities. Observation on 9/9/22 at 7:33 A.M., showed the resident lay on his/her back, in bed. The resident's urine collection bag hung on the bed frame, facing the door. There was no cover on the urine collection bag. Observation and interview on 9/9/22 at 10:44 A.M., showed the resident lay on his/her back, in bed. The resident's urine collection bag hung on the bed frame, facing the door. There was no cover on the urine collection bag. The urine collection bag contained 900 cubic centimeters (cc) of amber color urine. The resident said staff had not even looked at his/her Foley catheter once this shift. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back, in bed. The resident's urine collection bag hung on the bed frame, facing the door. There was no cover on the urine collection bag. The urine collection bag contained 1800 cc of amber color urine. The resident said staff had not provided any catheter care or emptied his/her urine collection bag this shift. Observation on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back, in bed. The resident's urine collection bag hung on the bed frame, facing the door. There was no cover on the urine collection bag. The urine collection bag contained 2100 cc of amber color urine. The resident said staff had not provided any catheter care or emptied his/her urine collection bag this shift. 3. During an interview on 9/2/22 at 2:10 P.M., Licensed Practical Nurse (LPN) B said: -The catheter tubing should be positioned where it could drain and the urine collection bag should be below the bladder; -If the catheter is not positioned below the bladder, it cannot drain correctly and will back up in the bladder, causing a UTI; -The catheter urine collection bag should be emptied at least once a shift and as needed; -The CNA is responsible for this when providing peri care; -It is not acceptable for the urine collection bag to be laying on the bed between the resident's feet, nor is it acceptable for it to remain full; -Catheter urine collection bags should be monitored several times throughout the shift and emptied as needed; -He/she was not aware of either situation with Residents #19 and #21; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Catheter care should be performed each shift; -Catheter collection bags should remain covered and not visible from the hallway for resident privacy. During an interview on 9/9/22 at 2:36 P.M., CNA C said: -He/she was agency staff and new to the facility; -Staff should provide catheter care and empty the urine collection bag as needed but at least each shift; -He/she was responsible for the care of Residents #19 and #21; -He/she was not aware Resident #19's collection bag was lying on the resident's bed between his/her feet; -He/she was not aware that Resident #19's collection bag was full and had been for several hours; -He/she had not been able to empty any urine collection bags that shift, he/she has not had the time to get it done; -He/she was not aware Resident #19 and Resident #21's collection bags had remained uncovered and visible from the doorway all shift. During an interview on 9/9/22 at 3:00 P.M., the Assistant Director of Nursing (ADON) said: -He/she expected CNAs to provide catheter care with each episode of peri care and empty the resident's urine collection bag as needed; -Licensed nursing staff were responsible for changing out the catheter monthly and monitoring the skin around the suprapubic catheter insertion site; -Resident #19 has a special SP catheter and the facility does not have the supplies to change it. The resident has an outside appointment to see if a different SP catheter can be placed; -He/she expected to have detailed physician orders for the resident's catheter to include the type and size of catheter, catheter care and skin care; -He/she expected nursing to document the assessment and care of the SP catheter in the resident progress notes and on the TAR; -He/she expected physician's orders on the MAR and TAR to be checked by nursing staff every shift; -Catheters should be addressed in the resident's care plan and should match physician orders; -It is not acceptable for the urine collection bag to be laying on the bed between the resident's feet, nor is it acceptable for it to remain full; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The catheter tubing should be positioned where it could drain and the urine collection bag should be below the bladder; -If the catheter is not positioned below the bladder, it cannot drain correctly and will back up in the bladder, causing a UTI; -The catheter urine collection bag should be emptied at least once a shift and as needed; -The CNA is responsible for this when providing peri care; -It is not acceptable for the urine collection bag to be laying on the bed between the resident's feet, nor is it acceptable for it to remain full for extended periods; -Catheter care should be performed each shift; -Catheter collection bags should remain covered and not visible from the hallway for resident privacy. During an interview on 9/13/22 at 10:14 A.M., the resident's physician said: -The catheter bag should remain below the level of the bladder to prevent backflow; -It is not acceptable to leave a catheter bag lying on the bed between the resident's feet for several hours, it can cause back flow into the bladder and cause a UTI; -It is not acceptable to leave a catheter bag that is completely full of urine so that it is backing up into the tubing and bladder. This is not good and can cause an UTI; -Catheter bags should be drained frequently; -There should be a detailed order for the catheter and for catheter care. MO00206339

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on interview and record review, the facility failed to ensure there were physician orders for colostomy (ostomy, an alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen stoma) care to include the type of appliances, skin barriers and skin care, and to document a detailed skin assessment of the colostomy site for one sampled resident (Resident #21). The census was 88. Review of the facility's Clinical Management: Ostomy Care policy, reviewed 1/5/22, showed: -Purpose: --To maintain cleanliness and skin integrity; --To prevent odors; --To prevent infection; -Procedure: --Verify physician's orders and nursing care plan; --Gather equipment; --Identify resident/patient, explain procedure, and provide privacy; --Wash hands and don gloves; --Assist resident/patient to a comfortable position; -Remove old appliance carefully; --Discard old appliance in the plastic bag. Retain the clamp as appropriate; --Block the opening of the stoma with a cotton ball or gauze to prevent leaking; --Wash skin around the stoma gently with warm water and allow to dry; --Use small amounts of adhesive remover as necessary to remove residual adhesive; --Observe and note any areas of redness or breakdown; --Remove gloves and discard in plastic bag; --Wash hands; (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Don (apply) second pair of clean gloves; --Observe the color of the stoma; -Color should be dark pink to red. Dark red, purple, or blanching may indicate circulation interference; --Measure the stoma; --Trace and cut the appropriate size on the adhesive backing of the appliance. Trace the circle 1/16 to 1/8 larger than the stoma; --Apply ostomy paste, powder, or seal as indicated around the stoma or around edge of the skin barrier; --Apply skin prep to area around the edge of the paste/powder/seal; --Remove paper backing of appliance and position over the stoma; --Press adhesive carefully and firmly around stoma. Avoid wrinkles in the adhesive; -Encourage resident/patient to rest quietly in position for five minutes to improve the adhesion of the appliance; --Close the bottom of the pouch. Apply the clamp as indicated; -Leave small amount of air to allow drainage to fall to bottom; --Dispose of used supplies in plastic bag and transport to the soiled utility room; --Remove gloves and discard in trash; --Wash hands; --Assist resident/patient to a position of comfort with call light in reach; --Notify physician of any changes in stoma color or skin around stoma; --Document: -Date and time of procedure; -Color and integrity of stoma and surrounding skin; -Color and amount of output from stoma; -Resident/patient tolerance to the procedure; (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Standard Precautions will be observed throughout procedure. Review of Resident #21's face sheet, showed he/she was admitted to the facility on [DATE] with diagnoses of diabetes mellitus II, dementia without behaviors, stage IV pressure ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers) of the sacrum (triangular bone located above the coccyx) and hereditary and idiopathic (unknown cause) neuropathy (abnormality of the nervous system). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/31/22, showed: -Cognitively intact; -Understood others and made his/her needs known; -Required extensive assistance of one or two staff members for bed mobility, transfers and dressing; -Total dependence with assistance of one staff member for toileting, personal hygiene, and bathing; -Did not indicate the resident had a colostomy at the time of admission, and was occasionally incontinent of bowel. Review of the resident's care plan, initiated 9/8/22, showed: -Focus: The resident was admitted with a colostomy; -Goal: The resident will have no complications related to colostomy through next review; -Interventions: --Check colostomy bag routinely; --Inform nurse if stool in colostomy bag becomes loose or changes in color; --Check resident every two hours and assist with toileting as needed; --Monitor stoma site and notify nurse if area becomes reddened. Review of the resident's electronic medical record (EMR), showed: -No physician's order for a colostomy, including the type or size of colostomy supplies needed and how often to change the colostomy; -No physician's order for colostomy care, scheduled or as needed (PRN). (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR), dated 8/24/22 to 8/31/22, showed: -No physician's order for a colostomy, including the type or size of colostomy supplies needed and how often to change the colostomy; -No physician's order for colostomy care, scheduled or PRN. Review of the resident's Treatment Administration Record (TAR), dated 8/24/22 to 8/31/22, showed: -No physician's order for a colostomy, including the type or size of colostomy supplies needed and how often to change the colostomy; -No physician's order for colostomy care, scheduled or PRN. Review of the resident's MAR, dated 9/1/22 to 9/30/22, showed: -No physician's order for a colostomy, including the type or size of colostomy supplies needed and how often to change the colostomy; -No physician's order for colostomy care, scheduled or PRN. Review of the resident's TAR, dated 9/1/22 to 9/30/22, showed: -No physician's order for a colostomy, including the type or size of colostomy supplies needed and how often to change the colostomy; -No physician's order for colostomy care, scheduled or PRN. Review of the resident's Weekly Skin Assessment Sheets, dated 8/24/22, 8/27/22, and 8/31/22, showed no documentation related to the assessment of the resident's colostomy site. Review of the resident's EMR, as of 9/9/22, showed: -No documentation the resident's colostomy care had been provided by Certified Nursing Assistants (CNAs) and/or licensed nursing staff; -No documented assessment of the resident's colostomy stoma site. During an interview on 9/2/22 at 11:04 A.M., the resident said: -He/she was unable to provide his/her own personal care, including his/her colostomy care; -Staff had changed the colostomy bag and emptied the colostomy bag that shift, but it does not always get done like it is supposed to; -He/she did not remember any nursing staff monitoring or assessing his/her stoma site daily, it would be long periods of time with no staff even looking at the site. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/2/22 at 2:10 P.M., Licensed Practical Nurse (LPN) B said: -The facility staff provided the resident's colostomy care, including emptying and changing the bag; -He/she expected to have a physician's order for colostomy care and appliance type; -He/she had recently changed the resident's colostomy bag; -He/she looked at the types of appliances in the nurse's cart and compared them to the resident's colostomy bag in use at the time to decide which type of appliance to use; -He/she does not know if this is the correct bag or not. During an interview on 9/9/22 at 2:36 P.M., CNA C said: -He/she was agency staff and new to the facility; -Staff should provide colostomy care of emptying of the colostomy bag each shift and as needed; -He/she was told in report the resident had a colostomy; -He/she is not sure where to find the type of bag or other care instructions for the resident's colostomy bag/site; -He/she had provided colostomy care that shift and had notified the nurse the resident needed his/her colostomy bag changed; -The nurse then changed the resident's colostomy bag. During an interview on 9/9/22 at 2:10 P.M., LPN B said: -Colostomy care included changing the bag and assessment of the surrounding skin; -There should be a physician's order for colostomy care and when/how often to change the colostomy bag; -There should be a detailed physician's order for the colostomy that would include the size, the type of care required and assessment of the surrounding skin and stoma; -He/she was told in report the resident had a colostomy and just did what was required by nursing standard of practice. During an interview on 9/9/22 at 3:00 P.M., the Assistant Director of Nursing (ADON) said: -He/she expected CNAs to change and empty the resident's colostomy bag and licensed nursing staff were responsible for changing out the whole system and monitoring the skin around the stoma; (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected to have detailed physician's orders for the resident's colostomy to include the type of appliances, skin barriers and skin care; -He/she does not know why there were no orders for the colostomy or colostomy care, these are regular orders for any resident that has a colostomy; -He/she expected nursing to document the assessment and care of the colostomy in the resident's progress notes and on the MAR; -He/she expected weekly assessments and the colostomy should be noted on the resident's shower sheets; -He/she expected physician's orders on the MAR and TAR checked by nursing staff every shift. During an interview on 9/13/22 at 10:14 A.M., the resident's physician said: -There should be an order for a colostomy that includes the type of appliances, skin barriers and skin care; -There should be an order for routine colostomy care and colostomy bag change; -There should be an order to document a detailed skin assessment of the colostomy site weekly; -He/she does not know why there were no orders for the colostomy or colostomy care, these are standard practice and standing orders for any resident that has a colostomy. MO00206339

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on observation, interview and record review, the facility failed to ensure pain management was provided to residents who require such services, by failing to adequately assess and treat pain for one resident. The resident developed an infection, experienced severe pain and was not provided effective pain management (Resident #22). The facility also failed to administer pain medication to alleviate pain during dressing changes for two residents (Residents #19 and #21) with pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction). The census was 88. Review of the facility's Pain Management Policy and Procedure, revised on 7/11/22, showed: -Purpose: To assess all residents for pain and to provide our residents with the highest level of comfort possible, using pain medications judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences; -Policy: All residents will be assessed on admission and in conjunction with initial assessment and as needed (PRN) for pain. The assessment should include an interdisciplinary team (IDT) approach; -Overview of Pain Recognition and Management: -Effective pain recognition and management requires an ongoing facility-wide commitment to resident comfort, to identifying and addressing barriers to managing pain, and to addressing any misconceptions that residents, families, and staff may have about managing pain; -Nursing home residents are at high risk for having pain that may affect function, impair mobility, impair mood, or disturb sleep, and diminish quality of life; -The onset of acute pain may indicate a new injury or a potentially life-threatening condition or illness. It is important, therefore, that a resident's reports of pain, or nonverbal signs suggesting pain, be evaluated. The resident's needs and goals as well as the etiology, type, and severity of pain are relevant to developing a plan for pain management; -Certain factors may affect the recognition, assessment, and management of pain. For example, residents, staff, or practitioners may misunderstand the indications for, and benefits and risks of, opioids (pain relieving drug) and other analgesics (pain relieving medication); or they may mistakenly believe that older individuals have a higher tolerance for pain than younger individuals, or that pain is an inevitable part of aging, a sign of weakness, or a way just to get attention; -Some individuals with advanced cognitive impairment can accurately report pain and/or respond to questions regarding pain; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Those who cannot report pain may present with nonspecific signs such as grimacing, increases in confusion or restlessness or other distressed behavior. Effective pain management may decrease distressed behaviors that are related to pain. However, these nonspecific signs and symptoms may reflect other clinically significant conditions (e.g., delirium, depression, or medication-related adverse consequences) instead of, or in addition to, pain. To distinguish these various causes of similar signs and symptoms, and in order to manage pain effectively, it is important to evaluate (e.g., touch, look at, move) the resident in detail, to confirm that the signs and symptoms are due to pain; -Pain is an unpleasant sensory and emotional experience that can be acute, recurrent or persistent. The following are descriptions of several different types of pain: -Acute pain is generally pain of abrupt onset and limited duration, often associated with an adverse chemical, thermal or mechanical stimulus such as surgery, trauma and acute illness; -Incident pain refers to pain that is typically predictable and is related to a precipitating event such as movement (e.g., walking, transferring, or dressing) or certain actions (e.g., wound care); -Persistent pain or chronic pain refers to a pain state that continues for a prolonged period of time or recurs more than intermittently for months or years; -Standards of Practice refers to approaches to care, procedures, techniques, treatments, etc., that are based on research and/or expert consensus and that are contained in current manuals, textbooks, or publications, or that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies; -Strategies for Pain Management: Strategies for the prevention and management of pain may include but are not limited to the following; -Assessing the potential for pain, recognizing the onset, presence and duration of pain, and assessing the characteristics of the pain; -Addressing/treating the underlying causes of the pain, to the extent possible; -Developing and implementing both non-pharmacological and pharmacological interventions, approaches to pain management, depending on factors such as whether the pain is episodic, continuous, or both; -Identifying and using specific strategies for preventing or minimizing different levels or sources of pain or pain-related symptoms based on the resident-specific assessment, preferences and choices, a pertinent clinical rationale, and the resident's goals and; using pain medications judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences; -Monitoring appropriately for effectiveness and/or adverse consequences (e.g., constipation, sedation) including defining how and when to monitor the resident's symptoms and degree of pain relief; and modifying the approaches, as necessary. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Skin Program Policy and Procedure, dated revised on 5/10/21, showed: - Purpose: The purpose of the skin program is to ensure that every resident's skin condition is assessed on admission and a comprehensive and interdisciplinary care plan is developed and maintained to treat actual and/or prevent potential skin problems; -Policy: All residents are assessed upon admission and as needed (PRN) for actual and/or potential skin problems. All residents will receive an individualized preventative skin plan of care at the time of admission. All residents with skin problems will receive an active skin plan of care at admission. Skin Care team meetings will be held weekly to address all ulcers and any other pertinent skin problems. Performance Improvement/quality assurance (QA) tracking and monitoring are done according to the performance improvement/QA schedule. All Performance Improvement/QA Tracking & Monitoring are attorney/client privileged information; -Procedure: --The nurse will assess resident pain originating from skin areas during assessment and treatment and care plan appropriately. 1. Review of Resident 22's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/20/22, showed: -No cognitive impairment; -Required one staff person's assistance for bed mobility, dressing, toileting and personal hygiene; -Required two staff persons' assistance for transfers; -On scheduled pain management regimen: No; -Verbal descriptor pain scale: Moderate; -Diagnoses included heart failure, urinary tract infection (UTI), high blood pressure, chronic lung disease and anxiety. Review of the resident's physician's orders, dated 9/1/22 through 9/30/22, showed: -On 6/10/22, an order for pain assessments, every day and night shift; -On 6/10/22, an order for Acetaminophen (for pain relief/fever reduction, brand name includes Tylenol) Extra Strength Tablet, 500 milligrams (mg), give two tablets by mouth every 6 hours as needed for pain; -On 8/5/22, an order for Oxycodone (a medication used to help relieve moderate to severe pain) HCl Tablet, 15 mg, give 1 tablet by mouth every 4 hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 8/30/2022, an order for Pyridium (used to relieve the pain, burning, and discomfort caused by urinary tract infections) tablet, 100 mg, give 100 mg by mouth two times a day for urinary discomfort for three days. Review of the resident's August 2022 medication administration record (MAR), showed: -An order, dated 6/10/22, for pain assessments, day and night shift, (pain levels ranging from 1 through 10, with 10 the most severe); -Staff documented: -8/27, night shift: 10; -8/28, day shift: 3, night shift: 3; -8/29, day shift: 7, night shift: 6; -8/30, day shift: 9, night shift: 7; -8/31/22, day shift: 0, night shift: 10. Further review of the resident's August 2022 MAR, showed: -An order, dated 6/10/22, for Acetaminophen, Extra Strength Tablet 500 mg, none documented as given on 8/29, 8/30 or 8/31/22; -An order, dated 8/5/22, for Oxycodone HCl Tablet, 15 mg, give 1 tablet by mouth every 4 hours as needed for pain, documented as administered on 8/30/22 at 10:11 A.M. Review of the resident's nurse's notes, showed: -On 8/29/22 at 2:13 A.M., the resident voiced complaints of urinary discomfort, and wanting to go to hospital regarding previous diagnosis of recurrent UTIs, upon entering resident's room this nurse noted resident resting with eyes closed, no signs or symptoms of distress, this nurse called this resident's name several times to arouse resident, upon resident opening his/her eyes, this nurse asked resident what was bothering him/her and where was his/her pain located, resident voiced to this nurse I want to go to the hospital because I am out of pain medication and this helps with my UTIs. Resident received PRN Tylenol for pain, upon departure from resident's room, this resident went back to sleep, will report to A.M. nurse regarding above, fluids offered and encouraged; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 8/29/22 at 6:30 P.M., Late Entry: resident called this nurse to the room, this resident voiced he/she has been in urinary discomfort throughout the day, resident voiced to this nurse I want to go to the hospital, I have been asking to speak with someone regarding this matter because I think my UTI has gotten worse. Resident voiced constant sharp pain and burning to genital area, resident afebrile (without fever), Temperature 97.2 degrees Fahrenheit (F), call placed to physician regarding above, this nurse voiced resident's request to go to the hospital, new orders given as follows, new order (N.O.) Pyridium (medication used for pain caused by UTIs) 100 mg two times per day (BID) for three days for urinary discomfort, collect a UA with culture and sensitivity, UA collected with two attempts, dark, foul smelling urine noted with presence of blood, resident tolerated urine collection without difficulty. First dose of Pyridium given with evening medication, resident voiced feeling relieved and stable at facility, in bed, resting quietly, will continue to monitor for change. Fluids and cranberry juice offered and encouraged, resident remains stable at this time, UA pending pick up from lab; -On 9/4/22 at 1:24 P.M., transfer to hospital summary. Patient complaint of pain during urination. Urine has foul odor. Blood tinged urine noted. Patient requesting to go to emergency room . Respiration even and non-labored. No shortness of breath noted. PRN pain medication administered. Physician made aware of clinical situation and transfer. During an interview on 9/9/22 at 10:20 A.M., the resident said he/she was in horrific pain. It felt like a hot curling iron inside me. He/she was in so much pain, he/she wanted to call an ambulance his/herself. When staff obtained the urine sample, the staff person said, Oh, blood! The resident said he/she saw there was blood in the urine. The resident said he/she was suffering so badly, he/she cried. The resident said the Pyridum didn't help the pain, it still burned after taking the Pyridium. Review of the resident's September 2022 MAR, showed: -An order, dated 6/10/22, for pain assessments, day and night shift; -Staff documented: -9/1, day shift: 0, night shift: 8; -9/2, day shift: 0, night shift: 9; -9/3, day shift: 0, night shift: 8. Further review of the resident's September 2022 MAR, showed: -An order, dated 6/10/22, for Acetaminophen, Extra Strength Tablet 500 mg, none documented as administered; -An order, dated 8/5/22, for Oxycodone HCl Tablet, 15 mg, give 1 tablet by mouth every 4 hours as needed for pain, documented as administered on 9/1 at 10:44 P.M., on 9/2 at 5:54 A.M. and 9/3 at 7:50 A.M., 1:09 P. M., and 9:29 P.M. Review of the resident's hospital record, showed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-On 9/4/22, no time noted, patient presented with dysuria (painful urination); -Patient arrived with severe pain dysuria, and flank pain (pain in one side of the body between the upper belly area (abdomen) and the back). This is similar symptoms to his/her recurrent infection. He/she denies any fever, any chills, night sweats, nausea, vomiting or abdominal pain. In the emergency department he/she was positive for UTI on the UA. During an interview on 9/13/22 at 10:15 A.M., the resident's physician said she expected staff to have called regarding the resident's continuous complaints of pain. The possible complications of a UTI are the symptoms getting worse, and they can become septic (the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an existing infection triggers a chain reaction throughout the body). 2. Review of Resident #19's face sheet, showed he/she was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included: -Dementia without behaviors; -Severe protein calorie malnutrition (associated with low muscle mass and function, and increased prevalence of physical frailty); -Pressure ulcers of unspecified stage; -Osteomyelitis (Inflammation of bone caused by infection, generally in the legs, arm, or spine. Infections can reach bones by traveling through the bloodstream or spreading from nearby tissue. Common symptoms include pain, fever, and chills). Review of the resident's quarterly MDS, dated [DATE], showed: -Severely cognitively impaired; -Understood others and made his/her needs known; -Total dependence of one staff member for bed mobility, mobility on and off the unit, dressing, toileting, personal hygiene and bathing; -At risk for developing pressure ulcers; -Three unhealed Stage IV pressure ulcers (Full thickness deep tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, thick, leathery tissue over wound bed) may be present on some parts of the wound bed. Often include undermining and tunneling); -Skin and pressure ulcer/injury treatments. Review of the resident's care plan, revised on 2/18/22, showed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Focus: the resident was admitted with one unstageable sacrum (located at the bottom of the spine and lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone) pressure ulcer, one right hip Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous (the layer of tissue that underlies the skin) fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface) and tunneling (has progressed to form passageways underneath the surface of the skin).); 1/30/22, following new wounds added: sacrum Stage IV, right hip Stage IV pressure ulcer, left hip Stage IV pressure ulcer; 7/28/2022, following new wounds added: sacrum Stage IV pressure ulcer, right hip Stage IV pressure ulcer, left hip Stage IV pressure ulcer, right buttock Stage III; -Goal: Wound will show signs of improvement; -Interventions included: --Encourage resident to frequently shift weight; --Low air loss (LAL) mattress with bolsters. Further review of the care plan, showed no interventions to address the resident's potential for pain. Review of the resident's electronic medical record (EMR), showed the following physician orders: -Pain assessment every day and night shift, dated 6/29/22; -Wound care treatment to left hip: cleanse with wound cleanser (WC) or normal saline (NS), apply Santyl (removes dead tissue from wounds so they can start to heal) to wound bed, apply calcium alginate (dressing used on moderate to heavily exudative (draining) wounds during the transition from debridement (the removal of damaged tissue or foreign objects from a wound) to repair phase of wound healing), skin prep to peri wound (skin area around the wound), cover with border gauze. Change daily and if dressing becomes saturated, soiled or dislodged every day shift, dated 6/21/22; -Wound care: Cleanse right hip with WC and apply antifungal cream every day shift and as needed, dated 8/9/22; -Wound care: Cleanse sacrum with WC and apply antifungal cream to wound and peri wound every day shift and as needed, dated 8/9/22; -Acetaminophen (non-narcotic pain reliever) 325 milligrams (mg), give 650 mg by mouth (PO) every four hours and PRN, 6/18/22; -Santyl ointment 250 units per gram (unit/gm), apply topically to left hip wound every day shift, 8/22/22. Review of the resident's Medication Administration Record (MAR), dated 9/1/22 to 9/30/22, showed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Pain assessment every day and night shift with 14 out of 17 assessments indicating no pain, pain score at 1 out of 10 on 9/3/22 night shift, and pain score at 8 out of 10 on 9/6/22 day and night shifts. Observation on 9/9/22 at 7:45 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. Observation on 9/9/22 at 9:09 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. Observation and interview on 9/9/22 at 10:26 A.M., showed the resident lay on his/her back, leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. The wound nurse turned the resident for wound care, and then placed the resident into the same position on his/her back as prior to wound care. The resident said staff never give him/her pain medication when he/she is in pain, including wound pain, or prior to wound care. The wound hurts when wound care is provided and he/she would like pain medication prior to wound care. His/her wounds become painful when lying in one position too long. The wound nurse left the room without notifying the charge nurse or CNA the resident was in pain after/related to wound care. He/she does have pain to the wound on a regular basis. Wound care increases the pain to the wound. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back leaning to the right with one pillow behind his/her left side of the back and one pillow between his/her knees. Observation and interview on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back with one pillow between his/her knees. He/she was uncomfortable and would like to be repositioned, but no one ever comes in to move or help him/her. 3. Review of Resident #21's face sheet, showed he/she was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus II, dementia without behaviors, Stage IV pressure ulcer of the sacrum and hereditary and idiopathic (unknown cause) neuropathy (abnormality of the nervous system). Review of the resident's admission MDS, dated [DATE], showed: -Cognitively intact; -Understood others and made his/her needs known; -One unhealed Stage IV pressure ulcer; -Skin and pressure ulcer/injury treatments: --Pressure relieving device for chair; --Pressure relieving device for bed; --Turning/repositioning program. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan, initiated 9/8/22, showed: -Focus: admitted with a Stage IV pressure ulcer to the sacrum and decreased mobility; -Goal: The resident's pressure ulcer will show signs of healing and remain free from infection through review date; -Interventions: --Administer treatments as ordered and monitor for effectiveness; --Followed by wound physician; --If the resident refuses treatment, confer with the resident, IDT and family to LPN determine why and try alternative methods to gain compliance. Document alternative methods; --Monitor dressing, if dressing becomes soiled, loose or comes off notify nurse; --Monitor/document/report PRN any changes in skin status including appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), and stage; --The resident required LAL mattress on bed and cushion in wheelchair. The resident did not have a LAL mattress on his/her bed; --Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Further review of the resident's care plan, showed the potential for pain was not identified. Review of the resident's admission Skin Only Evaluation, dated 8/24/22, showed: -One Stage IV pressure ulcer to the coccyx; -The pressure ulcer had no odor; -The pressure ulcer was painful; -No other skin issues noted; -No other skin assessments noted in the resident's EHR. Review of the wound physician's Initial Wound Evaluation and Management Summary, dated 9/2/22, showed: -Stage IV pressure ulcer to sacrum; -Wound size (L x W x D): 15.8 cm by 9.8 cm by 2.2 cm; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Recommendations: --Off-load wound; --Reposition per facility protocol; --Turn side to side and front to back in bed every 1-2 hours if able. Observation on 9/9/22 at 7:33 A.M., showed the resident lay on his/her back, in bed. The resident said he/she has pain during certain parts of wound care. Observation and interview on 9/9/22 at 10:44 A.M., showed the resident lay on his/her back, in bed. No LAL mattress noted to the bed. The resident said staff do not turn/reposition him/her unless asked to, and then sometimes they say they will be back to do it and they do not come back. Observation of wound care, showed the resident said ouch, this is where the wound care is painful, when she cleans the wound and applies the Dakin's soaked gauze. After wound care, the wound nurse positioned the resident into the same position on his/her back. Observation on 9/9/22 at 12:42 P.M., showed the resident lay on his/her back, in bed. Observation and interview on 9/9/22 at 1:49 P.M., showed the resident lay on his/her back in bed. No LAL mattress noted to the bed. The resident said staff had not attempted to reposition/turn him/her all shift. He/she was not offered pain medication prior to, during or after wound care. He/she would accept it if it was offered. After wound care, he/she had to ask for pain medication. He/she just received a Tylenol. He/she rated his/her pain at a 7 out of 10. 4. During an interview on 9/9/22 at 12:06 P.M., the Wound Nurse said: -He/she does not provide residents with pain medication. That is the charge nurse's job, he/she has the keys to the medication cart; -He/she would have to notify the charge nurse to provide pain medication to the resident during or before treatments, as needed; -He/she does not assess the residents for pain prior to, during, or after wound care; -He/she does not see any evidence of pain during wound care to any of the residents; -Resident #21 had never indicated pain during wound care; -Resident #19 complains of pain all the time and asks to be repositioned for the pain frequently, but staff does not do it as far as he/she can tell. During an interview on 9/9/22 at 2:10 P.M., Licensed Practical Nurse (LPN) B said: -He/she expected the wound nurse or other staff to let him/her know if the resident states they are in pain so he/she can provide pain medication; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The CNA notified him/her Resident #21 was in pain and he/she provided the resident with pain medication, if he/she was aware the resident was in pain during wound care, he/she would have provided pain medication earlier; -He/she was not aware Resident #19 was in pain and required pain medication. During an interview on 9/9/22 at 2:36 P.M., CNA C said: -If a resident is in pain, it should be reported to the nurse immediately; -He/she did not know Resident #19 was in pain; -Resident #21 complained of wound pain and he/she reported it to the nurse. During an interview on 9/9/22 at 3:00 P.M., the Assistant Director of Nursing (ADON) said: -When a resident voices pain, he/she expected the nurse to assess the resident's pain, ask the resident to rate the pain on a scale of 1-10, check to see what the resident has ordered, and provide pain medication based on the resident's level of pain. That is just basic nursing; -A resident pain rating of 2 to 5 would indicate providing the resident with Tylenol if ordered; -A resident pain rating over 5 would indicate providing the resident with narcotic pain medication if ordered; -He/she expected the wound nurse to report any statement of pain during wound care to the charge nurse for follow up and pain medication administration; -He/she expected the wound nurse to address pain with the resident before starting wound care; -If the resident voices pain, the wound nurse should notify the charge nurse so he/she can provide pain medication, let the pain medication take effect and then start wound care; -He/she expected the wound nurse to stop treatment if a resident voices pain during wound care, notify the charge nurse of voiced pain, and let the provided pain medication take effect before resuming wound care. During an interview on 9/13/22 at 10:14 A.M., Residents #19 and #21's physician/medical director said: -If a resident complains of pain during wound care, she expected staff to immediately inform the charge nurse the resident is in pain; -It should be up to the resident if staff continues the wound care at that time or wait to continue after the medication has taken effect; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-If a resident complains of pain prior to wound care beginning, she expected staff to notify the charge nurse of the resident pain and wait until the medication has taken effect prior to beginning wound care; -He/she expected staff to notify the charge nurse of resident pain immediately; -He/she expected pain management to be provided as soon as possible. MO00206339 36151

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F 0773 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when staff failed to notify the physician of Resident #22's positive urinalysis (a urine test, used to check for a urinary tract infections (UTI), kidney problems, or diabetes) on 8/30/2022. On 9/4/22, the resident was transferred to the hospital upon his/her request with complaints of pain during urination, foul smelling and blood tinged urine. The census was 88. 1. Review of Resident 22's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 6/20/22, showed: -No cognitive impairment; -One staff person assist for bed mobility, dressing, toileting and personal hygiene; -Two staff person assist for transfers; -On scheduled pain management regimen: No; -Verbal descriptor pain scale: Moderate; -Diagnoses included heart failure, UTI, high blood pressure, chronic lung disease and anxiety. Review of the resident's nurse's notes showed: -On 8/29/22 at 2:13 A.M., the resident voiced complaints of urinary discomfort, and wanting to go to hospital regarding previous diagnosis of recurrent UTIs, upon entering resident's room this nurse noted resident resting with eyes closed, no signs or symptoms of distress, this nurse called this resident's name several times to arouse resident, upon resident opening his/her eyes, this nurse asked resident what was bothering him/her and where was his/her pain located, resident voiced to this nurse I want to go to the hospital because I am out of pain medication and this helps with my UTIs. Resident received PRN Tylenol for pain, upon departure from resident's room, this resident went back to sleep, will report to A.M. nurse regarding above, fluids offered and encouraged; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265130	A. Building B. Wing	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Bend Woods Healthcare Center	110 Highland Avenue Valley Park, MO 63088

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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 0773 Level of Harm - Actual harm Residents Affected - Few	-On 8/29/22 at 6:30 P.M., Late Entry: resident called this nurse to the room, this resident voiced he/she has been in urinary discomfort throughout the day, resident voiced to this nurse I want to go to the hospital, I have been asking to speak with someone regarding this matter because I think my UTI has gotten worse. Resident voiced constant sharp pain and burning to genital area, resident afebrile (without fever), Temperature 97.2 degrees Fahrenheit (F), call placed to physician regarding above, this nurse voiced resident's request to go to the hospital, new orders given as follows, new order (N.O.) Pyridium 100 mg two times per day (BID) for three days for urinary discomfort, collect a UA with culture and sensitivity, UA collected with two attempts, dark, foul smelling urine noted with presence of blood, resident tolerated urine collection without difficulty. First dose of Pyridium given with evening medication, resident voiced feeling relieved and stable at facility, in bed, resting quietly, will continue to monitor for change. Fluids and cranberry juice offered and encouraged, resident remains stable at this time, UA pending pick up from lab. Review of the resident's laboratory UA, dated 8/30/22 and reported at 11:08 A.M., showed: organism 1 E. coli (Escherichia coli) extended-spectrum beta-lactamases (ESBL Producer, are most often made by E. coli and can cause a wide range of infections, ranging from urinary tract infections to severe blood poisoning) greater than 100,000 colony-forming unit (CFU, is a unit which estimates the number of microbial cells) per millimeter. During an interview on 9/20/22 at 12:39 P.M., laboratory technician F said the preliminary results indicating a positive urinary tract infection were faxed to the facility on [DATE] at 11:08 A.M., the culture and sensitivity test (C&S, a test that determines which antibiotic an organism is resistant and/or susceptible) results were faxed on 9/5/22. Further review of the resident's nurse's notes showed: -On 9/4/22 at 1:24 P.M., transfer to hospital summary. Patient complaint of pain during urination. Urine has foul odor. Blood tinged urine noted. Patient requesting to go to emergency room . Physician made aware of clinical situation and transfer; -No additional documentation noted regarding the pending UA results collected on 8/29/22. During an interview on 9/20/22 at 12:52 P.M., Licensed Practical Nurse (LPN) E said he/she was assigned to the resident on 8/30/22. He/she said an order for the UA should have been on the 24 hour report sheet, and given verbally as well, in case someone doesn't look at the sheet. He/she said he/she was either not aware of the pending UA on the 24 hours report sheet, or it was not communicated to him/her. The laboratory test results come in by fax, and if he/she had been aware of the pending results, he/she would have looked for them. They are supposed to call the physician with the results. During an interview on 9/9/22 at 10:20 A.M., the resident said he/she was in horrific pain. It felt like a hot curling iron inside me. He/she was in so much pain, he/she wanted to call an ambulance his/herself. When staff obtained the urine sample, the staff person said, Oh, blood! The resident said he/she saw there was blood in the urine. The resident said he/she was suffering so badly, he/she cried. The resident said the Pyridum didn't help the pain, it still burned after taking the Pyridium. Review of the resident's hospital record, showed: (continued on next page)

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F 0773 Level of Harm - Actual harm Residents Affected - Few	-On 9/4/22, no time noted, patient presented with dysuria (painful urination); -Patient arrived with severe pain dysuria, and flank pain (pain in one side of the body between the upper belly area (abdomen) and the back). This is similar symptoms to his/her recurrent infection. In the emergency department he/she was positive for UTI on the UA. During an interview on 9/13/22 at 10:15 A.M., the resident's physician said staff had not called her with the results of the UA. Had they called, she would have ordered the resident an antibiotic. She expected staff to have called regarding the resident's continuous complaints of pain. The possible complications of a UTI are the symptoms getting worse, and they can become septic (the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an existing infection triggers a chain reaction throughout the body). During an interview on 9/15/22 at 2:24 P.M., the administrator said she expected staff to document the results of the UA and call the physician with the positive results. 36151