STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265341	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillars of North County Health & Rehab Center, The	13700 Old Halls Ferry Road Florissant, MO 63033

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 22409 Based on observation, interview and record review, the facility failed to follow their pressure ulcer and wound care policies/procedures by failing to ensure Resident #3's wound care Physician's orders were initiated when ordered, and Registered Dietician's (RD) recommendations were promptly followed. The facility also failed to promptly identify, assess, document and notify the resident's Physician regarding the resident's pressure ulcers located on both feet/heels. In addition, the facility failed to ensure Resident #2, who was admitted on [DATE], with a pressure ulcer on the coccyx (the tailbone), had a treatment order in place until 7/1/24, failed to ensure a nurse contacted the physician for a treatment order prior to administering a treatment to the coccyx, failed to ensure the wound care Physician's orders were initiated and the RD's recommendations were promptly followed. The facility identified two residents with pressure ulcers and problems were found with both. The census was 57. Review of the facility Wound Management Program policy dated November 2022, showed: -Policy: It is the policy of this facility to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions; -Procedure: 1. The facility is provided with wound care protocols. These are to be utilized to assist in the care and treatment of wounds. Physician orders should be obtained and followed for each resident; 2. The Braden Scale (an assessment used to determine a resident's risk of developing a pressure ulcer (an injury that breaks down the skin and underlying tissue)) will be completed on admission weekly for four weeks post admission and quarterly thereafter to assess skin breakdown risk; 3. Residents identified at risk on the Braden Scale will have this addressed on their care plan and will have interventions put in place for preventative measure. Interventions: pressure reducing mattress and/or cushion, be reviewed by a Dietician and lab values as needed. Resident's identified with wounds will have a care plan initiated regarding impaired skin integrity; 4. The facility will assess residents weekly for current skin conditions; a. The charge nurse for each hall will do skin assessments; (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 0686 Level of Harm - Actual harm Residents Affected - Few	b. The skin assessment will be documented on the Weekly Skin Assessment, which is completed as follows: i. Observe the skin for the following: 1. Open areas; 2. Redness; 3. Rashes; 4. Discolored areas; ii. Indicate the location of any identified areas on the body figure; iii. Describe the area(s); c. If any new areas are identified, write a nurse's note describing the area found and the protocol followed to treat it. The new area should also be noted on the 24 Hour Report; d. The nurse will measure the area, call the physician to obtain appropriate treatment order, call the guardian/family member, document the area on the POS (physician's order sheet), and initiate the treatment; 5. The Skin Assessment should be also completed whenever a new skin condition is noted; 6. All wounds will be reported weekly on the Wound Report; 7. It is important that wounds are assessed correctly to differentiate between pressure and non pressure wounds; 8. It is the responsibility of the Administrator to review the Wound Report weekly; 9. Interdisciplinary team meetings will be held weekly. The committee should include at a minimum the nurse responsible for treatments, representative from therapy, Director of Nursing (DON), and representative from dietary; 10. During the meeting, the Wound Report will be reviewed to assess the progress of the residents. Any wounds designated as not improving should be discussed further in the meeting. Review of the facility Dressings, Dry/Clean policy, dated January 2018, included: -Verify that there is a physician's order for this procedure; -Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs; -Check the treatment record; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the dressing was changed; 2. Wound appearance, including wound bed, edges, presence of drainage; 3. The name and title of the individual changing the dressing; 4. The type of dressing used and wound care given; 5. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; 9. The signature and title of the person recording the data; -Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #3's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/17/24, showed: -Severe cognitive impairment; -No functional limitations of the upper/lower extremities; -Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity for: Toileting, shower/bathe, lower body dressing, putting on/taking off footwear, and personal hygiene; -Substantial/maximal assistance - Helper does more than half the effort required to: Roll left and right, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer, and toilet transfer; -Always incontinent of urine and bowel; -Diagnoses of anemia (the capacity of the blood to carry oxygen is reduced), and diabetes mellitus (high blood sugar); -Risk of Pressure Ulcers: Yes; -Unhealed Pressure Ulcers: No; -Hospice care. Review of the resident's Braden Scale dated 5/19/24, showed the resident was at moderate risk to develop pressure ulcers. Review of the resident's progress notes, located in the electronic healthcare record (EHR), showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-5/19/24 at 10:19 A.M., Stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous). May also present as an intact or open/ruptured blister) on coccyx. 4. 0 centimeters (cm) (height) x 4.5 cm (width) x 1.0 cm (depth) reported to on-call Physician. Received new order to cleanse with wound cleanser, apply Medihoney (a medical grade honey used for wound care), optifoam every three days and PRN (as necessary); -5/22/24 at 1:02 P.M. and documented by the RD, quarterly note. New onset pressure ulcer on coccyx. Appropriate to consider addition of vitamin/protein supplementation. Currently on no added sodium/salt (NAS), low concentrated sweets (LCS) diet. Appropriate to consider liberalizing diet due to wishes for comfort. Recommend: 1) Discontinue NAS/LCS diet. 2) Add multivitamin with minerals daily. 3) Add liquid protein (for wound healing) 30 milliliter (ml) two times a day; -6/1/24 at 2:21 P.M., Resident seen by the wound care Physician. No new orders. Review of the resident's medication administration record (MAR), dated 5/1/24 through 5/31/24, showed no order for a multivitamin with minerals daily or liquid protein 30 ml daily. Review of the resident's care plan, located in the EHR and last edited on 6/4/24, showed: -7/1/20: Problem: Activities of daily living functional status. Goal: Resident will be able to maintain present level of functioning through next review. Approach: Staff assist 1-2 with transfers, bed mobility and personal care. Resident is non-ambulatory and can self propel in his/her wheelchair. Observe skin condition with daily care; -7/1/20: Problem: Pressure Ulcer/Injury. Goal: Resident will have skin remain intact by next review date. Approach: Provide treatments and medication as ordered. Assist with mobility and transfers. Ensure proper body alignment in bed or chair. Observe skin condition with daily care. Report changes to the physician and obtain treatment as ordered. Weekly body audit; -The resident's care plan had not been updated to include any known pressure ulcers or that the skin was no longer intact. Review of the resident's Skin Observation assessments, showed: -6/21/24: Pressure Injury/Blister/Open Areas - Yes, coccyx. Describe any additional body marks or sores: Blank; -6/26/24 and completed by Licensed Practical Nurse (LPN) E: Pressure Injury/Blister/Open Areas - Yes. Wound to bottom and lle (left lower extremity). Describe any additional body marks or sores: Blank; -Review of the resident's progress notes, POS and MAR, showed no assessment, physician notification or treatment order for the resident's left lower extremity. Review of the wound care Physician's progress note, dated 6/28/24, showed: -Wound Location: Coccyx; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound Type: Pressure Ulcer - Unstageable (Slough and/or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin); -Wound Status: Improving; -Pre-debridement Measurement: 4.5 cm x 4.6 cm x 1.5 cm; -Tunneling (passageways underneath the skin): Absent; -Undermining (a pocket of dead space under the skin originating from the edges and spreading outwards): Absent; -Odor: Absent; -Eschar (dead tissue that forms over healthy skin and then, over time, falls off (sheds)): Absent; -Exposure: Tendon/Muscle/Ligament; -Tissue Type: Slough, Granulating (new tissue/healing); -Exudate (is fluid that leaks out of blood vessels into nearby tissues) Amount: Moderate; -Exudate Color: Serosanguineous (thin, clear pink drainage); -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement (removal of tissue): Indication for debridement: Reduce devitalized tissue, decrease risk of infection, and promote wound healing; -Type of Debridement: Nonexcisional (a scalpel is not used to remove devitalized tissue); -Description of Tissue Removed: Slough. Blood Loss: None. Instrument Used: 4x4's (gauze); -Dressing Order: Cleanse wound with wound cleanser, slightly moistened collagen (protein based) pad, 4x4's gauze lightly packed, Zetuvit (an absorbent dressing for moderate to heavy exudate) plus silicone border dressing, ok to substitute with generic border gauze if unavailable; -Change Dressing: Every 24 hours; -No documentation about the resident's left lower extremity. Review of the resident's physician's orders sheet (POS) on 7/1/24 at 12:43 P.M., located in the EHR, showed: -6/5/24: Liquid protein 30 ml twice a day; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-6/5/24: One multi-vitamin with mineral daily; -6/5/24: Regular diet; -The liquid protein, multivitamin with mineral and regular diet were not ordered until 14 days after the RD's recommendations on 5/22/24; -6/9/24: Cleanse coccyx wound with full strength Dakins solution (a diluted bleach solution), pat dry, apply Medihoney in and around wound bed, gently pack with calcium alginate (absorbs exudate (wound drainage)), apply foam dressing daily and PRN; -No order dated 6/28/24 (from the wound care Physician) to cleanse the coccyx with wound cleanser, slightly moistened collagen (protein based) pad, 4x4's gauze lightly packed, Zetuvit (an absorbent dressing for moderate to heavy exudate) plus silicone border dressing, ok to substitute with generic border gauze if unavailable. Review of the resident's MAR, dated 6/1/24 through 6/30/24, showed: -6/5/24: Multivitamin with minerals daily; -6/5/24: Liquid protein 30 ml daily; -5/28/24 - 6/4/24: Cleanse coccyx with wound cleanser, apply Medihoney with bordered gauze daily; -6/4/24 - 6/9/24: Cleanse coccyx with wound cleanser, apply Medihoney with bordered gauze daily; -6/9/24 - 7/1/24: Cleanse coccyx wound with full strength Dakins solution, pat dry, apply Medihoney in and around wound bed, gently pack with calcium alginate, apply foam dressing daily and PRN; -No order dated 6/28/24 (from the wound care Physician progress notes) to cleanse the coccyx with wound cleanser, slightly moistened collagen pad, 4x4's gauze lightly packed, Zetuvit plus silicone border dressing, ok to substitute with generic border gauze if unavailable; -The resident did not have a treatment administration record (TAR). All physician orders were on the MAR. Review of the resident's MAR dated 7/1/24 through 7/31/24, showed: -7/1/24: Cleanse wound with wound cleanser, apply collagen pad and pack 4x4 in wound bed, cover with foam dressing daily. During a telephone interview on 7/10/24 at 8:10 A.M., LPN E said he/she reviewed the skin observation he/she completed on 6/26/24. He/She documented the information wrong. He/She did not mean to document the resident had a wound on the left lower extremity, only the coccyx. There was a piece of Duoderm (a cushioned/absorbent adhesive dressing) on the left lower extremity, but there was no pressure ulcer or wound underneath it. There was no order for the Duoderm. He/She thought it was there as a preventative measure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 7/1/24 at 9:07 A.M., showed the resident lay in bed for a skin assessment. Certified Nursing Assistant (CNA) C and CNA D assisted the resident onto his/her left side, showing an undressed pressure ulcer with a small amount of yellow slough on the resident's coccyx. CNA D said he/she had to remove the dressing earlier that morning when he/she cleaned the resident because it was soiled. The resident's left foot was wrapped with clean kling gauze (rolled gauze used for wrapping a dressing to a pressure ulcer/wound). There was no date on the left foot dressing. The right foot showed two dark/red circular areas on the right heel. Observation on 7/2/24 at 10:39 A.M., showed the resident lay in bed. CNA G and LPN F prepared the resident for his/her coccyx treatment. LPN F applied collagen to the pressure ulcer and covered it with a dressing. LPN F said he/she was not aware of the dark/red areas on the resident's right and left feet/heels. He/She thought the areas were caused from pressure. He/She worked yesterday and no one told him/her about the areas on the resident's feet/heels. Had he/she been made aware, he/she would have assessed the areas and called the physician. He/She did not know how long the areas had been there. There were no current treatment orders for those areas. At 10:45 A.M., the DON entered the room to assess the resident's heels/ankle. She identified the areas as pressure related. She was not aware of the areas. The CNAs should have reported any new areas to the charge nurse when they were first noted and the charge nurse should have assessed, contacted the physician and documented any new orders. LPN G measured the areas and noted the following: right outer heel 3.6 cm x 4.4 cm, right inner heel 3.4 cm x 2.7 cm, left inner ankle 3.2 cm x 0.9 cm and left heel 4.7 cm x 6.7 cm. During an interview on 7/2/24 at 11:22 A.M., LPN F said he/she worked 6/29/24 (Saturday) and did the resident's treatment. He/She did not use the treatment ordered by the wound care Physician on 6/28/24, because it had not been entered on the MAR. He/She did the previous treatment for Dakins and Medihoney that began on 6/9/24. During an interview on 7/2/24 at 11:50 A.M., CNA D said he/she worked at the facility for about a month and had taken care of the resident several times. The areas on the resident's right/left feet/heels had been there since he/she had been taking care of the resident. He/She told the nurses about the areas, but could not recall who he/she had told. During an interview on 7/2/24 at 12:00 P.M., Registered Nurse (RN) A said he/she did not usually work on the resident's hall. No one reported any pressure ulcers on the resident's feet to him/her. Had that been reported to him/her, RN A would have assessed the areas, called the physician and documented it in EHR. During an interview on 7/2/24 at 12:37 P.M., the DON said she had no idea who put the dressing on the resident's left foot that was observed on 7/1/24. She reviewed the resident's EHR and there was no documentation about the resident's heels/ankle. She was not aware the wound care Physician wrote a new order for the coccyx on 6/28/24. That treatment should have been implemented before 7/1/24. Review of the wound care Physician's progress note, dated 7/5/24, showed: -Wound Location: Coccyx; -Wound Type: Pressure Ulcer Stage 4; -Wound Status: Improving; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Pre-debridement Measurement: 5.0 cm x 5.0 cm x 1.1 cm; -Tunneling: Absent; -Undermining: Absent; -Odor: Absent; -Eschar: Absent; -Exposure: Tendon/Muscle/Ligament; -Tissue Type: Granulating; -Exudate Amount: Moderate; -Exudate Color: Serosanguineous; -Surrounding Skin: Intact; -Signs of Infection: Absent; -Debridement: In for debridement: Reduce devitalized tissue, decrease risk of infection, and promote wound healing; -Type of Debridement: Nonexcisional; -Description of Tissue Removed: Slough. Blood Loss: None. Instrument Used: 4x4's; -Dressing Order: Cleanse wound with wound cleanser, slightly moistened collagen pad, 4x4's gauze lightly packed, Zetuvit plus silicone border dressing, ok to substitute with generic border gauze if unavailable; -Change Dressing: Every 24 hours; -Wound Location: Right lateral (toward the outside) heel; -Wound Type: Pressure Unstageable; -Wound Status: First Visit; -Pre-debridement Measurement: 4.0 cm x 4.0 cm x 0.0; -Exudate Amount: None; -Surrounding Skin: Intact; -Signs of Infection: None; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Debridement: Debridement not indicated; -Dressing Order: Apply Skin Prep (a liquid that when applied to the skin forms a protective film or barrier) daily. Offloading boots (designed to alleviate pressure) at all times; -Wound Location: Right medial (toward the middle) heel; -Wound Type: Pressure Ulcer Unstageable; -Wound Status: First Visit; -Pre-debridement Measurement: 1.5 cm x 0.3 cm x 0.0; -Exudate Amount: None; -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement: Debridement not indicated; -Dressing Order: Apply Skin Prep daily. Off loading boots at all times; -Wound Location: Left medial heel; -Wound Type: Pressure Ulcer Unstageable; -Wound Status: First Visit; -Pre-debridement Measurement: 4.0 cm x 4.0 cm x 0.0; -Exudate Amount: None; -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement: Debridement not indicated; -Dressing Order: Apply Skin Prep daily. Off loading boots at all times; -Wound Location: Left medial ankle; -Wound Type: Pressure Ulcer Unstageable; -Wound Status: First Visit; -Pre-debridement Measurement: 4.0 cm x 5.0 cm x 0.0; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Exudate Amount: None; -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement: Debridement not indicated; -Dressing Order: Skin Prep daily. Off loading boots. During a telephone interview on 7/10/24 at 10:51 A.M., the Medical Director said he expected CNAs to promptly report any new pressure ulcers or areas of concerns to the charge nurse immediately. The nurse should assess the areas and contact the physician for any new orders. This should be documented on the POS, MAR and in the EHR. During a telephone interview on 7/10/24 at 11:30 A.M., the wound care Physician said he did not do a total skin assessment on the residents he saw. He only looked at what the facility had identified. If a staff member noticed a new pressure ulcer it should be communicated to the nurse and DON and they could call him for new orders. He was not aware of the pressure ulcers on the resident's feet until 7/5/24. The pressure ulcers on the resident's feet could occur anywhere from a few hours to several days. 2. Review of Resident #2's admission face sheet, located in the EHR, showed: -admitted [DATE]; -Diagnoses of Alzheimer's disease, dementia, anemia, and pressure ulcer of sacral region (the area between the lower back and the upper buttocks). Review of the resident's Baseline Care Plan, undated, showed: -Respite (short term stay); -Disease/Illness Management: Pain, weight loss, weakness and wound; -Other Special Care Instructions: Follow protocol to care for wound care: Blank. Review of the resident's Braden Scale dated 6/25/24, showed the resident had a very high risk to develop pressure ulcers. Review of the resident's progress notes, located in the EHR, showed: -6/25/24 at 3:10 P.M.: Returned by ambulance, transferred from stretcher to bed by two emergency medical staff. Alert and oriented to self. On hospice and here for respite care for 5 days. All orders verified by physician. Skin issues noted. Area on coccyx 9.0 cm x 9.0 cm with tunneling area 5.0 cm x 4.0 cm x 1.5 cm. Treatment to coccyx changed; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	-6/26/24 at 7:33 P.M. and documented by the RD: Admission on hospice services. Skin with pressure ulcer coccyx. Recommend 1) add liquid protein 30 ml twice a day. 2) Add Boost (nutritional drink) twice daily. Review of a hospice order dated 7/1/24 at 5:39 P.M., and received by the facility on 7/1/24 at 6:56 P.M. from hospice, showed: Late entry 6/26/24. Cleanse stage 4 pressure ulcer to coccyx with wound cleanser, rinse with normal saline, gently pat dry, cover with dry dressing. HSN (hospice skilled nurse) two times a week and FSN (facility skilled nurse) daily and PRN if soiled. May discontinue when wound is healed. Review of the resident's MAR dated 6/25/24 through 6/30/24, showed: -No treatment order for the coccyx, liquid protein or Boost; -The resident did not have a TAR. All physician orders were on the MAR. Review of the wound care Physician's progress note, dated 6/28/24, showed: -Wound Location: Coccyx; -Wound Type: Pressure Ulcer Stage 4; -Wound Status: First Visit; -Pre-debridement Measurement: 13.0 cm x 9.0 cm x 3.0 cm; -Tunneling: Absent; -Undermining: Absent; -Odor: Absent; -Eschar: Absent; -Exposure: Tendon/Muscle/Ligament; -Exudate Amount: Moderate; -Exudate Color: Serosanguineous; -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement: Indication for debridement: Reduce devitalized tissue, decrease risk of infection. and promote wound healing; -Type of Debridement: Nonexcisional; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265341	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pillars of North County Health & Rehab Center, The	13700 Old Halls Ferry Road Florissant, MO 63033

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	-Description of Tissue Removed: Slough. Blood Loss: None. Instrument Used: 4x4s; -Dressing Order: Cleanse wound with wound cleanser. Flagyl (antibiotic) powder. Medihoney gel. Zetuvit plus silicone border dressing, ok to substitute with generic border gauze if unavailable; -Change Dressing: Every 24 hours and as needed. Review of the resident's POS located in the EHR on 7/1/24 at 1:44 P.M., showed: -7/1/24: Cleanse wound with wound cleanser, apply Flagyl powder and Medihoney to wound bed, then cover with border gauze daily; -No order for liquid protein or Boost. Observation of the resident on 7/1/24, showed: -8:21 A.M.: The resident lay in bed sleeping on a low air loss (pressure reducing) mattress; -8:56 A.M.: The resident lay in bed. The Assistant Director of Nursing (ADON), RN A and Certified Medication Technician B turned the resident onto his/her left side. A strong foul odor was immediately noted. The resident's dressing was dated 6/29/24, and heavily saturated with drainage. The ADON said the dressing should be changed daily. She did not know why it was not changed the day before on 6/30/24. RN A packed the pressure ulcer with wet to dry 4x4s (saturated with normal saline) and covered it with a foam dressing; -2:20 P.M.: The DON said the resident did not have an treatment order in the EHR for the resident's coccyx until today. She did not know why. Review of the resident's POS located in the EHR on 7/2/24 at 9:15 A.M., showed: -An order, dated 7/1/24, five days after the RD recommendation on 6/26/24, for: Liquid protein 30 ml two times a day; -An order, dated 7/1/24, five days after the RD recommendation on 6/26/24, for: Boost two times a day with meals. During an interview on 7/2/24 at 9:38 A.M., the ADON said she spoke to hospice. Hospice said they verbally told the charge nurse on 6/26/24 about the order for the coccyx, but did not leave the order in writing. She contacted hospice and received the late entry order yesterday evening. If hospice told the admitting nurse about the treatment order for the coccyx, the admitting nurse should have entered the treatment order on the POS and MAR at that time. She was not sure what staff had been treating the pressure ulcer with or how often prior to 7/1/24. The resident was no longer at the facility on respite. He/She would be staying long term. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/2/24 at 11:22 A.M., LPN F said he/she worked on 6/29/24 and completed the resident's coccyx treatment. He/She could not find a treatment order on the POS or MAR. He/She was not aware the resident was being seen by the wound care Physician and was not aware he wrote new orders on 6/28/24. He/She used a Dakins wet to dry dressing on 6/29/24. He/She did not have a physician's order to do that. He/She had experience as a wound nurse and thought the Dakins wet to dry dressing would be best since there was no order. He/She should not have done that. He/She should have contacted the physician or hospice and gotten a treatment order. During an interview on 7/2/24 at 12:00 P.M., RN A said he/she could not find an order on the POS or MAR yesterday. RN A used a wet to dry dressing on the resident's coccyx because he/she had previously heard the hospice Nurse say that was the order. He/She should have contacted hospice or the Physician to confirm the order. He/She was not aware the wound care Physician had written a new order on 6/28/24, or he/she would have used that order. The wound care Physician sent his orders to the DON. When he/she admitted a new resident he/she assessed any pressure ulcers/wounds and contacted the physician for an order. He/She documented all of that at the time of admission and entered it on the POS and MAR. Review of the wound care Physician's progress note, dated 7/5/24, showed: -Wound Location: Coccyx; -Wound Type: Pressure Ulcer Stage 4; -Wound Status: Deteriorating; -Pre-debridement Measurement: 14.0 cm x 12.0 cm x 3.0 cm; -Tunneling: Absent; -Undermining: Absent; -Odor: Absent; -Eschar: Absent; -Exposure: Tendon/Muscle/Ligament; -Exudate Amount: Moderate; -Exudate Color: Serosanguineous; -Surrounding Skin: Intact; -Signs of Infection: None; -Debridement: Indication for debridement: Reduce devitalized tissue, decrease risk of infection, and promote wound healing; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Type of Debridement: Nonexcisional; -Description of Tissue Removed: Slough. Blood Loss: None. Instrument Used: 4x4s; -Dressing Order: Cleanse wound with wound cleanser. Flagyl powder (antibiotic). Dakins moistened gauze dressing; -Change Dressing: Every 72 hours. During a telephone interview on 7/10/24 at 10:51 A.M., the Medical Director said it was the facility's responsibility to ensure a newly admitted resident with a pressure ulcer had an order in place upon admission. Someone between the resident's admitted and 7/1/24 should have noticed there was not a treatment order and contacted him, the wound care Physician or hospice for an order. Nurses should not administer any treatment without a physician's order. During a telephone interview on 7/10/24 at 11:30 A.M., the wound care Physician said he did not feel the resident's pressure ulcer would ever heal due to the resident's declining condition. He ordered the Flagyl to help with the odor. 3. During an interview on 7/2/24 at 12:37 P.M., the DON said the facility wound care policies were current and should be followed. The wound care Physician typically made rounds on Fridays. A facility nurse made rounds with the wound care Physician but not always. The wound care Physician would normally tell the nurses if there were any new orders. He sent copies of any order changes via e-mail to her, the ADON and Administrator by Monday the following week. She realized his treatment orders needed to be implemented the same day he wrote the orders. They would start making sure a nurse made rounds with the wound care Physician going forward to ensure any new treatment orders were implemented the day he made rounds. The RD sent her recommendations to her, the ADON and the Dietary Manager the day she was in the building or no later than the next day after she left. They should have any new recommendations followed up on within 72 hours after the RD's recommendations. She was not sure why that had not been done consistently. 4. During a telephone interview on 7/10/24 at 10:51 A.M., the facility Medical Director said the facility should follow their pressure ulcer and wound policies. The RD recommendations should be called to him within a day after she wrote the recommendations. 72 hours was too long to wait. The wound care Physician's orders should be implemented at the time he wrote the orders. It should not take three days to implement the orders. 5. During a telephone interview on 7/10 24 at 11:30 A.M., the wound care Physician said he typically made rounds on Fridays and sometimes on the weekend if he was behind. After he rounded he always told the nurse on duty if there were any new treatment orders. He expected the orders to be changed at that time. He also followed up by e-mailing any orders to the Administrator, DON and ADON. MO00238085