STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335489	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningstar Residential Care Center	17 Sunrise Terrace Oswego, NY 13126

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 - 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** 34465 Based on observation, record review and interview during the abbreviated survey (NY00347901), the facility did not ensure residents with pressure ulcers or at risk of pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 3 residents (Residents #1 and 3) reviewed. Specifically: -Resident #1 developed new pressure ulcers and there was no documented evidence that recommended treatment orders obtained or implemented timely and no documented evidence diagnostic tests were ordered or obtained timely. -Resident #2 developed a Stage 3 pressure ulcer on their coccyx and there was no documented evidence the registered dietitian reassessed the resident's nutritional needs. Additionally, the resident had a significant weight loss and there was no documented evidence the registered dietitian was made aware to reassess. Findings include: The facility's policy Weights, effective ,d+[DATE] documented residents were weighed upon admission, weekly for 4 weeks after admission, readmission and monthly thereafter to establish a weight patter and monitor for changes. Re-weights were to be obtained for any discrepancies, the Interdisciplinary Team reviewed possible causes of weight change and initiated appropriate interventions, and weight loss or gain of 5% in one month and/or 10% in 6 months must be reported to the registered dietitian, physician, and Minimum Data Set coordinators to review for possible significant change in status. The facility's policy Medication: Physicians Orders Management, revised [DATE] documented outside consultants wrote their orders and details of their visit on a consultation form or in their company documentation format. Outside consultants' documentation and orders would be scanned or uploaded into the resident's medical record. The orders and visit description would be reviewed by the resident's primary care provider, orders would be implemented and written by an in-house provider as deemed appropriate. 1) Resident #1 had diagnoses including dementia. The [DATE] Minimum Data Set Assessment documented the resident's cognition was moderately impaired, they required substantial/maximal assistance with rolling left to right, they were dependent for chair/bed-to-chair transfers, and they had no unhealed pressure ulcers. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] Comprehensive Care Plan documented the resident was at risk for skin breakdown related to immobility, deconditioning and incontinence. Interventions included keep skin clean and dry, pressure relieving device in wheelchair and on bed, and skin team to monitor weekly. The [DATE] at 5:24 PM Licensed Practical Nurse #4 Manager note documented the resident had a wound to the left buttocks that was 4 centimeters x 4.3 centimeters and the resident also had multiple unmeasurable sores to the right side of buttocks. The registered nurse assessed, and orders were obtained. The [DATE] physician orders documented to cleanse left side of buttock with normal saline, apply normal saline to wound bed and cover with Allevyn (silicone dressing). To the right side of buttocks, apply Desitin (protective barrier cream) three times daily for wound. The [DATE] Wound Physician #2 note documented the resident had left buttock moisture associated skin damage (skin problem that occurs from repeated exposure to bodily fluids) that was 4 centimeters x 11 centimeters by 0.2 centimeters. The plan was to use calcium alginate (wound treatment) with a bordered dressing daily. The [DATE] physician order documented to left side of buttock, cleanse with normal saline, apply calcium alginate to wound bed and cover with a 4 x 4 bordered dressing daily. The [DATE] updated Comprehensive Care Plan documented the resident had a wound to the left buttock. Interventions included treatments as ordered, monitor that dressing was intact, and obtain and monitor lab work and diagnostics as needed. The [DATE] Wound Physician #2 note documented the resident had a Stage 3 (full thickness loss of tissue) sacral (triangular bone in the lower back between two hipbones of the pelvis) ulcer that was 4 centimeters x 5 centimeters x 0.2 centimeters and was 30% necrotic (non-viable tissue). The plan was to use calcium alginate and Medihoney (wound treatment) covered with a foam silicone bordered dressing daily. The [DATE] physician order documented to left buttock, apply Medihoney and calcium alginate to wound bed and cover with a foam dressing daily. There was no documented evidence the treatment order was updated to apply to the sacral ulcer as documented in the wound physician note. The [DATE] at 1:35 PM Wound Physician #2 note documented the resident had: -an Unstageable sacral ulcer that was 4 centimeters x 2.5 centimeters x 0.2 centimeters. The plan was to continue calcium alginate and Medihoney covered with a foam silicone bordered dressing daily. -a Deep Tissue Injury (injury of underlying soft tissue from pressure or shear) on the left ischium (lower bone of the pelvis) that was 4 centimeters x 4 centimeters and was intact with purple discoloration. The plan was for hydrocolloidal paste (wound treatment) every shift. -a Deep Tissue Injury of the right ischium that was 6 centimeters x 2 centimeters and was intact with purple discoloration. The plan was to use hydrocolloid paste every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] physician orders documented to left buttock, apply Medihoney and calcium alginate to wound bed and cover with a foam dressing daily. There was no documented evidence of an order for hydrocolloid paste every shift to left and right ischiums as recommended by the wound physician. The resident's previous order for Desitin to the right side of the buttocks continued three times daily as ordered on [DATE]. The [DATE] Attending Physician #3 note documented the resident's white blood cell count (potential indicator of infection) was up a bit. The resident was followed by wound care for a very significant sacral ulcer. No changes were made today. The [DATE] at 1:35 PM Wound Physician #2 note documented the resident had: -an Unstageable sacral ulcer that was 4 centimeters x 2 centimeters x 0.2 centimeters. The wound had 100% slough (non-viable tissue). The plan was to change the treatment to Santyl (wound treatment used to remove damaged skin), use a gauze sponge dressing moistened with saline and cover with a foam silicone bordered dressing daily. -an Unstageable left ischium ulcer that was 5 centimeters x 7 centimeters x 0.2 centimeters. The wound was 50% necrotic, 50% slough. The plan was to change to Santyl, use a gauze sponge soaked in saline and cover with a bordered dressing daily. -an Unstageable right ischium ulcer that was 3 centimeters x 6 centimeters x 0.2 centimeters. The wound was 100% necrotic. The plan was to continue hydrocolloid paste every shift, and add Santyl with saline soaked gauze pad daily, There was no documented evidence the resident's sacral ulcer treatment was changed from Medihoney/calcium alginate to Santyl as recommended by the wound physician and there was no documented evidence of a treatment order for the right and left ischium's as recommended. The [DATE] at 7:22 PM Registered Nurse #5 note documented they spoke with the on-call provider as the resident had a temperature of 101.6 and were lethargic. They observed the resident's sacral wound with purulent (pus) drainage. New orders were obtained for doxycycline (antibiotic) 100 milligrams twice daily for 7 days. Wound culture and labs ordered. The [DATE] physician order documented doxycycline 100 milligrams twice daily for 7 days and obtain wound culture from sacral wound bed. There was no corresponding provider note. There was no documented evidence a wound culture was obtained. The [DATE] Wound Physician #2 note documented the resident had: -an Unstageable sacral ulcer that was 2.6 centimeters x 2.7 centimeters x 0.2 centimeters. The plan was to continue Santyl. -an Unstageable left ischium ulcer that was 4.5 centimeters x 9.3 centimeters x 0.2 centimeters. Continue Santyl. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-an Unstageable right ischium ulcer that was 8 centimeters x 4.6 centimeters x 0.2 centimeters. The wound was 100% necrotic with undermining (tissue beneath the visible edges of ulcer erodes, creating pockets between skin and underlying tissue) of 2.4 centimeters at 5 o'clock. The plan was to continue hydrocolloid paste every shift along with Santyl. The ,d+[DATE] to [DATE] Medication Administration Record documented calcium alginate and Medihoney were applied to the resident's left buttock daily. The Treatment Administration Record did not document a treatment to the resident's left and right ischium's. The [DATE] Nurse Practitioner #6 note documented both resident's buttocks ulcers and the coccyx (tailbone) ulcer continued to worsen, and their wounds were noted with tunneling (a wound that had progressed to form passageways underneath the skin surface), black eschar (non-viable tissue) and foul odor (potential indicator of infection). The resident was moaning in pain anytime they were positioned, and they only had Tylenol as needed for pain. The [DATE] physician order documented Tramadol (narcotic pain medications) 50 milligrams two times daily. The [DATE] at 10:22 AM Wound Physician #2 note documented the resident had: -an Unstageable sacral ulcer that was 4 centimeters x 2 centimeters x 0.2 centimeters. Continue Santyl. -a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) to left ischium ulcer that was 5 centimeters x 10 centimeters x 3 centimeters. The wound was previously Unstageable and after debridement, revealed itself to be Stage 4. Continue Santyl. -a Stage 4 right ischium ulcer that was 9 centimeters x 5 centimeters x 2 centimeters. The wound was previously unstageable and after debridement, revealed itself to be a Stage 4. Continue hydrocolloid paste every shift and continue Santyl. The note documented they recommended a complete blood count (blood test, provides information about blood cells including infection), erythrocyte sedimentation rate (blood test, shows inflammation or cell damage), C-reactive protein (blood test, shows inflammation or infection), x-ray both ischial wounds to assess osteomyelitis (serious bone infection) due to depth of wounds and significant short-term worsening of wounds. The [DATE] physician order documented to both buttock wounds, apply Santyl, wet to dry dressing with normal saline, pack kerlix (dressing) in wounds and cover with a bordered dressing daily. There was no documented evidence of a treatment order for the resident's sacral ulcer and no documented evidence the lab tests or x-rays recommended by the wound physician were ordered or obtained. The [DATE] Nurse Practitioner #6 note documented resident had increased pain when moving and when wound care was done to wounds on buttocks. Pain was not controlled on tramadol. The resident was started on Hydrocodone (strong narcotic pain reliever) with better results. The [DATE] Medical Records Clerk #10 note documented the resident was sent to the hospital. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] hospital discharge instructions documented the resident had osteomyelitis in both ischium's and sepsis (life-threatening complication of infection). The resident's family initially wanted a feeding tube (tube that delivers nutrition) but decided to make them comfort measures. To both buttock wounds, apply Santyl to bed of wounds then apply Amerigel (barrier ointment) and loosely pack wounds with Aquacel AG (wound treatment). To sacral wound, apply Amerigel and loosely pack with Aquacel AG. For superficial sacral wounds cleanse then apply Amerigel. Cover all 4 wounds with Allevyn. Zinc (protective ointment) to skin surrounding wounds. The [DATE] at 9:45 PM note documented comfort care continued, the resident was restless and displaying air hunger. Roxanol (strong narcotic medication) given with effect. The [DATE] at 10:54 AM Licensed Practical Nurse #7 documented the resident expired at 9:45 AM. During a telephone interview on [DATE] at 9:58 AM, Wound Physician #2 stated during wound rounds, staff knew what recommendation they made because they discussed the recommendations during wound rounds with the wound team including Licensed Practical Nurse Manager #4. They could not write their own orders. On [DATE], the resident's orders should have been changed to the sacrum because the location of the wound changed. They were not aware orders were not updated. The ischium's were located near the folds under the buttock cheeks and were not near the sacrum. When they recommended hydrocolloid paste on [DATE], they were not aware an order was not obtained and should have been. Treatments were implemented to slow or delay the deterioration of the resident's skin. The resident was not eating or drinking, their body was breaking down and the resident was actively dying. On [DATE], they ordered Santyl which was usually used to improve a wound. The resident's family was not on the same page about end-of-life care and why they went ahead and ordered Santyl. They changed the treatment order for the ischium ulcers to Santyl because hydrocolloid paste was for intact skin and those wounds were no longer intact. They were not aware calcium alginate/Medihoney continued to the sacrum and not aware there continued to be no treatment to the resident's ischium's. On [DATE], they documented the resident had undermining of skin which was like a cave formation where the under tissue had died and fallen away. It was a marker of a wound worsening. On [DATE], when the facility ordered treatment to the right and left buttocks, those dressings would not have covered the sacral wound and expected a separate order for the sacrum. They were not aware there was no treatment order to the sacrum. It was not timely when it took 3 weeks for an ordered treatment to be obtained to the resident's ischial wounds. When they documented recommended labs and x-rays for the resident, they were aware they were not obtained because to their understanding, the family wanted comfort care and end of life goals. When the resident was hospitalized and diagnosed with sepsis and osteomyelitis, they stated the resident's wounds would not have been the cause of sepsis because the wounds were open and draining. The resident was in such a state of decline and treatments would have slowed the progression but would not have cured them. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 11:21 AM, Licensed Practical Nurse Manager #4 stated themself and the Interdisciplinary Team were responsible to review consultant recommendations. Wound Physician #2 gave them orders during wound rounds, and they entered them into the resident's electronic record. They were not required to confirm the order with a facility provider. The wound physician communicated with providers and if they disagreed with the order, the provider would change it. During the interview, Licensed Practical Nurse #4 verified the order on the Treatment Administration Record was to the left buttock and not the sacrum as Wound Physician #2 documented on [DATE]. A treatment order should have been obtained for the resident's right and left ischium ulcers and if an order was not obtained then ulcers could possibly worsen. It was not timely when the resident went 3 weeks without orders to their ischium's. On [DATE], there was a shortage of Santyl, it was not available, and they thought they discussed that with Wound Physician #2. That was why the resident's calcium alginate and Medihoney order continued. On [DATE], they recalled the on-call provider ordered a wound culture and another provider (could not recall who) discontinued the order. They stated if the wound culture was obtained, the results would have been in the record. On [DATE], they were not sure why labs and x-rays were not obtained as recommended by Wound Physician #2. They also were not sure why there was no ordered treatment to the resident's sacrum on [DATE]. During a telephone interview on [DATE] at 1:37 PM, the Director of Nursing stated the manager for the unit was usually responsible to review consult recommendations and communicate the recommendations to the provider to get them implemented. Wound Physician #2's recommendations should be communicated to the providers however they had providers who said Wound Physician #2's orders should be implemented without contacting them. On [DATE], they expected a treatment order to have been obtained to the resident's ischium's. On [DATE], treatment orders should have been changed to Santyl per Wound Physician #2's recommendations. On [DATE], there should have been documentation because the resident's wound culture was not obtained. On [DATE], the labs and diagnostic tests recommended by Wound Physician #2 should have been obtained. Additionally, there should have been treatment orders on [DATE] for all 3 of the resident's wounds. It was not timely when it took 3 weeks to obtain orders to the resident's ischium wounds. 2) Resident #3 had diagnoses including dementia and protein calorie malnutrition. The [DATE] Admission Minimum Data Set assessment documented the resident's cognition was severely impaired, they required partial/moderate assistance with rolling left and right and they required substantial/maximal assistance with transfers. The resident had no unhealed pressure ulcers. The [DATE] Comprehensive Care Plan documented the resident had a nutritional problem related to need for a therapeutic diet and mechanically altered diet, and the resident was at risk for skin breakdown. Interventions included to monitor, document, and report to provider the signs and symptoms of emaciation (muscle wasting, significant weight loss 3 pounds in 1 week, over 5% in 1 month, over 7.5 % in 3 months, or over 10% in 6 months), keep skin clean and dry, monitor for skin discoloration, open areas, and report to nurse. The [DATE] physician order documented Calmoseptine (protective skin treatment) ointment to buttocks every shift for prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] at 11:35 AM nutritional assessment completed by Registered Dietitian #9 documented the resident's diet was no added salt, ground consistency, and nectar thickened fluids. Supplements included Boost 120 milliliters three times daily, fortified mashed potatoes at lunch, and chocolate milk at all meals. Intakes averaged ,d+[DATE]%. No significant weight changes noted. The registered dietitian remained available and would follow up. The [DATE] Wound Physician #2 note documented the resident had a new Stage 3 pressure ulcer on their sacrum that was 3 centimeters x 2.5 centimeters x 0.2 centimeters with moderate serous drainage and 100% granulation tissue. The plan was to use calcium alginate and Medihoney covered with bordered dressing daily. The [DATE] physician order documented cleanse coccyx with wound cleanser, apply Medihoney and calcium alginate to wound and cover with Allevyn (dressing). The [DATE] Weight and Vitals Summary documented the resident weighed 111.8 pounds (5.4% loss, previously 118.2 pounds on [DATE]). There was no documented evidence the resident's nutritional needs were reassessed timely after they developed a Stage 3 pressure ulcer and after they had a 5.4% weight loss. The [DATE] Comprehensive Care Plan documented the resident had impaired skin integrity related to a Stage 3 pressure ulcer. Interventions included monitor nutritional status, diet as ordered, monitor intake and record. Dietary consults as needed. During a wound observation on [DATE] at 11:48 AM with Wound Physician #2 and Licensed Practical Nurse Manager #1, the resident was lying on their back in bed and the alternating air mattress was on and functioning. The resident was rolled to the left, no dressing was in place on the sacrum. The wound was approximately 1 centimeter x 1 centimeter x 0.1 centimeters with granulation tissue. Per Licensed Practical Nurse Manager #1, the dressing was removed just prior to the wound physician evaluation. Licensed Practical Nurse Manager #1 cleansed the wound, placed Medihoney and calcium alginate cut to size into the wound bed and covered with a bordered dressing. During a telephone interview on [DATE] at 10:16 AM, Licensed Practical Nurse Manager #1 stated when a resident had weight loss, nursing was responsible to update the registered dietitian. The registered dietitian also had access to weights in the medical records. When a resident developed a new pressure ulcer, the registered dietitian would be notified. For weight loss and pressure ulcers, the registered dietitian typically assessed within 1 week. They were not sure if the registered dietitian was notified of the resident's weight loss or new pressure ulcer, and they should have been notified and it was not done timely. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 12:57 PM, Registered Dietitian #9 they stated if a resident lost weight they became notified during the high-risk meeting held every week. If a resident had a significant weight loss of 5 or more pounds, the unit Manager notified them. They would then assess the resident, write a note, and possibly add more calories and protein. They typically assessed weight loss as soon as they were notified. The unit Manager was also responsible to notify them of new wounds. They would assess as soon as they were notified, write a note, and possibly add interventions. They first became aware the resident had a new pressure ulcer around [DATE] when they did their assessment. The resident was already on several supplements however they switched one of the supplements for 2 Cal which was higher in protein and calories. They stated they should have been notified sooner for assessment and their assessment was not timely. They stated they addressed the resident's weight loss in their [DATE] note, they could not recall if they were notified, and the assessment was not done timely. During a telephone interview on [DATE] at 1:37 PM, the Director of Nursing stated nursing should be looking at weights when they were obtained and if significant loss was noted, nursing should notify the registered dietitian. Nursing should also notify the registered dietitian for new pressure ulcers. They expected the registered dietitian to assess weight loss in 2 weeks and new pressure ulcers within a couple of days. They were not aware Registered Dietitian #9's assessment for weight loss took 11 days and that was not timely. When it took Registered Dietitian #9 two and a half weeks to reassess the resident's nutritional needs after they developed a new pressure ulcer, it was not done timely. 10NYCRR 415.12(c)(1)