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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure wound care treatments and skin assessments were completed and documented for one sampled resident (Resident #3) out of five sampled residents. The facility census was 55 residents. Review of the facility's policy titled "Non-Pressure Ulcer Assessment and Treatment" dated from 2006 showed: -The purpose of the policy was to maintain skin integrity and prevent any type of wound development. -All non-pressure ulcers would be assessed and documented weekly using the provided form. -All residents would be assessed every thirty days for skin integrity. -All non-pressure wounds would be treated according to physician order. -Skin screenings were done according to bath schedule. -Assessment weekly/monthly or more frequent would occur as instructed by the Registered Nurse (RN) or Director of Nursing (DON). -A focused assessment should be completed of the wound area.	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natasha Travis LPNA | TITLE: Administrator | (X6) DATE: 5/12/25

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.

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-Communicate among shifts of progress and healing.
-Provide treatment per physician order not limited to pain or infection.

1. Review of Resident #3's Admission Record showed he/she admitted to the facility with the following diagnoses:
-Cerebral Palsy (a group of conditions that affect movement and posture caused by damage that occurs to the developing brain, most often before birth).
-Peripheral Vascular Disease (PVD- inadequate blood flow to the extremities).

Review of the resident's undated care plan showed:
-He/She had limited physical mobility related to his/her diagnosis of cerebral palsy.
-He/She had PVD with the following interventions:
--The resident was to wear bunny boots (a protective boot for foot wounds designed to offload pressure).
--Monitor the extremities for signs and symptoms of injury, infection or ulcers.

Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by staff for care planning) dated 2/24/25 showed:
-The resident was cognitively intact.
-The resident had a Stage I (intact skin with non-blanchable redness of a localized area usually over a bony prominence) or great, a scar over a bony prominence, or non-removable dressing/device.
-The resident did not have any pressure ulcers with the seven day look back period.
-The resident did not have any current venous

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ulcers (a wound on the leg or ankle caused by abnormal or damaged veins).

Review of the resident's Physician Order Sheet (POS) dated March 2025 showed:
-An order for skin gel protective (an invisible skin protectant gel that moisturizes and protects while the skin is recovering), apply topically to his/her right great toe two times a day.
-An order for staff to clean the resident's right foot with water and soap, apply vitamin A and D ointment (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) and zinc ointment (ointment containing zinc oxide, used for various skin conditions) to areas on his/her right great toe and third toe daily dated 3/10/25.
-An order for staff to clean bilateral lower extremities with water and soap, apply Vitamin A and D ointment, two times a day.
-An order for staff to apply Calmoseptine to the resident's open areas on his/her right leg daily.

Review of the resident's Treatment Administration Record (TAR) dated March 2025 showed:
-The resident missed or lacked documentation of seven treatments of the skin gel protective during the 7:00 A.M. to 3:00 P.M. shift through the month of March 2025.
-The resident missed or lacked documentation of his/her right great toe and third toe treatments eight times from 3/10/25 through 3/31/25.
-The resident missed or lacked documentation of his/her bilateral lower extremities treatment seven times during the 7:00 A.M. to 3:00 P.M. shift through the month of March 2025.
-The resident missed or lacked documentation of his/her bilateral lower extremities treatment ten times during the 3:00 P.M. to 11:00 P.M. shift

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through the month of March 2025.
-The resident missed or lacked documentation of his/her right leg treatment 15 times through the month of March 2025.

Review of the resident's POS dated April 2025 showed an order for skin gel protective (an invisible skin protectant gel that moisturizes and protects while the skin is recovering), apply topically to his/her right great toe two times a day.

Review of the resident's TAR dated April 2025 showed the resident missed or lacked documentation of 12 right great toe treatments during the 3:00 P.M. shift to 11:00 P.M. shift from 4/1/25-4/20/25.

Review of the resident's weekly skin assessment on 4/21/25 for the month of April 2025 showed the resident's last skin assessment was 4/10/25.

During an interview on 4/21/25 at 12:37 P.M. Licensed Practical Nurse (LPN) A said:
-The resident's open wounds had healed, so the facility's contracted wound care team had stopped seeing the resident.
-It was identified the resident's previous heel wound had opened back up.
-The resident was to start seeing the contracted wound care team at the facility later in the week due to his/her heel wound opening back up.

During an interview on 4/21/25 at 2:47 P.M. Certified Nursing Assistant (CNA) A said:
-Resident skin was checked by CNAs during resident showers.
-If CNAs were to find any new skin issues, they were responsible for telling the nurse on duty immediately.

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-The resident had chronic wounds to his/her feet.
-The resident had a history of heel wounds, so the resident wore heel protectant boots.
-The resident's heel wound had re-opened.

During an interview on 4/21/25 at 3:20 P.M. LPN A said:
-Residents skin assessments were in a separate binder from the resident's regular medical chart.
-Skin assessments were completed weekly by the facility nurses.
-There was a skin assessment schedule in the skin assessment binder.
-The nurses were expected to document the skin assessments upon completion of the assessment.
-The nurses were expected to perform treatments as ordered by the physician.
-The Director of Nursing (DON) was responsible for ensuring the completion of treatments.
-He/She was unsure why the other shifts were not getting wound treatments done.
-He/She thought that treatments were getting done and not getting documented.
-The nurses were expected to document the completion of each treatment.

During an interview on 4/22/25 at 8:46 A.M. the DON said:
-Skins assessments were completed weekly.
-There was a schedule that was in the skin assessment binder that staff were expected to follow in order to get the assessments completed.
-He/She was responsible for ensuring completion of the skin assessments.
-Treatments should be done as ordered.
-The nursing staff tell him/her that the treatments are getting completed, the nursing staff are just not documenting the completion of the

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F 684	Continued From page 5 treatments. -He/She expected staff to document on the TAR when treatments were completed. -The nursing staff should have been documenting all of the resident ' s wound treatments. -Resident #3 should have had an additional skin assessment completed between 4/10/25-4/21/25. During an interview on 4/24/25 at 1:04 P.M. LPN B said: -He/She worked the 3:00 P.M. to 11:00 P.M. shift. -Treatments were supposed to be documented on resident TARs upon completion of the treatment. -He/She had too much work to do on his/her shift and he/she did not have time to document treatments. -The residents did get their treatments on the days he/she worked at the facility. -The DON was responsible for ensuring treatments were documented on resident TARs. -The resident should have had an additional skin assessment completed between 4/10/25-4/21/25. -He/She only treated the resident's wounds when the resident had open wounds. -The resident had refused some treatments in the past. -If a resident refused any treatment, it should be documented on the TAR. -The resident only had redness on his/her feet and buttocks.	F 684		
F 686 SS=D	MO00252072 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that wound care treatments were completed and documented including weekly wound tracking and measuring was completed for one sampled resident (Resident #2) who had pressure ulcers (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin); and failed to ensure weekly skin assessments were completed and documented for one sampled resident (Resident #1) out of five sampled residents. The facility census was 55 residents.

Review of the facility's policy titled "Pressure Ulcer Treatment Policy and Procedure" dated from 2006 showed:
-Staff were to assess pressure ulcers by using the wound assessment form weekly and for any change in condition.
-The staff were to use appropriate topical therapy per physician order or recommendation from wound care specialists.
-The staff were to monitor skin surfaces daily and document on the appropriate form.

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Review of the facility's policy titled "Ulcer Documentation" dated from 2006 showed:
-After assessing a wound, proper documentation was necessary for medical, legal, and reimbursement reasons.
-The documentation was to include:
--The resident's name and date of assessment or treatment.
--Vital signs if applicable.
--If the dressings were intact or not.
--Locations of wound.
--Size of wound.
--Any tracking or undermining of the wound.
--Any wound drainage or odor.
--What the wound tissue looked like.
--The stage of the pressure ulcer.
--Past treatment and current treatment.
--Any follow-up needed.

1. Review of Resident #2's admission record showed he/she admitted to the facility on 3/12/25 with the following diagnoses:
-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses).
-Diabetes Mellitus (DMII- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).
-Essential Hypertension (high blood pressure).

Review of the resident's Physician Order Sheet (POS) dated March 2025 showed an order for the resident to be admitted to hospice (end of life care) on 3/23/25.

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Review of the resident's skilled nursing visit note from hospice dated 3/23/25 showed:
-The resident had a left medial buttock/gluteal fold Stage III (a full thickness tissue loss. Subcutaneous fat may be visible but, bone, tendon, or muscle is not exposed. Slough may be present but dies not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcer which measured two and a half centimeters (cm) in length, two cm in width, and one cm in depth.
-The resident had a right arm/elbow Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister)which measured four cm in length and one cm in width.
-The resident had a right arm/elbow unstageable (slough and/or eschar, known but not stageable due to coverage of wound bed by slough and/or eschar)pressure ulcer which measured two cm in length and two cm in width.
-The resident had a right proximal arm/forearm Stage II pressure ulcer which measured four cm in length and one cm in width.

Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 3/25/25 showed:
-The resident was severely cognitively impaired.
-The resident had one or more unhealed pressure ulcers at Stage I (intact skin with non-blanchable redness of a localized area usually over a bony prominence) or higher.
-The resident had four Stage II.
-The resident had one Stage III

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-The resident had one unstageable pressure ulcer.
-The resident was receiving hospice care.

Review of the resident's hospice visit note dated 4/2/25 showed:
-The resident's right upper arm wound appeared to be a Stage III pressure ulcer.
-The resident had two left ischial wounds which were improving.
-The resident had a coccyx wound which was improving.
-The resident had right forearm wounds that were improving.
-No wound measurements were documented in this note.

Review of the resident's care plan dated 4/8/25 showed:
-The resident had a pressure ulcer to the left ischium (a paired bone forming the lower and back part of the hip bone) with the following interventions:
--Staff were to administer treatments as ordered and to monitor effectiveness.
--Staff were to assess/record/monitor wound healing weekly.
--Staff were to measure the length, width, and depth where possible.
--Report improvements and declines to the Medical Director.

Review of the resident's POS dated April 2025 showed:
-An order for Calmoseptine (primarily used as a moisture barrier to protect and heal skin irritations) to be used on his/her right arm open areas, daily, every shift with an order stop date of 4/11/25.

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-An order for betadine (rapidly kills bacteria commonly responsible for wound and skin infections) to be used on the left hip, daily, every shift.

Review of the resident's Treatment Administration Record (TAR) dated April 2025 showed:
-The resident missed or lacked documentation for one treatment of Calmoseptine from 4/1/25-4/11/25 on the 7:00 A.M. to 3:00 P.M. shift.
-The resident missed or lacked documentation for nine treatments of the Calmoseptine from 4/1/25-4/11/25 on the 3:00 P.M. to 11:00 P.M. shift.
-The resident missed or lacked documentation of seven treatments of the Calmoseptine from 4/1/25-4/11/25 on the 11:00 P.M. to 7:00 A.M. shift.
-The resident missed or lacked documentation of two treatments of the betadine from 4/1/25-4/21/25 on the 7:00 A.M. to 3:00 P.M. shift.
-The resident missed or lacked documentation of 17 treatments of the betadine from 4/1/25-4/20/25 on the 3:00 P.M. to 11:00 P.M. shift.
-The resident missed or lacked documentation of nine treatments of the betadine from 4/1/25-4/20/25 on the 11:00 P.M. to 7:00 A.M. shift.
-On 4/9/25 the resident's four arm wounds were measured.
NOTE: The measurements on 4/9/25 were the only measurements found in the resident's medical record documented by the facility.

2. Review of Resident #1's Admission Record showed the resident admitted to the facility on 3/28/25 with the following diagnoses:
-Diabetes Mellitus (DMII- a complex disorder or

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carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).
-Acquired Absence of Other Right Toes.
-Acquired Deformities of Toes, Unspecified Foot.
-Fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia).
- Rheumatoid Arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet).

Review of the resident's admission MDS dated 4/10/25 showed:
-The resident was cognitively intact.
-The resident was at risk for developing pressure ulcers.
-The resident had a Stage I or greater, a scar over bony prominence, or non-removable dressing/device.
-The resident had one Stage III pressure ulcer that was present upon admission to the facility.

Review of the resident's undated care plan showed the resident did not have a care plan focus for skin impairment.

Review of the resident's wound report assessment completed by the facility's contracted wound company on 4/4/25 showed the resident had an open pressure wound on his/her coccyx.

Review of the resident's weekly skin assessment form on 4/21/25 for the month of April 2025 showed the resident had not had a full body skin assessment sine 4/9/25.

3. During an interview on 4/21/25 at 12:37 P.M.

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Licensed Practical Nurse (LPN) A said Resident #2 was unable to see the facility's contracted wound care team due to the resident receiving hospice services.

During an interview on 4/21/25 at 2:00 P.M. LPN A said the back of resident TARs was the place nurses were to document wound measurements.

During an interview on 4/21/25 at 2:47 P.M. Certified Nursing Assistant (CNA) A said:
-Resident #2 had his/her wounds upon admission to the facility.
-Resident #2 had a tendency to pick at the treatments that were done to the wounds on his/her arm.
-Resident's skin was checked by CNAs during resident showers.
-If CNAs were to find any new skin issues, they were responsible for telling the nurse on duty immediately.
-Any resident with wounds should have a wound care focus on their care plan.

During an interview on 4/21/25 at 3:20 P.M. LPN A said:
-Resident skin assessments were in a separate binder from the resident's regular medical chart.
-Skin assessments were completed weekly by the facility nurses.
-There was a skin assessment schedule in the skin assessment binder.
-The nurses were expected to document the skin assessments upon completion of the assessment.
-Wound measurements were completed weekly.
-The hospice company was responsible for measuring the Resident #2's wounds weekly.
-Resident #2's wounds were improving, and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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some were almost healed.
-The nurses were expected to perform treatments as ordered by the physician.
-The Director of Nursing (DON) was responsible for ensuring the completion of treatments.
-He/She was unsure why the other shifts were not getting wound treatments done.
-He/She thought that treatments were getting done and not getting documented.
-The nurses were expected to document the completion of each treatment.

During an interview on 4/22/25 at 8:46 A.M. the DON said:
-Skins assessments were completed weekly.
-There was a schedule that was in the skin assessment binder that staff were expected to follow in order to get the assessments completed.
-He/She was responsible for ensuring completion of the skin assessments.
-He/She expected weekly wound measurements to be completed for all identified wounds in the building.
-The contracted wound care team was responsible for measuring the wounds.
-The nurses were expected to document the weekly measurements on the resident's TARs.
-Resident #2's TAR should have more than just the one weekly measurement on his/her TAR.
-Daily documentation of the wounds should be completed with wound type and response to treatment.
-He/She was aware that the daily wound documentation was not getting completed.
-Resident #2 did not have any pressure ulcers.
-Resident #2's wound on his/her bottom was almost healed.
-He/She was unsure of what type of wounds Resident #2 had.

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	265769	A. BUILDING _____ B. WING _____	C 04/22/2025

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-Treatments should be done as ordered.
-Resident #2 was unable to see the contracted wound team due to being on hospice, so the hospice company managed the Resident #2's wounds.
-The facility should also be measuring Resident #2's wounds, not just hospice.
-The nursing staff tell him/her that the treatments are getting completed, the nursing staff are just not documenting the completion of the treatments.
-He/She expected staff to document on the TAR when treatments were completed.
-The nursing staff should have been documenting all of the resident's wound treatments.
-Resident #1 did not have a skin/wound care plan because he/she had not created one yet.
-Resident #1 should have had an additional skin assessment completed between 4/9/25-4/21/25.

During an interview on 4/24/25 at 1:04 P.M. LPN B said:
-He/She worked the 3:00 P.M. to 11:00 P.M. shift.
-Treatments were supposed to be documented on resident TARs upon completion of the treatment.
-He/She had too much work to do on his/her shift and he/she did not have time to document treatments.
-The residents did get their treatments on the days he/she worked at the facility.
-Resident #2's wounds were healing.
-He/She was unsure if Resident #2's hospice nurse completed weekly wound measurements.
-Weekly measurements were completed for all wounds in the facility.
-The contracted wound care team usually came to the facility during the 7:00 A.M. to 3:00 P.M. shift, so he/she did not normally have to measure

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F 686	Continued From page 15 wounds. -All wound measurements could be found in the wound book. -The DON was responsible for ensuring the weekly measurements were completed. -The DON was responsible for ensuring treatments were documented on resident TARs. -Resident #1 should have had an additional skin assessment completed between 4/9/25-4/21/25. -Resident #1 should have a wound/skin focus on his/her care plan.	F 686		
F 689 SS=D	MO00252072 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure fall investigations were complete and thorough to include root-cause analysis (RCA- a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems) for three sampled residents (Resident #1, Resident #4, and Resident #5) out of five sampled residents. The facility census was 55 residents. Review of the facility's policy titled "Policy and	F 689		

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Procedures for Fall Investigation" dated from 2006 showed:
-Licensed nurses perform an assessment within a time frame appropriate to the clinical circumstance, right after a fall has occurred and coordinate other indicated evaluation and management of injuries or underlying causative conditions.
-Licensed nurses completed the fall investigation upon each fall on the provided form.
-The safety committee reviewed the fall incident and would make a referral by physical therapy (PT)/ occupational therapy (OT) or enrolled the resident into restorative program upon approval and ordered by the attending physician.
-The safety committee coordinated fall risk assessments and fall management.
-Nursing staff was encouraged to comply with the clinical practice guidelines on falls and fall prevention.
-The safety committee would meet and discuss preventative measures, a new plan of care or develop a new practice guideline to prevent falls.
-Licensed nurses were to conduct an immediate investigation of the accident/incident.
-The following data needed to be included on the investigation form:
--The date, time, and place the accident/incident took place.
--The surrounding of the occurrence including medical devices or equipment that involve in the accident.
--Time that the attending physician was notified and the response.
--Date and time that the resident's family or responsible party was notified.
--The condition of the injured resident including the resident response and reaction.
--The disposition of the injured.

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--Signature and title of the person completing the form.
-The following information needed to be documented in the resident's clinical record:
--Date and Time of when the physician and family were notified.
--Administration contacted, according to facility policy.
--Resident first aide and treatment.
--Neurological checks if applicable.
--Vital Signs.
--Signs and Symptoms of injuries.
--Medical conditions that may have contributed to the incident.
--The position of the resident upon discovery.
--Resident and witness statements.

Review of the facility's policy titled "Incident Reports" dated September 2006 showed:
-Within 24 hours of the incident the Director of Nurse (DON) was responsible for the following:
--Verifying the information.
--Checking the appropriateness of all chart entries.
--Ensures that all blanks are filled in.
--Submitting the form to the Administrator and notifying corporate office if needed.
--Signing the form.
-Incident reports would be reviewed each month and/or quarter in the facility Quality Assurance meeting and a summary of findings would be included in the minutes of the meetings.

1. Review of Resident #1's admission record showed he/she admitted to the facility with the following diagnoses:
-Fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia).

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-Restless Leg Syndrome (RLS- a condition characterized by a nearly irresistible urge to move the legs, typically in the evenings).

Review of the resident's admission Minimum Data Set (a federally mandated assessment instrument completed by facility staff for care planning) dated 4/10/25 showed:
-The facility was unable to determine if the resident had a fall any time in the last month prior to admission.
-The facility was unable to determine if the resident had a fall any time in the last two to six months prior to admission.
-The resident had fallen since admission to the facility.
-The resident had two non-injury falls since admission to the facility.

Review of the resident's undated care plan showed:
-The resident had a potential to fall.
-The resident had non-injury falls that occurred on 3/28/25 and 3/31/25.
-The following interventions were in place:
--Assist with hygiene, bathing, and toileting.
--Provide instruction and small tasks in a simple sentence and set up as needed.
--Encourage the resident to use the call light for help when needing something.
--Explain procedure and care provided.
--Provide comfort and support during care.
--Monitor condition and level of Activities of Daily Living (ADLs-a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility).

Review of the resident's incident/accident report dated 3/28/25 showed:

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-The resident was "hollering" that he/she was sliding out of his/her wheelchair.
-An unnamed resident saw the resident scooting out of his/her chair, attempting to get his/her legs out of the wheelchair pedals, and slid to the floor.
-The resident asked why it took so long for Emergency Medical Technicians (EMTs) to get to the facility.
-No other information about the fall was in the investigation.
-No RCA was completed for the fall.
NOTE: No nurse note, or progress note could be found in the resident's chart related to the fall.

Review of the resident's nurse note dated 3/31/25 at 3:00 P.M. showed:
-The resident had a fall from his/her bed.
-The resident slid from his/her bed.
-The resident's vital signs were stable.

Review of the resident's incident/accident report dated 3/31/25 showed:
-The resident was in bed.
-The resident was found on the floor on his/her right side.
-No injury was noted.
-In the assessment an evaluation section of the investigation it identified a behavioral concern, but no explanation of what kind of behavior the resident was exhibiting.
-In the internal factor section of the investigation showed the resident's current diagnosis was check-marked, but no further explanation as to which diagnosis of the resident's was included.
-The resident was to have a positioning bar placed as one of his/her interventions after the fall occurred.
-No RCA was completed for the fall.

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Observation on 4/21/25 at 10:34 A.M. showed the resident did not have a positioning bar in place.

During an interview on 4/21/25 at 10:34 A.M. the resident said he/she had not remembered falling anytime at the facility.

2. Review of Resident #4's quarterly MDS dated 1/26/25 showed:
-The resident was cognitively intact.
-The resident had not had any falls prior to the assessment date.

Review of the resident's undated care plan showed:
-The resident was at risk for falls related to his/her gait/balance problems.
-The resident had the following interventions in place:
--Anticipate and meet the resident's needs.
--Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.
--The resident needed prompt response to all requests for assistance.
--Educate the resident/family/caregivers about safety reminders and what to do if fall occurs.
--Ensure the resident was wearing the appropriate footwear when ambulating or mobilizing in wheelchair.
--Follow facility fall protocol.
-The resident's care plan was not updated to reflect the resident had an actual fall.

Review of the resident's incident/accident report dated 4/5/25 showed:
-The resident said he/she slipped to the floor when trying to get out of his/her room.
-The door made the resident fall.

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-The resident had landed on his/her buttocks.
-His/her roller walker was in use.
-In the assessment and evaluation section of the investigation it identified a behavioral concern, but no explanation of what kind of behavior the resident was exhibiting.
-No RCA was completed for the fall.
NOTE: No nurse note, or progress note could be found in the resident's chart related to the fall.

During an interview on 4/21/25 at 12:12 P.M. the resident said:
-He/She had not really fallen but slid down to the floor.
-He/She had lost his/her balance trying to get out of his/her room.
-He/She was going Physical Therapy (PT) as a result of the fall.

3. Review of Resident #5's admission record showed he/she admitted to the facility with the following diagnoses:
-Parkinsonism (Parkinson's Disease- a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement).
-Tremor, Unspecified.
-Ataxic Gait (clumsy, staggering movements with a wide-based gait).

Review of the resident's care plan dated 8/5/24 showed:
-The resident was at high risk for falls related to his/her gait/imbalance problems with the following interventions:
--Anticipate and meet the resident's needs.
--Fall mat at bedside on floor while the resident was in bed.
--Be sure the resident's call light was within reach

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and encourage the resident to use it for assistance as needed.
--The resident needed prompt response to all requests for assistance.
--Educate the resident/family/caregivers about safety reminders and what to do if a fall occurred.
--Encourage the resident to participate in activities that promote exercise and physical activity for strengthening and improved mobility.
--Follow the facility fall protocol.
-The resident had two recorded falls.
-The resident's care plan was not updated to reflect his/her most recent fall.

Review of the resident's quarterly MDS dated 1/25/25 showed:
-The resident was cognitively intact.
-The resident did not have any falls prior to the assessment.

Review of the resident's incident/accident report dated 3/31/25 showed:
-The resident fell out of his/her wheelchair while going into his/her room.
-The resident landed on his/her right side.
-No injury noted and no complaints of pain.
-The incident resolution included educating the resident to ask for assistance and slow down.
-No RCA was completed for the fall.
NOTE: No nurse note, or progress note could be found in the resident's chart related to the fall.

During an interview on 4/21/25 at 10:27 A.M. the resident said:
-He/She had not had a recent fall.
-He/She had fallen in the past.
-He/She had fallen getting into the shower before.
-He/She did not think there were any fall interventions currently in place for him/her.

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4. During an interview on 2/21/25 at 2:47 P.M. Certified Nursing Assistant (CNA) A said:
-The CNAs were responsible for getting the nurse when a resident falls.
-Nurses were responsible for completing all assessments and documentation related to falls.
-All fall interventions that were determined post-fall were put into place immediately after the fall occurred.
-Resident #1's fall interventions included regular re-positioning, putting the bed in the lowest position, and having a fall mat on the floor.
-Resident #1 was also supposed to have a positioning bar placed but thought that it was "a work-in-progress."
-He/She was unsure about Resident #4's fall interventions.
-Resident #5's main fall intervention included increased monitoring during transfers.
-He/She was aware of the interventions by looking at resident care plans.

During an interview on 4/21/25 at 3:20 P.M. Licensed Practical Nurse (LPN) A said:
-The nurses were responsible for completing the incident reports after a resident falls.
-He/She reviewed the fall investigations received and said that they were not complete.
-The information in the incident reports received for Resident #1, Resident #4, and Resident #5 were not detailed enough to show the root cause of the falls.
-All parts of the incident were supposed to be filled out.
-A nurse note was also supposed to go into the resident's chart after a fall.
-The DON was responsible for ensuring completion of the fall investigation.

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During an interview on 4/22/25 at 8:46 A.M. the DON said:
-The nurses were responsible for completing the incident report after a fall occurred.
-All sections of the incident report needed to be completed.
-The nurses were also expected to put any interventions put in place after the fall on the incident report.
-The facility ran out of positioning bars and that was why Resident #1 did not have one in his/her room.
-He/She would have expected more information and a better description for both of Resident #1's falls on the incident reports.
-Resident #4 had reported his/her fall to the nurse.
-Based on the information provided in Resident #4's incident report, a person would not be able to see that the resident had gotten up by himself/herself and reported the fall to the nurse.
-Resident #5's incident report should have been more detailed.
-A summary of the investigation and the RCA was not documented in the residents' medical charts after a fall.
-There was no place on the incident report to specifically summarize or document the RCA of the fall.
-He/She does complete RCAs after each fall and shares the information with all pertinent staff verbally.
-Care plans should be updated after each fall.
-The care plans should include the date of the fall, and the specific intervention put into place after each fall.

During an interview on 4/24/25 at 1:04 P.M. LPN

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F 689	Continued From page 25 B said: -The nurses were responsible for completing the fall investigations. -The nurses were also responsible for documenting a note in the resident's chart after a fall occurred. -The DON ensures completion of the fall investigations. -The description of the fall was only completed if the fall was witnessed. -He/She was unsure of the fall interventions in place for Resident #1, Resident #4, and Resident #5. -Resident #5 had neurological issues and would try to be too independent at times which was why he/she would fall. -Resident #1 was known to throw himself/herself on the floor at his/her previous facility. -Resident #1 had RLS which caused the resident to fall out of his/her wheelchair at times. -The DON and the MDS Coordinator updated the care plans. -He/She did not look at resident care plans. -All care plans should be up to date and include the date of the fall and interventions in place. -He/She was unsure if RCA was getting completed after each fall and did not remember the DON educating staff after the most recent falls. MO00252072	F 689		

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A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Refer to F684. 2. Refer to F689.	A4075		
A4083	19 CSR 30-85.042(74) Pressure Sore Prevention/Treatment Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II This regulation is not met as evidenced by: Class II 1. Refer to F686	A4083		

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	PLAN OF CORRECTION	Survey Date
Provider/Supplier Name:	SUMMIT, THE NURSING HOME	04/22/2025
STREET ADDRESS, CITY, ZIP:	3660 SUMMIT KANSAS CITY, MO 64111	
	(X1) PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER 17-	265769
(X4) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Corrections for all citations will be completed before the completion date. All staff will be in-informed about this deficiency, this corrective plan and communication to report repair needs. The in-service will be conducted no later than completion date by the administrator; DON and/or outside professional consultants and the maintenance director. The deficiencies and corrective plans will be discussed and incorporated into the QA program.	05/20/2025
	This plan of correction is submitted as required under State and Federal law. The submission of this plan does not constitute an admission on the part of Summit the Nursing home that the citations are accurate and that the findings constitute a deficiency or that the scope and severity regarding the deficiencies cited are correctly applied Any change to Facility policies and procedures should be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on the basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. The facility will provide in-services for all facility staff regarding the statement of deficiencies and the plan of correction. The result of the survey and the plan of correction will be discussed and incorporated in the QA meeting for addressing and evaluating for compliance. All in-services will be completed before 0 and the Quality Assurance meeting is scheduled no later than 05/20/2025	05/20/2025
F684 **MO00252072**	***Corrective action for affected residents (will be completed before*** completion date) • *Resident #3: Due to the PVD, the resident has chronic would on the lower extremities that has potential healing and reopening. The staff fail to document the treatment on the TAR consistently. The nursing staff will complete the skin assessment including the re-open wound and will notify the DON and contact the physician. She will ensure weekly skin assessment and treatment records are completed upon treatment. Al nursing staff will be in-serviced documentation and wound care. The care plan will address the weekly skin assessment, wound care and treatment documentation.* The facility will reinforce the skin system no later than completion date to identify other residents having the potential to be affected by the same deficient practice and the systematic changes to ensure that the deficient practice will not recur. Currently the facility considers all residents who are at risk for potentially affecting the same deficient practice. **System changes:** • The reinforcement of skin care program, that the CNAs/CMTs screen skin during the shower and report to the charge nurse for changes or abnormality. The staff who provides the bath/shower reports to the charge nurse any irregularity when screening the skin. The charge nurse reviews the shower sheets for further assessments if there are any additional notes for further investigation. • The facility performs skin weekly assessments by the licensed nurse. The CNAs inspect the skin when providing shower or other ADL tasks and report to the charge nurses for further investigation and assessments. The facility will complete it and place in the skin logbook/folder that the DON reviews weekly to ensure completion and starts further	05/20/2025

	investigations if there are concerns/issues. Findings will be documented on the form provided. • The DON reviews the weekly skin assessments to ensure completion. The weekly skin assessments will be placed in a three-ring binder for easier audit by the DON. This record is located at nurse stations. • The weekly review of MAR, TAR, wound and lab reports by the DON and/ or designated nurses to audit the accuracy of orders and reflect the resident conditions. • The DON audits medical records on each new admission for the following: admission assessment; physician orders; treatment and reasons or diagnoses for each prescribed medication or other medical monitoring such as finger stick, blood pressure, vital signs, pulses, risk assessments or others…. • The re-implementation of the correct documentation and recording according to nursing assessment and intervention for changes in condition or abnormal test values, allergies; skin assessments, ancillary services or change in score of quarterly risk assessments. • An educational workshop will be provided to all nursing staff no later than the completion date. The staff will be educated on the policy for skin management and care, which includes skin documentation, signing when completed, skin screening during the bath/shower and weekly skin assessment. **Monitor performance:** • The director of nursing/designated nurses will be responsible for monitoring this compliance by auditing at least 5 medical records a month and informing the disciplinary team about the new care plan if applicable. The audit tool is the facility's internal record only. • The DON is responsible for enforcing the policy and procedure by daily round observation of care and treatments, communication with nursing staff, and reinforcing physician notification protocol. • The DON/designated licensed nurse and the administrator will review the monthly MARS and TARs and medical records or upon service professional recommendations to ensure the timely follow-up with physician orders and professional recommendations; appropriate reasons for treatments, medications, t or/and other professional ancillary services. • All nursing staff will be in-serviced by the DON no later than the completion date about this deficiency and plan of correction as well as the new care plans for the above residents. The above system and plan will be incorporated into the Quality assurance program and to continue monitoring, revising, and discussing with medical director for effective follow-up until it reaches 100% compliance. **QUESTION FROM THE DHSS ON 5/21/25** F684: Please clarify who will educate the CNAs/CMTs regarding the skin screen during showers. ▪ Please clarify who will educate the licensed nurse regarding the weekly skin assessments. ▪ Please clarify who will provide education related to documentation on the MAR/TAR and wound/skin assessments. **Answer:** Please refer to the last bullet under "monitor performance that we stated that the DON will provide the education to all nursing staff that we addressed on the POC. The skin screening, skin assessment and documentation are addressed in the POC (we underline that paragraph for your review)	
F686	***Corrective action for affected residents (will be completed before completion date)*** • *Resident #2: This resident is under hospice care. He/she has a stage III ulcer on the left medial buttock/gluteal and a stage II ulcer and an eschar unstageable wound on right arm/elbow and on right proximal arm/forearm and other wounds on the bottoms. The facility care plan team assesses and treats in coordinated care from the hospice per*	05/20/2025

facility's policy. The staff fail to document the treatment on the TAR consistently. The DON will reinforce and monitor weekly assessments including measurements, stagging, characteristics of the wounds and the healing process. The care plan will be revised to address the wound assessment, and wound care documentation

- *Resident #1: This resident is under hospice care. He/she has a pressure wound on his/her coccyx that is healed. The staff fail to document wound assessment and wound care per scheduled. The DON will reinforce and monitor weekly assessments including measurements, stagging, characteristics of the wounds and the healing process. The care plan will be revised to address the wound assessment, and wound care documentation*

The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable by developing a system for maintaining and monitoring skin integrity. This system will include:

- The reimplementation of the policy and procedure for risk assessment wound care protocol, nutritional assessment and approaches, preventative measures and promote the healing progress as well as the frequency of assessment, measurement, monitoring, and documentation. The facility performs skin weekly assessments by the licensed nurse. The CNAs inspect the skin when providing shower or other ADL tasks and report to the charge nurses for further investigation and assessments. The facility will complete it and place in the skin logbook/folder that the DON reviews weekly to ensure completion and starts further investigations if there are concerns/issues. Findings will be documented on the form provided.
- The reconstruction of wound care team to effectively communicate with the physician about healing process; treatment course and changed interventions.
- The continuation of weekly wound care meetings to analyze and address preventive measures and treatment modalities for residents with wound or high risk for wound development.
- The education to nursing staff about the policy and procedures for skin and wound assessment, monitoring as well as the documentation for assessments and interventions. All nursing staff will be in-serviced about the weekly monitoring progress for wounds, care plan implementation for the above residents and the skin management program. This education will be provided at least twice a year or more by an RN professional.
- The director of nursing will be responsible for implementing the skin care protocol by providing educational in-service during daily round to nursing staff about wound care, risk assessment and preventative measurements such as repositioning, hygiene and nutritional approaches according to the care plan instructions.
- The licensed nurses will be responsible for weekly tracking and auditing wounds. The DON will be responsible for collecting the tracking information and present it to the wound committee weekly.

Monitor performance:

- The DON chairs the weekly wound committee to re-evaluate healing process, risk mitigation and development of wound. The DON/designated charge nurses audit the treatment record at the weekly meeting and communicate with the physician for further interventions if needed.
- The director of nursing will be responsible for implementing this plan and to monitor for compliance by daily round observation staff performance on wound care and treatment.
- The DON will review weekly wound documentation; compare with the physician order for treatment and other professional recommendations to monitor the healing progress.
- The DON will be responsible for ensuring compliance as specified above and will continue to be responsible for continuously educating staff by observing, auditing, monitoring for performance during round and documentation when auditing the treatment records.

	The above plans will be incorporated into the quality assurance program on-going basic. The plan and function of the wound committee will be discussed with the medical director during the QA meeting that is planned no later than the completion date. **QUESTION FROM THE DHSS ON 5/21/25** F686: Please clarify who will provide the education to the licensed nurse regarding weekly skin assessments. ▪ Please clarify who will provide the education to the CNA's related to skin inspection during showers or ADL tasks. ▪ Please clarify who will provide education to the licensed nurses regarding weekly tracking and auditing of wounds. **Answer:** Please review the bullet #4 under "systematic changes" that we addressed "This education will be provided at least twice a year or more by an RN professional" The DON or the RN will provide the education to all nursing staff that we addressed on the POC. The skin screening inspection, skin assessment and documentation are addressed in the POC (we underline that paragraph for your review)	
F689 **MO00252072**	***Corrective action for affected residents (will be completed before completion date)*** • *Resident #1: This resident has a high risk for fall due to the DX of Restless Leg Syndrome and Fibromyalgia and history of falls. The fall risk assessment is completed using RCA form and the to identify the causation of fall and will be used for interventions. The facility will reassess if the resident needs the positioning bar for mobility and will consult the physician for recommendations. The care plan will be revised to address the residents monitoring for safety to prevent further falls* • *Resident#4: The facility will complete the RCA process to identify the fall. This resident is not high risk for fall. The incident happened once from the door on his way that caused him/her slipped on the floor. The fall risk assessment is completed using RCA form and the to identify the causation of fall and will be used for interventions. The care plan will be revised to address resident instruction on the environment and slow down on moving to maintain the steady gait and balance* • *Resident #5: This resident is at high risk for fall due to Parkinsonism, Ataxic Gait and tremors. Th facility place Fall mat at bedside on floor to prevent injury from falling. The fall risk assessment is completed using RCA form and the to identify the causation of fall and will be used for interventions. The facility will assess if the resident needs physical therapy or RA program and will consult the physician for recommendations. The care plan will be revised to address the residents monitoring for safety to prevent further falls* The facility will implement a new system no later than completion date to identify other residents having the potential to be affected by the same deficient practice and the systematic changes to ensure that the deficient practice will not recur. Currently the facility considers residents who are at high risk of falling at risk for potentially affecting the same deficient practice. The systematic changes include • The re-implementation of post fall assessments and interventions, neurological check, fall investigation using *root-cause analysis* for resident who sustain frequent falls. • The reinforcement of staff training and development on safety measures on how to try different interventions to prevent falls, assign staff duty for floor/unit monitor during the mealtime, identify who are in the units, who are in the dining room, identify the fall risk residents and establish a monitoring system including observations, teaching instruction and evaluation of physical condition • The reinforcement of policy and procedures for follow-up care and investigation on any unwitnessed incidence • Assign a final round by any staff member before reporting to the dining room for dining assistance to ensure no residents who require supervision or monitoring are left alone in the room or hallway. • A standup meeting every morning with all department heads on Monday to Friday to discuss residents' conditions, behaviors and the 24-hour report to approach the issue in a timely manner • The reinforcement of policy and procedures for Positioning and Transferring to all nursing staffs addressing non-weight bearing transfer techniques and will be posted at the nurse station. These procedures will be served as an educational tool for accomplishing success in the competency test. **Monitor performance:**	05/20/2025

	• The DON is responsible for enforcing the policy and procedure by daily observation of care and treatments, communication with nursing staff, and reinforce nursing care safety by applying standards of practices for all ADL cares and reviewing each RCA for each resident's fall occurrence. • The DON will be responsible for monitoring this compliance by observing proper procedure during the round and informing the QA team about the findings • All nursing staff will be in-serviced by the DON about this deficiency and the plan of correction as well as the care plans for the cited residents The above systems will be incorporated into the Quality assurance program and to continue monitoring, revising and discussing with medical director for effective follow-up care. This will be addressed and consulted with the medical director during the QA meeting. This will be a focus component for the QAPI monitoring until it 100% compliance is reached **QUESTION FROM THE DHSS ON 5/21/25** F689: Please clarify who will be educated, and who will provide the education related to fall investigations, assessments, and neurological checks. ▪ Please clarify who will provide the education for positioning and transferring residents. **Answer:** Please refer to the last bullet under "monitor performance that we stated that the DON will provide the education to all nursing staff that we addressed on the POC. The position, transfer, fall assessments including neurological checks and fall investigations are addressed in the POC (we underline that paragraph for your review)	

A4075	The facility will ensure Nursing Care per Res condition. Refer to F684 and F689	05/20/2025
A4083	The facility will ensure pressure ulcer prevention. Refer to F686	05/20/2025