STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265512	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee's Summit Place	1501 SW 3rd Street Lees Summit, MO 64081

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** Based on observation, interview and record review, the facility failed to follow the facility's policies; failed to ensure prevention and treatment of pressure injuries (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction); failed to identify individuals at risk for developing pressure injuries; failed to assess, monitor, and measure the wounds at least weekly and document the findings; failed to observe for changes in the pressure injury that could indicate a change in the treatment; failed to implement the interventions on the residents plan of care; and failed to follow physician's orders for the treatment of pressure injuries for two sampled residents (Resident #26 and #307) out of 12 sampled residents. The facility census was 48 residents. Review of the facility policy titled Comprehensive Care Plan, dated 9/1/21, showed: -It was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. -The comprehensive care plan will describe any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. -The facility would attempt alternate methods for refusal of treatment and services and document such attempts in the clinical records, including discussion with the resident and/or resident representative. Review of the facility policy titled Medical Provider Orders, dated 4/7/22, showed: -The facility used uniformed guidelines for the ordering and following of medical provider orders. -Medical provider orders should be reviewed prior to administration of medication and/or treatment to validate the orders contained all required elements. -Staff would follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order. -If an order did not contain all of the required elements, staff should contact the ordering provider for clarification of the order prior to implementation of the order. (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	-Written transfer orders (sent with a resident by a hospital or other health care facility) would be implemented without further validation, if It was signed and dated by the resident's current attending medical provider, unless the order was unclear or incomplete, or the date signed is different from the date of admission. -If a transfer order was unsigned, signed by a different medical provider, or the date was other than the admission date, the receiving nurse should verify the order with the current attending medical provider. Review of the facility policy titled Skin Assessment, dated 9/1/22, showed: -It was the facility's policy to perform a full body skin assessment as part of the facility systematic approach to pressure injury prevention and management. -A full body, or head to toe skin assessment would be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. -The skin assessment may also be performed after a change of condition or after any newly identified pressure injury. -Documentation of the skin assessment included: Date and time of the skin assessment, the staff members name, and the staff members position title. -Documentation of the skin assessment included observations (skin condition, how the resident tolerated the procedure, etc.) -Documentation of the skin assessment included the type of wound. -Documentation of the skin assessment included description of the wound (measurement, color, type of tissue in wound bed, drainage, odor, pain). -Documentation of the skin assessment included if resident refused assessment and why. 1. Review of Resident #26's admission record showed: -The resident had a diagnosis of cognitive deficit (a problem or impairment in one or more aspects of a person's mental abilities, such as memory, attention, or problem-solving). -There was no diagnosis of pressure injury and/or any other skin wounds on the resident's admission record. Review of the resident's care plan dated 2/20/25, showed: -The resident had potential for impairment to skin integrity. -The resident would maintain or develop clean and intact skin by the review date. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Physician Order Sheet (POS) dated 2/21/25, showed weekly skin assessments were to be performed every Friday. Review of the resident's admission Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 2/24/25 showed the resident: -Had moderate cognitive impairment. -Was at risk for developing pressure injury. -Did not have any pressure injuries, or any other skin problems. -Did not have any skin or ulcer/wound treatments. Review of the resident's weekly nursing skin assessment dated [DATE], showed: -A pressure injury on the resident's right outer ankle. --There were no measurements documented. --There was no description documented. -An area of discoloration on the resident's left outer ankle. --There were no measurements documented. --There was not description documented. Review of the resident's skin monitoring: Comprehensive Certified Nurse Assistant (CNA) shower review sheet dated 3/14/25, showed no wounds or other skin concerns were documented. Review of the resident's weekly nursing skin assessment dated [DATE], showed no documentation and/or description of the resident's pressure injuries. Review of the resident's skin monitoring: Comprehensive CNA shower review sheet dated 3/24/25, showed no wounds or other skin concerns were documented. Review of the resident's Initial outside wound company evaluation and management summary dated 3/25/25, showed: -The resident presented with wounds on his/her left lateral ankle, left lateral (outer) heel; and right lateral ankle. -Left lateral ankle measured 0.6 centimeters (cm) X 1.7 cm X Not measurable. --The dressing treatment plan was to apply skin prep once daily for 30 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	---This was an unstageable pressure injury (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) -Left lateral heel measured 0.6 cm X 1.5 cm X Not measurable. --The dressing treatment plan was to apply skin prep once daily for 30 days. ---This was an unstageable pressure injury. -Right lateral ankle measured 1.1 cm X 1.0 cm X Not measurable. --The dressing treatment plan was to apply betadine once daily for 30 days. ---This was an unstageable pressure injury. --NOTE: The wound care company evaluated the resident 13 days after the left lateral ankle and the right lateral ankle were found. Review of the resident's Treatment Administration Record (TAR) dated March 2025 showed: -The left lateral ankle and left lateral heel treatment was: apply skin prep every shift, two times a day to start on 3/30/25. --The treatment started five days after the wound care company evaluated the wound and was 18 days after recognizing the pressure injuries. -NOTE: There were no orders that addressed the right lateral ankle. Review of the resident's weekly nursing skin assessment dated [DATE], showed no observation and/or description of the resident's pressure injuries. Review of the resident's skin monitoring: Comprehensive CNA shower review sheet dated 3/28/25, showed no wounds or other skin concerns were documented. Review of the resident's POS dated 3/30/25, showed: -Treatment to the left lateral ankle and left lateral heel was to apply skin prep every shift, two times a day. -NOTE: There were no orders that addressed the resident's right lateral ankle. Review of the resident's weekly wound assessment dated [DATE], showed: -The resident had a facility acquired pressure injury on his/her right lateral ankle. --The date of onset for the pressure injury was 3/12/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	--The wound measured 1.1 cm in length X 1.0 cm in width X undetermined depth. -The resident had a facility acquired pressure wound on his/her left lateral ankle. --The date of onset for the pressure injury was 3/12/25. --The wound measured 0.6 cm in length X 1.7 cm in width X undetermined depth. -NOTE: The right lateral ankle was not assessed, Review of the resident's skin monitoring: Comprehensive CNA shower review sheet dated 3/31/25, showed no wounds or other skin concerns were documented. Review of the resident's weekly nursing skin assessment dated [DATE], showed no observation and/or description of the resident's pressure injuries. Observation on 4/3/25 at 11:49 A.M. of wound care with Licensed Practical Nurse (LPN) A and Registered Nurse (RN) A showed: -The resident had three wounds on his/her left lateral ankle. -Gauze was in between the resident's socks and his/her left lateral ankle. -There was no wound dressing and/or bandages in place on the resident's left lateral ankle. -RN A placed skin prep on all three wounds on the resident's left lateral ankle. -RN A placed a dressing over the three wounds on the resident's left lateral ankle. --NOTE: No wound care was completed on the resident's right lateral ankle. During an interview on 4/3/25 at 11:49 A.M. LPN A and RN A said the wound care for the resident was complete. During an interview on 4/3/25 at 11:49 A.M. the resident said RN A may remove the sock from his/her right foot. Observation on 4/3/25 at 11:49 A.M. showed the resident had a pressure injury on his/her right lateral ankle that measured approximately 1.1 cm X 1.0 cm X not measurable. During an interview on 4/3/25 at 11:58 A.M., LPN A said: -He/She was not aware there was a wound on the resident's right lateral ankle. -There were no physician orders for any treatment to the the resident's right lateral ankle. -He/She had not been completing any treatments or medication application on the resident's right lateral ankle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/25 at 12:10 P.M., the resident said the staff had not been doing any type of wound care to his/her right lateral ankle. Observation on 4/7/25 at 9:39 A.M., of wound care with LPN A and the Assistant Director of Nursing (ADON), showed: -A dressing was removed from the resident's right lateral small toe that was dated 4/6/25. -LPN A applied skin prep to the pinpoint sized wound on the outside of the resident's small toe and applied a wound bandage. -An open wound was seen on the resident's right lateral foot. --LPN A measured the wound to the resident's lateral right foot 1.5 cm X 1 cm X non measurable. -An open wound seen on the resident's coccyx (tailbone). --A crumbled up dressing that had no initials or date was removed from the resident;'s coccyx area by the ADON, ---The coccyx wound measured 1.0 cm X 1.0 cm. ---The ADON applied ointment to the coccyx area and left it open to air. The resident was repositioned to his/her back. During an interview on 4/7/25 at 9:48 A.M., LPN A said there were no orders for the coccyx wound. During an interview on 4/7/25 at 10:02 A.M., the resident said: -He/She could not recall when his/her coccyx wound started. -He/She could not recall who placed the wound dressing on the coccyx wound or when it was placed, he/she believed it was the previous shift night nurse. -The coccyx wound was causing him/her some discomfort. Review of the resident's POS dated April 2025 showed no orders for any treatment to the resident's coccyx area. 2. Review of Resident #307's admission record, dated 3/25/25, showed: -The resident was his/her own responsible party. -The resident had a diagnosis of pressure injury to his/her sacral (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) area, Stage IV (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident had a diagnosis of pressure injury at other site, unstageable. -The resident had a diagnosis of cognitive communication deficit. Review of the resident's facility to facility transfer report from the hospital dated 3/25/25, showed: -Left sided ischial tuberosity (the rounded bone that extends from the ischium - the curved bone that makes up the bottom of your pelvis). pressure injury; 4 cm X 2 cm X 4 cm; Stage IV. --Cleanse wound with wound cleanser, pat dry. Pack to depth with Dakin's (A solution that kills germs and prevent their growth in wounds. It can also help dissolve dead tissue- necrosis). 1/4 strength soaked kerlex to depth. Cover with foam adhesive dressing every shift. -Right sided ischial tuberosity pressure injury; 1.5 cm X 1.5 cm X 1 cm; Stage IV. --Cleanse wound with wound cleanser, pat dry. Pack to depth with Dakin's 1/4 strength soaked kerlex to depth. Cover with foam adhesive dressing every shift. -Sacrum pressure injury; 6 cm X 5 cm X 4.5 cm; Stage IV. -- Cleanse wound with wound cleanser, pat dry. Pack to depth with Dakin's 1/4 strength soaked kerlex to depth. Cover with foam adhesive dressing every shift. -Left lateral (outside) knee pressure injury; 1 cm X 0.5 cm X 0.1 cm; 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 does not obscure the depth of tissue loss. May include undermining or tunneling). --Cleanse wound with wound cleanser, pat dry. Apply Silvadene to wound bed. Apply 1-2 layers of Xeroform gauze to wound. Cover with foam adhesive dressing every shift. -Right sided toe pressure injury; Unstageable. --Cleanse wound with wound cleanser, pat dry. Apply betadine painting to toe. Leave open to air daily. -Contact isolation precautions for Methicillin Resistant Staphylococcus Aureus (MRSA-a type of bacteria that is resistant to many antibiotics) in the wound. Follow facility guidelines. Review of the resident's admission skin assessment dated [DATE], showed: -The resident had a Stage III pressure injury on his/her right buttock. --There were no measurements documented. -The resident had a Stage III pressure injury on his/her left buttock. --There were no measurements documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident had a Stage III pressure injury on his/her sacrum. --There were no measurements documented. -The resident had a pressure injury on his/her left knee. --There were no measurements documented. --Described as open and covered with 4X4 for protection. -The resident had a pressure injury on his/her right lower leg (front). --There were no measurements documented. --Described as closed and covered with 4X4 for protection. -There was no mention of the right toe wound. -NOTE: There was no mentioned of the resident's wounds having MRSA. Review of the resident's admission MDS dated [DATE], showed: -One Stage III pressure injury upon admission to the facility. -Three Stage IV pressure injuries upon admission to the facility. -The resident had zero unstageable pressure injuries upon admission to the facility. -NOTE: The right toe wound was not captured on the resident's MDS. Review of the resident's POS dated 3/25/25, showed: -Left Ischial Tuberosity cleanse with wound cleanser, pat dry. Pack with Dakins soaked kerlix (A type of bandage roll made from 100% woven cotton with a unique crinkle-weave pattern) to depth. Cover with foam Dressing every shift (twice per day) and as needed for soiling. -Right ischial tuberosity wound cleanse with wound cleanser, pat dry. Pack with Dakins soaked kerlix to depth. Cover with foam dressing every shift (twice per day) and as needed for Soiling. -Sacrum wound cleanse with wound cleanser, pat dry. Pack with Dakins 1/4 strength soaked kerlex to depth. Cover with foam adhesive every shift (twice per day) and as needed for soiling. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Left lateral knee wound cleanse with wound wash, pat dry. Apply Silvadene to wound bed. Apply a layer of Xeroform to wound bed. Cover with foam adhesive dressing every shift (twice per day) and as needed for soiling. every shift -Right 4th toe wound. Cleanse wound with wound wash, pat dry. Apply betadine to toe. Leave open to air daily and as needed. -There were no orders for skin assessments. Review of the resident's care plan dated 3/28/25, showed: -An unstageable pressure injury of the left foot, third digit. --The wound was actually on the resident's right fourth digit. -A Stage IV pressure injury of the sacral region. -The resident's left ischial tuberosity, right ischial tuberosity, and left lateral knee were not addressed in the care plan. -There were no updates to the care plan that indicated the resident refused treatments to his/her wounds. Review of the resident's TAR dated April 2025, showed: -Left Ischial Tuberosity wound cleanse with wound cleanser, pat dry. Pack with Dakins soaked kerlix to depth. Cover with foam dressing every shift (twice per day) and as needed for soiling every shift. --The resident refused wound treatment on 4/1/25, 4/2/25, and 4/3/25 on the day shift. -Right ischial tuberosity wound cleanse with wound cleanser, pat dry. Pack with Dakins soaked kerlix to depth. Cover with foam dressing every shift (twice per day) and as needed for soiling every shift. --The resident refused wound treatment on 4/1/25, 4/2/25, and 4/3/25 on the day shift. -Sacrum wound cleanse with wound cleanser, pat dry. Pack with Dakins 1/4 strength soaked kerlex to depth. Cover with foam adhesive every shift (twice per day) and as needed for Soiling every shift. --The resident refused wound treatment on 4/1/25, 4/2/25, and 4/3/25 on the day shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Left lateral knee wound cleanse with wound wash, pat dry. Apply Silvadene to wound bed. Apply a layer of Xeroform to wound bed. Cover with foam adhesive dressing every shift (twice per day) and as needed for soiling, every shift. --The resident refused wound treatment on 4/1/25, 4/2/25, and 4/3/25 on the day shift. -Right 4th toe wound cleanse wound with wound wash, pat dry. Apply betadine to toe. Leave open to air daily and as needed. --The resident refused wound treatment on 4/1/25, 4/2/25, and 4/3/25 on the day shift. -NOTE: There were no orders for skin assessments. During an interview on 4/1/25 at 9:45 A.M., the resident said: -Since being admitted staff had not changed the dressings to his/her left and right ischial tuberosities, sacrum and left lateral knee. -Since his/her admission the right toe wound dressing had been changed one time. -He/she has never refused a wound treatment for any of his/her wounds. -He/She was admitted for wound care. -He/She would be able to go home when they were better. -He/She was upset that they were not changing the dressings because that was the whole reason he/she was at the facility. Review of the resident's medical record dated 4/1/25 to 4/3/25 showed: -There was no documentation with any details about the resident's refusal of wound treatments. -There were no skin assessments in the resident's record. -There were no wound measurements in the resident's record. -There were no nursing notes regarding the resident's wounds. During an interview on 4/3/25 at 10:32 A.M., the Medical Director said: -He/She would expect weekly skin assessments to be completed and documented on residents in the facility. -He/She would expect physicians orders to be implemented and documented when completed. During an interview on 4/3/25 at 1:45 P.M., the resident said: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The staff had not been in his/her room today, 4/3/25, to offer or complete wound care. -LPN A asked to change the dressings on 4/2/25 around 4:30 P.M., he/she gave permission. LPN A went to get supplies and did not return until 6:20 P.M. When LPN A came into the resident's room at 6:20 P.M., asked if he/she was ready for the dressings to be changed, he/she responded, yes. LPN A left and never returned to change his/her wound dressings on 4/2/25. -The night shift nurse did not offer or complete the dressing changes throughout the night of 4/2/25. -He would like to have his/her wound dressings changed as soon as possible as they were causing him/her discomfort and were dirty. During an interview on 4/3/25 at 2:15 P.M., LPN A said: -The resident refused his/her wound care treatments today (4/3/25). -He/She forgot to document the refusal in a progress note and should have done so. Observation on 4/3/25 at 3:04 P.M., showed: -LPN A and RN A changed the resident's wound dressings. -LPN A removed the resident's soiled dressing from the sacrum. --The sacrum was a Stage IV wound with visible bone: approximately 6 cm X 5 cm X 4.5 cm. --The dressing was soiled with exudate of numerous color; clear, yellow, and brown. --The dressing was crumbled up and not covering the wound completely. --The dressing did not have any nurse initials or a date. -The left ischial tuberosity and right ischial tuberosity dressings were not covering the wound. --The dressings were soiled with exudate of numerous color; clear, yellow, and brown. --The dressings were partially hanging and partially crumbled up. --The left ischial tuberosity and the right ischial tuberosity were exposed to and in contact with the resident's feces. --Wound dressings for the left ischial tuberosity and the right ischial tuberosity did not have a date or initials. --The left ischial tuberosity was approximately 1.5 cm X 1.5 cm X 1 cm; Stage IV. --The right ischial tuberosity was approximately 4 cm X 2 cm X 4 cm; Stage IV. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound care for the left lateral knee was not completed. --The left lateral knee had no dressing and was open to air. --The left lateral knee was approximately 1 cm X 0.5 cm X 0.1 cm. ---Wound care orders for the left lateral knee were cleanse with wound wash, pat dry. Apply Silvadene to wound bed. Apply a layer of Xeroform to wound bed. Cover with foam adhesive dressing every shift (twice per day) and as needed for soiling. Every shift. -Wound care for the right toe was not completed. --The right toe was covered by a dressing with the date of 3/30/25. --Right 4th toe wound. Cleanse wound with wound wash, pat dry. Apply betadine to toe. Leave open to air daily and as needed. -NOTE: There was a strong malodorous smell in the resident's room. During in an interview on 4/3/25 at 4:00 P.M., LPN A said: -The dressings that were on the resident's wounds had not been in stock since sometime last week. -The dressings were currently on back order. 3. During in an interview on 4/7/25 at 1:46 P.M., CNA A said: -The nurses were responsible to complete the weekly skin assessments on the resident's in the facility. -The CNA's were responsible for the bath skin assessments in the facility. -He/She was not sure where the weekly and the bath assessments were documented. -He/She gave his/her bath skin assessments to the charge nurse on duty for his/her shift. -He/She reported skin issues to his/her charge nurse. -He/She could not recall where the wounds were located for Resident #26 and Resident #307. -He/She had never completed a bath skin assessment on Resident #26 or Resident #307. During in an interview on 4/7/25 at 1:49 P.M., LPN A said: -He/She was not sure who was responsible for resident's weekly skin assessments. -The skin assessment duties were handed off from the floor nurses to the ADON recently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265512	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee's Summit Place	1501 SW 3rd Street Lees Summit, MO 64081

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-There had been some confusion on who was responsible for weekly skin assessments. -He/She was unsure of who was responsible for the skin assessments from week to week. -Skin assessments were documented in the resident's electronic medical record when completed under the assessment tab. -The previous DON came in and made a lot of changes and caused a lot of confusion. -The new DON started on Monday. -He/She was unsure who was responsible for wound assessments. -Wound assessments should be documented in the resident's electronic medical record. -18 days would be an excessive and unacceptable amount of time for a resident's wounds to not receive wound care or treatments. -The charge nurse who was on duty when a wound was brought to their attention was the one responsible for ensuring that a resident received timely wound care treatment orders. -The physician should be notified within the same shift that a wound was brought to the attention of the charge nurse to receive wound care treatment orders. -When a resident refused wound care treatments, it should be documented on the TAR and in a progress note but sometimes the progress note was bypassed. -He/She was unsure of what the policy was for assessment and treatment of resident's with wounds. During an interview on 4/7/25 at 2:44 P.M., the DON said: -Upon admission the charge nurse was responsible for a complete skin assessment and measurements of any current pressure injuries that the resident may have. -Weekly skin assessments should be completed and documented by the charge nurses on the floor. -Weekly skin assessment should be documented in the resident's electronic medical records under assessments. -If a wound was found on an assessment the nurse should notify the physician as soon as they found the wound but definitely within that shift. -18 days would be an excessive and unacceptable amount of time for a resident's wounds to not receive care and treatment orders. -He/She was unsure of who was responsible for the care plans regarding wounds and wound care or what they were doing before he/she started. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-He/She would expect a resident that refused wound care treatments to be care planned for those refusals. -He/She would expect the floor nurses to document in a progress note and notify him/her if a resident refused wound care treatments. -He/She would expect a resident's wounds to be measured upon assessment and documented in the resident's electronic medical record under weekly wound assessments. -The facility did not currently have a MDS Coordinator and one was being shared between another facility. MO00248773