STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265586	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atrium Place Health and Rehabilitation	2600 Redman Road Saint Louis, MO 63136

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure one resident (Resident #12) received the correct treatment order for a pressure injury (damage to the skin and underlying tissue caused by prolonged pressure) and failed to update the resident's care plan to include the resident's pressure injury. In addition, two residents received new treatment orders for pressure injuries on 1/2/26, that were not implemented until 1/5/26, and staff failed to ensure one of those two residents with an order for off-loading boots (pressure relieving boots) wore those boots at all times as ordered (Residents #4 and #1). Five residents were sampled for pressure injuries, four current residents and one discharged resident, and problems were found with three. The census was 98.Review of the facility Pressure Injury Prevention and Management policy dated 9/1/21 and revised on 1/23/23, showed:-Policy: This facility is committed to the prevention and avoidable pressure injuries and the promotion of healing of existing pressure injuries;-Definitions:- Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device;-Policy Explanation and Compliance Guidelines: -There are multiple terms used to describe this type of skin damage, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. For the purpose of this policy, pressure injury, as the current standard terminology, will be used;-The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate;-Interventions for Prevention and to Promote Healing:-After completing a thorough assessment/evaluation, the interdisciplinary team (IDT) shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions;-Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.). Provide appropriate, pressure-redistributing, support surfaces;-Modifications of Interventions:-Any changes to the facility's pressure injury prevention and management process will be communicated to relevant staff in a timely manner;-Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include changes in resident's degree of risk for developing a pressure injury; new onset or recurrent pressure injury development. Review of the facility and Wound Care Company (Provider) service agreement, dated 1/13/25, showed:-Facility Responsibilities:-Facility agrees to support the Wound Care Company's delivery of wound care services and commits to: -Provide a dedicated nurse to round and communicate with the Provider;-Discuss recommendations/wound care plan with the Provider on the day of rounds;-Grant the Provider rendering services with access privileges to the Facility's internet service and electronic health record;-Respect the (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 - Minimal harm or potential for actual harm Residents Affected - Some	physician-patient relationship and allow the Provider, once consulted, to provide services and procedures to such resident as Provider determines to be medically necessary. Review of the facility Medical Provider Orders policy, dated 9/1/21 and revised on 4/7/22, showed:Policy: This facility shall use the uniform guidelines for the ordering and following of medical provider orders;-Policy Explanation and Compliance Guidelines:1. Medications and/or treatments should be administered only upon the signed order of a person lawfully authorized to prescribe;2. Verbal orders should be received only by licensed nurses, or pharmacists, and confirmed in writing by the medical provider, on the next visit to the facility;3. Elements of the Medication and/or Treatment Order;-Date and time the order is written;4. Documentation of Medication and/or Treatment Orders;-If using electronic medication records, input the medication and/or treatment order according to the electronic health record (EHR) instructions and facility policy;-Validate newly prescribed medications and/or treatment is in the electronic MAR (medication administration record)/TAR (treatment administration record);5. Following of Medication and/or Treatment Orders: Medical provider orders should be reviewed prior to administration of medication and/or treatment to validate the orders contain all required elements. Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order;6. Specific Procedures for Medication Orders;-Handwritten Order Signed by the Medical Provider: The charge nurse on duty at the time the order is received should note the order and enter it on the medical provider order sheet or electronic order format, if not written by the medical provider. Review of the facility Treatment Nurse - LPN (Licensed Practical Nurse) job description, undated, showed:-Position Description: Responsible for the center's general application of the skin management program. Responsible for delivering safe, efficient and effective treatment to heal various types of wounds, including ulcers, and bed sores;-Principle Responsibilities:-Performs resident skin assessments, obtain treatment orders, administer treatment as ordered, and document appropriately to ensure that resident skin integrity is improved/or maintained;-Administer treatments as prescribed within standard nursing practice guidelines and in full compliance with established infection control protocols;-Coordinate and lead weekly wound rounds and processes, including rounds, measurements, interdisciplinary care plan review, treatment recommendations, physician orders, and required documentation;-Receives, transcribes and implements new treatment orders in a timely manner. 1. Review of Resident #12's admission face sheet, located in the EHR, showed diagnoses of: Quadriplegia (paralysis of the body from the neck down), pressure injury of the sacral (triangular bone area located above the tailbone) region, diabetes, muscle weakness, and cognitive communication deficit. Review of the resident's Braden Scale (an assessment tool used to determine pressure injury risk) located in the EHR and dated 10/26/25, showed a score of 15, or low risk to develop pressure injuries. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 10/30/25, and located in the EHR, showed:-Moderately impaired cognition;-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer;-Always incontinent of bowel;-Is the resident at risk of developing pressure ulcers/injuries: Yes;-Does the resident have one or more unhealed pressure ulcers/injuries: No. Review of the resident's care plan, located in the EHR, showed:-12/25/22: Focus: Impaired cognitive function/dementia or impaired thought processes. Goal: Will maintain current level of cognitive function. Interventions: Ask yes/no questions to determine resident's needs. Cue, reorient and supervise as needed;-12/25/22: Focus: At risk for impairment to skin integrity related to quadriplegia. Goal: Will (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maintain or develop clean and intact skin. Interventions: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces;-7/5/23: Focus: Current Functional Performance. Goal: Functional status will progress towards personal discharge goal. Interventions: Bed mobility, dressing, personal hygiene, toilet use and transfers - Total assist/one-person physical assist;-7/5/23: Focus: Impaired Physical Mobility. Goal: Resident will be able to perform activity within physical limits. Interventions: Will use call monitor to ask for assistance. Staff will answer call monitor in a timely manner;-The care plan did not identify the resident had a current pressure injury. Review of the resident's weekly skin check assessment (completed by a licensed nurse), located in the EHR, showed:-11/2/25 at 10:15 A.M., and completed by the facility Wound Nurse: No wounds were identified during the skin check;-11/9/25 at 8:54 P.M.: Left buttock, pressure, 7.0 centimeters (cm) (Length) x 5.0 cm (Width). Area cleaned with normal saline (NS, salt/sodium water mixture) and foam dressing applied. Review of the resident's progress note dated 11/10/25 at 5:03 P.M., located in EHR, and documented by the facility Wound Nurse, showed a full body assessment performed. Resident noted to have recurrent wound to coccyx (tail bone). Resident and family educated on repositioning and new treatment plan. Review of the resident's physician's order sheet (POS) located in the EHR, showed:-11/11/25: Cleanse sacrum (bony area between the small of the back and the upper buttocks) with NS, pat dry and apply calcium alginate (highly absorbent dressing for wounds with moderate to heavy exudate (drainage)) every day shift for wound healing. Review of the resident's progress note dated 11/11/25 at 12:26 P.M. and completed by the Director of Nurses (DON), showed: Resident reviewed via IDT for skin area reopening. At this time, resident referred to wound team for follow-up and treatment order in place. Physician, resident and family aware of plan of care and in agreement at this time. Will follow-up as needed. Review of the resident's TAR, dated 11/1/25 through 11/30/25, located in the EHR, showed:-11/11/25: Cleanse sacrum with normal saline, pat dry and apply calcium alginate dry dressing every 24 hours and PRN (as needed/necessary). Review of the resident's wound company Wound Evaluation and Management Summaries, completed by the Wound Care Company Physician and located in the EHR, showed:-11/13/25:-Chief Complaint: Resident has a wound on the right buttock (the POS and TAR identified as the sacrum);-Focused Wound Exam: Unstageable (due to necrosis (dead tissue)) (known but not stageable due to coverage of wound bed by slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) and/or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)) of the right buttock full thickness;-Etiology: Pressure;-MDS 3.0 Stage: Unstageable necrosis;-Objective: Healing/Maintain Healing;-Healing Potential: Fair;-Care Goal: Decrease Wound Area, Decrease Necrosis;-Wound Size (Length x Width x Depth): 7.0 cm x 7.7 cm x 0.1 cm;-Surface Areas: 53.90 cm;-Exudate: Heavy Sero-sanguinous (contains both serum (the liquid part of blood) and a small amount of blood. It typically appears as a thin, watery discharge that is light pink in color);-Thick adherent devitalized necrotic tissue: 30%;-Slough: 30%;-Granulation tissue (new connective tissue that forms during the healing process): 40%;-Pain Assessment: Described as mild;-Infection Assessment: No sign(s) of infection;-Dressing Treatment Plan: Alginate calcium with silver (combines calcium alginate's absorbent properties with silver's antimicrobial (agents that kill or inhibit the growth of microorganisms, including bacteria, viruses, fungi, and parasites) properties, apply once daily and as needed;-The Wound Care Company Physician surgically debrided (removal of necrotic tissue) the wound on this date.-11/20/25:-Right buttock;-MDS 3.0 Stage: Stage 3 (full thickness tissue loss. Subcutaneous fat may be viable but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.);-Wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Size: 7.0 cm x 10 cm x 0.1 cm;-Surface Area: 70.00 cm;-Exudate: Heavy Sero-sanguinous;-Granulation tissue: 100%;-Wound Progress: Improved evidenced by decreased necrotic tissue;-Pain Assessment: Described as Moderate;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-11/24/25:-The resident's visit has been rescheduled. Resident unable to be seen as he/she is already up and out of bed. Review of the resident's TAR, dated 11/1/25 through 11/30/25, showed:-11/11/25: Cleanse sacrum with normal saline, pat dry and apply calcium alginate dry dressing every 24 hours and PRN; -11/13/25 through 11/30/25: The facility failed to change the resident's treatment order from calcium alginate to calcium alginate with silver as ordered by the Wound Care Company Physician on 11/13/25. Review of the resident's wound company Wound Evaluation and Management Summaries, showed:-12/4/25: -Right buttock;-MDS 3.0 Stage: Stage 3;-Wound Size: 8.0 cm x 8.8 cm x 0.1 cm;-Surface Area: 70.40 cm;-Exudate: Moderate Sero-sanguinous;-Thick adherent devitalized necrotic tissue: 40%;-Slough: 20%-Granulation tissue: 40%;-Wound Progress: Not a goal due to resident non-compliant with wound care;-Pain Assessment: None;-Infection Assessment: None;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-12/11/25:-The resident's visit has been rescheduled. Out at an appointment;-12/18/25:-Right buttock;-MDS 3.0 Stage: Stage 3;-Wound Size: 5.1 cm x 7.0 cm x 0.1 cm;-Surface Area: 35.70 cm;-Exudate: Moderate Sero-sanguinous;-Granulation tissue: 70%;-Other viable tissues: 30%;-Wound Progress: Improved as evidenced by decreased necrotic tissue, decreased surface size;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-12/22/25:-Right buttock;-MDS 3.0 Stage: Stage 3;-Wound Size: 4.5 cm x 6.6 cm x 0.1 cm;-Surface Area: 29.70 cm;-Exudate: Moderate Sero-sanguinous;-Slough: 20%;-Granulation tissue: 50%;-Other viable tissues: 30%;-Wound Progress: Improved as evidenced by decreased surface area;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed. Review of the resident's TARs, dated 12/1/25 through 12/31/25, and 1/1/26 through 1/7/26, showed:-11/11/25: Cleanse sacrum with NS, pat dry and apply calcium alginate dry dressing every 24 hours and PRN;-The facility failed to change the resident's treatment order from calcium alginate to calcium alginate with silver as ordered by the Wound Care Company Physician on 11/13/25. Review of the resident's wound company Wound Evaluation and Management Summary, showed:-1/2/26: -Right buttock;-MDS 3.0 Stage: Stage 3;-Wound Size: 8.0 cm x 6.3 cm x 0.1 cm;-Surface Area: 50.40 cm;-Exudate: Heavy Serous (clear to yellow fluid);-Thick adherent devitalized necrotic tissue: 20%;-Granulation tissue: 50%;-Other viable tissues: 30%;-Wound Progress: Not at goal due to patient non-compliant with wound care;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-Prescription Recommendations: amoxicillin-clavulanate (antibiotic) 875/125 milligram (mg) twice daily for 10 days. Start 1/2/26. End 1/12/26. Review of the resident's POS, showed:-1/3/2026: Bactrim DS (antibiotic) 800-160 mg. Give one tablet by mouth in the morning for wound infection for 10 days and give one tablet by mouth at bedtime for wound infection for 10 days. Review of the resident's MAR, dated 1/1/26 through 1/7/26, showed:-1/3/26: Bactrim DS 800-160 mg, give one tablet at 7:30 A.M. and one tablet at 7:30 A.M. and at 7:30 P.M. Review of the resident's EHR showed no explanation why the facility was administering Bactrim DS 800-160 mg when the Wound Care Physician ordered amoxicillin-clavulanate 875/125 mg. During a telephone interview on 1/13/26 at 3:38 P.M., the DON said she spoke to the Wound Care Company Physician on 1/12/26 and she confirmed she wanted the resident's antibiotic to be Bactrim DS, not amoxicillin-clavulanate. Observation on 1/5/26 at 8:22 A.M., showed the resident lay in bed on a low air loss mattress (a pressure relieving mattress) for a skin assessment. The facility Wound Nurse (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peeled back the dressing covering the resident's sacrum showing a large open area. The facility Treatment Nurse said the pressure injury was covered by 40-50% dark tissue and 40-50% red beefy tissue. During an interview on 1/7/26 at 8:38 A.M., the facility Treatment Nurse said she works Monday through Friday. On her days off the facility nurses complete the resident treatments. At 11:19 A.M., the facility Treatment Nurse said she rounds with the Wound Care Company Physician every week, usually on Thursdays. The Wound Care Company Physician will verbally tell her as they round any new orders, and she writes them down. Before the Wound Care Company Physician leaves the facility, she will upload her Wound Evaluation and Management Summary notes into the resident's EHR. She (the facility Treatment Nurse) is responsible to accurately transcribe the Wound Care Company Physician's orders on the POS and TAR. She did not change the resident's treatment order from calcium alginate to calcium alginate with silver on the POS and TAR like she should have. She has been using the calcium alginate with silver when she does the resident's treatment, but because the TAR shows calcium alginate only, she cannot be sure the nurses are using the calcium alginate with silver. She did not round with the Wound Care Company Physician on 1/2/26, when she ordered the amoxicillin-clavulanate 875/125 mg. She was off last week and did not return until 1/5/26. During an interview on 1/7/26 at 12:15 P.M., LPN F said he/she works the day shift and every other weekend. The facility Treatment Nurse usually does the treatments Monday - Friday, but he/she does treatments on the weekends he/she works. He/She looks at the TAR in the EHR to know what treatment to administer. If the order on the TAR showed calcium alginate, that is what he/she would use, not calcium alginate with silver. During an interview on 1/7/26 at 12:31 P.M., LPN H said if he/she was doing the treatments, he/she would look at the TAR in the EHR. If the treatment order showed calcium alginate, that is what he/she would use, not calcium alginate with silver. During an interview on 1/7/26 at the DON said what the Wound Care Company Physician orders is what should be on the POS, MAR and TAR. Any orders from the Wound Care Company Physician should begin the same day the facility received the order(s). During an interview on 1/8/26 at 8:21 A.M., the Wound Care Company Physician said calcium alginate with silver has antimicrobial properties while calcium alginate does not. She expected staff to follow her treatment orders as written. Review of the resident's wound company Wound Evaluation and Management Summary, showed:-1/8/26: -Right buttock;-MDS 3.0 Stage: Stage 3;-Wound Size: 8.0 cm x 6.0 cm x 0.1 cm;-Surface Area: 48.00 cm;-Exudate: Moderate Serous;-Thick adherent devitalized necrotic tissue: 30%;-Slough: 10%;-Granulation tissue: 40%;-Other viable tissues: 10%;-Skin: Intact normal color: 10%;-Wound Progress: Improved, evidenced by decreased surface area;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-Prescription Recommendations: Continue amoxicillin-clavulanate (antibiotic) 875/125 milligram (mg) twice daily for 10 days. Start 1/2/26. End 1/12/26. 2. Review of Resident #4's quarterly MDS dated [DATE], and located in the EHR, showed:-Makes Self Understood: Rarely/never understood;-Ability To Understand Others: Rarely/never understands;-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer;-Always incontinent of bowel and bladder;-Diagnoses of cerebral palsy (a group of conditions that affect movement and posture caused by brain damage most often before birth), and seizure disorder;-Is this resident at risk of developing pressure ulcers/injuries: Yes;-Does this resident have one or more unhealed pressure ulcers/injuries: Yes;-Number of Stage 3 pressure ulcers: One. Review of the resident's care plan, located in the EHR, showed:-5/1/24: Focus: Bowel and Bladder Incontinence. Goal: Will remain free from skin breakdown due to incontinence and brief use. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: Check resident every two hours and assist with toileting as needed. Provide perineal care (care to the surface area between the thighs, extending from the pubic bone to tail bone) after each incontinent episode;-5/13/24: Focus: Requires assistance with activities of daily living. Goal: Will maintain current activity of daily living status. Interventions: Encourage resident to participate to the fullest extent possible with each interaction;-5/13/24: Focus: Impaired cognitive function/dementia or impaired thought processes related to cerebral palsy. Goal: Will develop skills to cope with cognitive decline and maintain safety. Interventions: Communicate with the resident/family/caregivers regarding residents' capabilities and needs. Engage the resident in simple, structured activities that avoid overly demanding tasks;-6/21/24: Focus: Actual impairment to skin integrity. Goal: Will have no complications related to the alteration of skin integrity. Interventions: Followed by wound company. Treatment of wounds per physician's orders;-1/9/26: Focus: Actual skin impairment. Goal: Area will improve. Interventions: Incontinence care as needed. Skin prevention intervention as ordered. Treatment as ordered. Review of the resident's POS, located in the EHR, showed:-12/18/25: Off-loading boots on at all times;-12/19/25: Skin prep (a liquid forming film that forms a protective barrier on the skin) to the dorsal (top of the foot) left foot and the left heel every day shift for wound healing. Review of the resident's TAR dated 12/1/25 through 12/31/25, and located in the EHR, showed:-12/1/25 through 12/31/25: 12/18/25: Off-loading boots on at all times;-12/19/25: Skin prep (a liquid forming film that forms a protective barrier) to the left dorsal (top of the foot) foot and left heel, every day shift for wound healing. Review of the resident's TAR dated 1/1/26 through 1/31/26, showed:-12/18/25: Off-loading boots on at all times;-12/19/25: Skin prep to the left dorsal foot and left heel every day for wound healing. Staff initialed the skin prep had been applied to the resident's dorsal left foot and left heel on 1/1 and 1/2/26. Review of the resident's wound company Wound Evaluation and Management Summary, showed:-1/2/26:-Left Dorsal Foot;-Etiology: Pressure;-MDS 3.0 Stage: Stage 3;-Wound Size: 1.5 cm x 0.5 cm x 0.1 cm;-Surface Area: 0.75 cm;-Exudate: Moderate Serous;-Granulation Tissue: 60%;-Other viable tissues: 50%;-Wound progress: Not a goal due to need more time;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver once daily and as needed;-Left Heel;-Etiology: Pressure;-MDS 3.0 Stage: Stage 3;-Wound Size: 1.8 cm x 1.2 cm x 0.1 cm;-Surface Area: 2.16 cm;-Exudate: Moderate Serous;-Granulation tissue: 100%;-Wound progress: Exacerbated due to resident scratches, need to make sure pressure boots are in place;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed;-Specific To Visit Recommendations: Pressure Off-Loading boot. Review of the resident's POS, showed:-Discontinue Date 1/5/26: Skin prep to the left dorsal foot and the left heel daily for wound healing;-Start Date 1/5/26: Cleanse left dorsal foot and left heel with normal saline and apply calcium alginate with silver every day shift for wound healing. Review of the resident's TAR, dated 1/1/26 through 1/31/26, showed:-1/3/26 and 1/4/26: Staff initialed skin prep had been applied to the resident's dorsal left foot and left heel;-No order for calcium alginate with silver to the left dorsal foot and left heel on 1/2, 1/3 or 1/4/26. Observation on 1/5/26 at 8:33 A.M., showed the resident lay in bed with contractures to the upper and lower extremities. He/She was not wearing pressure off-loading boots. The facility Treatment Nurse completed the resident's skin assessment. The resident had a dressing on the left dorsal foot and the left heel. Both dressings were dated 1/2/26. The facility Wound Nurse said she was off last week and did not round with the Wound Care Physician on 1/2/26. Prior to being off last week, the resident had an order for skin prep (skin prep does not require dressings) to the left dorsal foot and the left heel. The Wound Care Company Physician may have changed the order on 1/2/26. At (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:58 A.M., the facility Treatment Nurse said the Wound Care Company Physician changed the resident's treatment order on the left dorsal foot and left heel to calcium alginate with silver on 1/2/26. The new treatment orders should have been changed on the POS and TAR on 1/2/26. She was not sure why that did not happen. The left dorsal foot pressure injury was open with red beefy tissue and measured 1.5 cm x 0.5 cm. The left heel pressure injury had 50% brown slough and 50% red beefy tissue and measured 1.7 cm x 2.0 cm x 3.0 cm. Review of the resident's POS, showed:-12/18/25: Off-loading boots on at all times;-1/5/26: Cleanse left dorsal foot and left heel with normal saline. Apply calcium alginate with silver daily and as needed. Review of the resident's TAR dated 1/1/26 through 1/31/26, showed:-1/5/26: Cleanse the left dorsal foot and left heel with NS and apply calcium alginate with silver daily and as needed. Observation and interview on 1/7/26 at 8:16 A.M., showed the resident lay in bed. Certified Nursing Assistant (CNA) C and CNA D were providing personal care to the resident. The resident was not wearing an off-loading boot. CNA C said the resident does have off-loading boots, but they were taken to the laundry yesterday and have not come back yet. During an interview on 1/7/26 at 12:47 P.M., the DON said if the resident had an order for off-loading pressure boots at all times, they should be worn at all times. Review of the resident's wound company Wound Evaluation and Management Summary, showed:-1/8/26:-Left Dorsal Foot;-Etiology: Pressure;-Wound Progress: Resolved, anatomic location of previously existing wound examined today and resolved. Follow up only as needed;-Left Heel;-Etiology: Pressure;-MDS 3.0 Stage: Stage 3;-Wound Size: 1.3 cm x 0.9 cm x 0.1 cm;-Surface Area: 1.17 cm;-Exudate: Moderate Serous;-Granulation tissue: 100%;-Wound progress: Improved as evidenced by decreased surface area;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver apply once daily and as needed;-Specific To Visit Recommendations: Pressure Off-Loading boot. 3. Review of Resident #1's quarterly MDS dated [DATE] and located in the EHR, showed:-Makes Self Understood: Rarely/never understood;-Ability To Understand Others: Rarely/never understands;-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer;-Always incontinent of bowel and bladder;-Diagnoses of wound infection, diabetes and stroke;-Is this resident at risk of developing pressure ulcers/injuries: Yes;-Does this resident have one or more unhealed pressure ulcers/injuries: No. Review of the resident's care plan, located in the EHR, showed:-8/25/25: Focus: Actual impairment to skin integrity. Goal: Will have no complications related to the alteration of skin integrity. Intervention: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, and signs/symptoms of infection;-8/27/25: Focus: The resident has an activity of daily living self-care performance deficit. Goal: Will maintain/improve level of functioning. Interventions: Bedfast all or most of the time. Requires two staff for bathing/showering, dressing, bed mobility and toilet use. Encourage the resident to participate to the fullest extent possible with each interaction. Review of the resident's Braden Scale assessment dated [DATE], showed the resident was a low risk to develop a pressure injury. Review of the resident's POS located in the EHR, showed:-12/19/25: Zinc oxide ointment (used to prevent and treat skin irritations), apply to right buttock topically every shift for wound healing. Review of the resident's Wound Evaluation and Management Summary dated 1/2/26, and located in the EHR, showed:-Right Posterior Thigh;-Etiology: Pressure;-MDS 3.0 Stage: Stage 3;-Objective: Healing/Maintain Healing;-Healing Potential: Good;-Wound Size: 0.8 cm x 5.0 cm x 0.1 cm;-Surface Area: 4.00 cm;-Exudate: Moderate Serous;-Granulation tissue: 100%;-Wound progress: Exacerbated due to likely reinjury;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate (continued on next page)

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	265586	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calcium with silver, apply once daily and as needed. Review of the resident's POS, showed:-1/5/26: Cleanse the right posterior thigh with NS and pat dry. Apply calcium alginate with silver and dry dressing every day for wound healing. Review of the resident's TAR dated 1/1/26 through 1/31/26, showed:-Nurses initialed they applied zinc oxide to the right buttocks on 1/2, 1/3 and 1/4/26;-1/5/26: Cleanse right posterior thigh with normal saline and pat dry. Apply calcium alginate with silver and dry dressing every day shift for wound healing. Observation and interview on 1/5/26 at 8:45 A.M., showed the resident lay in bed. The facility Treatment Nurse stood at the bedside to complete the resident's skin assessment. The facility Wound Nurse said she went on vacation last week and did not make rounds with the Wound Care Company Physician on 1/2/26. When she went on vacation, the resident had an order for zinc oxide ointment. When she returned today, she noted the treatment order had been changed to calcium alginate with silver daily on 1/2/26. That order had not been added to the POS or TAR until today when she added it. Observation of the resident's right posterior thigh showed thin horizontal open areas across the posterior right thigh and no dressing in place. Review of the resident's Wound Evaluation and Management Summary dated 1/8/26, and located in the EHR, showed:-Right Posterior Thigh;-Etiology: Pressure;-MDS 3.0 Stage: Stage 3;-Objective: Healing/Maintain Healing;-Healing Potential: Good;-Wound Size: 6.3 cm x 2.8 cm x 0.1 cm;-Surface Area: 17.64 cm;-Exudate: Moderate Serous;-Granulation tissue: 20%;-Skin: Intact normal color 80%;-Wound progress: Improved as evidenced by decreased surface area;-Pain Assessment: None;-Infection Assessment: No signs of infection;-Primary Dressing: Alginate calcium with silver, apply once daily and as needed. 4. During an interview on 1/8/26 at 8:21 A.M., the Wound Care Physician said she rounds with a facility nurse, usually the facility Wound Nurse, every week when she is in the facility. She will verbally tell the nurse what changes she is making, and she will upload her Wound Evaluation and Management Summary notes into the EHR before she leaves that day, so her written orders are available. She expected staff to begin any new orders the same day she is here. 5. During an interview on 1/8/26 at 2:30 P.M., the Administrator said the policies and procedures are current, and she expected facility staff to follow them. 27064942706772

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed their Enhanced Barrier Precautions (EBP) policy while providing care to residents that required EBP precautions during high contact activities. Five residents were observed during skin assessments, treatments and/or personal care, and staff failed to wear gowns during four of those five observations. (Residents #1, #4, #7 and #12). The census was 98.Review of the facility Enhanced [NAME] Precautions policy dated 1/1/23 and revised on 4/23/25, showed:-Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs);-Definitions: - Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and gloves use during high contact resident care activities that provide opportunities for transfer of MDROs to staff and clothing;-Policy Explanation and Compliance Guidelines:-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;-All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities;-Initiation of Enhanced Barrier Precautions:-An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers (wound due to poor blood flow in the veins) and/or indwelling medical devices (e.g., central lines, urinary catheters (thin, flexible tube), feeding tubes, tracheostomy (surgical procedure that creates an opening in the trachea)/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters) even if the resident is not known to be infected or colonized with MDRO;-Implementation of Enhanced Barrier Precautions:-Make gowns and gloves available immediately near or outside of the resident's room;PPE (personal protection equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room;-The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education;-High-contact resident care activities include: Dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting in toileting, device care or use, and wound care to any skin opening requiring a dressing. Review of the facility's Enhanced Barrier Precautions sign (posted on the outside of resident room doors of those residents requiring EBP) showed:-Everyone Must: Clean their hands, including before entering and when leaving the room. Providers And Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities: -Dressing; -Bathing/Showering; -Transferring;-Changing Linens;-Providing Hygiene;-Changing briefs or assisting with toileting;-Device care or use: Central line, urinary catheter, feeding tube, tracheostomy;-Wound Care: Any skin opening requiring a dressing. Review of the facility Treatment Nurse - LPN (Licensed Practical Nurse) job description, undated, showed:-Position Description: Responsible for the center's general application of the skin management program. Responsible for delivering safe, efficient and effective treatment to heal various types of wounds, including ulcers, and bed sores;-Principle Responsibilities:-Performs resident skin assessments, obtain treatment orders, administer treatment as ordered, and document appropriately to ensure that resident skin integrity is improved/or maintained;-Administer treatments as prescribed within standard nursing practice guidelines and in full compliance with established infection control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protocols;-Safety and Sanitation: Wears and/or uses safety equipment and supplies when indicated and properly trained to use. Review of the facility's Certified Nursing Assistant (CNA) job description, undated, showed:-Position Description: The CNA is responsible for delivering and assisting residents with daily needs, including personal care needs. Provide basic nursing care to residents within the scope of the nursing assistant responsibilities and performs basic nursing procedures under the direction of the licensed nurse supervisor;-Principal Responsibilities: -Responsible for knowledge of proper procedures to provide personal care services to residents; provide requested personal care services to residents;-Serves and protect the center's community by adhering to professional standards, company policies and procedures, federal, state, and local requirements. 1. Review of Resident #1's quarterly minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/10/25 and located in the electronic healthcare record (EHR), showed:-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer;-Diagnoses of wound infection, diabetes and stroke;-Feeding tube (gastrostomy tube/a tube inserted through the abdomen into the stomach to provide medication/nutrition/fluids);-Is this resident at risk of developing pressure ulcers/injuries: Yes. Review of the resident's care plan, located in the EHR, showed:-8/25/25: Focus: Actual impairment to skin integrity. Goal: Will have no complications related to the alteration of skin integrity. Intervention: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, and signs/symptoms of infection;-8/27/25: Focus: The resident has an activity of daily living self-care performance deficit. Goal: Will maintain/improve level of functioning. Interventions: Bedfast all or most of the time. Requires two staff for bathing/showering, dressing, bed mobility and toilet use. Encourage the resident to participate to the fullest extent possible with each interaction;-10/6/25: Focus: Requires a tube feeding. Goal: Will be free from aspiration (substance(s) enters the lungs such as food/liquids). Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. Review of the resident's physician's orders sheet (POS), located in the EHR, showed:-10/7/25: Tube feeding. Check for placement every shift;-1/5/26: Cleanse right posterior thigh with normal saline (NS), pat dry and apply calcium alginate (an absorbent treatment) and cover with dry dressing daily;-No order for EBP. Observation on 1/5/26 at 8:45 A.M., showed an EBP sign posted on the outside of the resident's door and a supply of gloves and gowns on the inside of the room door. The resident lay in bed as LPN A and the facility Treatment Nurse completed the resident's skin assessment. Both LPN A and the facility Treatment Nurse donned gloves, but not gowns during the skin assessment. The resident had a tube feeding stoma (surgically created opening) on the abdomen covered by a dressing and open areas on the right posterior thigh. 2. Review of Resident #4's quarterly MDS dated [DATE], and located in the EHR, showed:-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer;-Always incontinent of bowel and bladder;-Diagnoses of cerebral palsy (a group of conditions that affect movement and posture caused by brain damage most often before birth), and seizure disorder;-Does this resident have one or more unhealed pressure ulcers/injuries: Yes;-Number of Stage 3 pressure ulcers (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) may be present but does not obscure the depth of tissue loss. May include undermining and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tunneling): One. Review of the resident's care plan, located in the EHR, showed:-5/13/24: Focus: Requires assistance with activities of daily living. Goal: Will maintain current activity of daily living status. Interventions: Encourage resident to participate to the fullest extent possible with each interaction;-6/21/24: Focus: Actual impairment to skin integrity. Goal: Will have no complications related to the alteration of skin integrity. Interventions: Followed by wound company. Treatment of wounds per physician's orders;-11/21/24: Requires Enhanced Barrier Precautions due to chronic wounds. Goal: EBP will reduce the risk of transmission (spread) of known or unknown MDROs. Interventions: Discuss EBP and reason needed with resident and responsible party. EBP includes the use of gowns and gloves during high-contact resident care;-1/9/26: Focus: Actual skin impairment. Goal: Area will improve. Interventions: Incontinence care as needed. Skin prevention intervention as ordered. Treatment as ordered. Review of the resident's POS, located in the EHR, showed:-9/16/25: Enhanced Barrier Precautions for chronic wound. Gown and gloves required for high-contact resident care;1/5/26: Cleanse the dorsal (top) left foot and left heel with NS, pat dry and apply calcium alginate with silver daily. Observation on 1/5/26 at 8:33 A.M., showed an EBP sign posted on the outside of the resident's room door and a supply of gloves and gowns on the inside of the room door. The resident lay in bed as the facility Treatment Nurse completed a skin assessment. The resident had uncovered open areas on his/her left dorsal foot and on his/her left heel. The Treatment Nurse donned a pair of gloves but did not don a gown to complete the skin assessment. Observation on 1/5/26 at 10:58 A.M., showed the resident lay in bed as the facility Treatment Nurse completed the resident's treatment to the left dorsal foot and left heel. The Treatment Nurse donned a pair of gloves but did not don a gown during the treatment. Observation on 1/7/26 At 8:16 A.M., showed the resident lay in bed. CNA D, wearing a pair of gloves but not a gown, prepared to complete personal care. CNA C entered the room to assist CNA D with providing personal care, including a bed bath. CNA C donned a pair of gloves but did not don a gown. During an interview on 1/7/26 at 8:44 A.M., CNA D said he/she was aware the resident had a pressure injury (damage to the skin and underlying tissue caused by prolonged pressure), and he/she should have worn a gown while providing care. During an interview on 1/7/26 at 9:28 A.M., CNA C said he/she was aware the resident had pressure injuries, but he/she was not aware he/she needed to wear a gown while providing personal care. 3. Review of Resident #7's quarterly MDS, located in the EHR and dated 12/8/25, showed:-Dependent for oral hygiene, toileting, shower/bathing, upper/lower dressing, and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfers;-Diagnoses of stroke, seizure disorder and respiratory failure;-Feeding tube;-Tracheostomy care. Review of the resident's care plan, located in the EHR, showed:-9/2/25: Focus: Activity of Daily Living self-care performance deficit. Goal: Will maintain/improve level of functioning. Interventions: Resident is totally dependent on one staff for: Bathing/showering, bed mobility, dressing, and personal hygiene;-9/2/26: Focus: Tracheostomy. Goal: Will have clear and equal breath sounds. Interventions: Administer oxygen as ordered. Provide good oral care daily. Suction as necessary. Review of the resident's POS, located in the EHR, showed:-9/3/25: Enhanced Barrier Precautions for tracheostomy and feeding tube. Gown and gloves required for high contact resident care. Observation on 1/6/26 at 8:33 A.M., showed an EBP sign posted on the outside of the resident's room door and a supply of gloves and gowns on the inside of the door. The resident lay in bed with humidified oxygen infusing through his/her tracheostomy tubing and collar. LPN A and CNA E entered the room to complete the resident's skin assessment. Both the LPN and CNA donned gloves but did not don gowns for the skin assessments. The resident had a dressing covering his/her feeding tube stoma. The resident had a large loose bowel movement, and both staff cleaned the resident and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changed the resident's incontinent brief. During an interview on 1/8/26 at 8:17 A.M., LPN A said he/she should have worn a gown to take of the resident on 1/6/26. All the supplies, including gowns are on the back of the room door. 4. Review of Resident #12's admission face sheet, located in the EHR, showed a diagnoses of: quadriplegia (paralysis of the body from the neck down), pressure injury of the sacral (triangular bone area above the tailbone) region, diabetes, muscle weakness, and cognitive communication deficit. Review of the resident's quarterly MDS, dated [DATE] and located in the EHR, showed:-Functional Limitation in Range of Motion: Impairment of both upper and lower extremities;-Dependent for toileting, shower/bathe, upper/lower body dressing and personal hygiene;-Dependent for roll left and right, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer. Review of the resident's care plan, located in the EHR, showed:-12/25/22: Focus: At risk for impairment to skin integrity related to quadriplegia. Goal: Will maintain or develop clean and intact skin. Interventions: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces;-7/5/23: Focus: Current Functional Performance. Goal: Functional status will progress towards personal discharge goal. Interventions: Bed mobility, dressing, personal hygiene, toilet use and transfers - Total assist/one-person physical assistance;-7/5/23: Focus: Impaired Physical Mobility. Goal: Resident will be able to perform activity within physical limits. Interventions: Will use call monitor to ask for assistance. Staff will answer call monitor in a timely manner. Review of the resident's POS, located in the EHR, showed:-11/10/25: Cleanse sacrum (the area between the top of the buttocks and lower back) with NS, pat dry and apply calcium alginate and dry dressing daily;-No order for EBP. Observation on 1/5/26 at 8:22 A.M., showed an EBP sign posted on the outside of the resident's room door. On the inside of the room door was a supply of gowns and gloves. The resident lay in bed. The facility Treatment Nurse donned a pair of gloves but did not don a gown to complete the skin assessment. The resident had a large dressing covering the sacrum. 5. During an interview on 1/7/26 at 10:27 A.M., the facility Infection Preventionist said she expected staff to follow the instructions on the EBP signs on the resident room doors. The purpose of EBP is to protect the resident, other residents' staff are taking care of and the staff, from the spread of infection. 6. During an interview on 1/7/26 at 11:19 A.M., the facility Treatment Nurse said she should have worn a gown when she was doing the skin assessments and treatments. Gowns should be worn for infection control purposes. 7. During an interview on 1/7/26 at 12:47 P.M., the Director of Nursing (DON) said she expected staff to follow the instructions for EBP that are on the signs on the resident room doors. 8. During an interview on 1/8/26 at P.M., the Administrator said the policies and procedures are current, and staff are expected to follow them.