STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review and interview, the facility failed to prevent neglect for 1 (R #7) of 1 (R #7) resident by not ensuring he was dressed appropriately for the winter weather when attending appointments outside of the facility. This deficient practice could likely result in a decrease of body temperature and feelings of embarrassment (awkwardness or uneasiness), helplessness and not being cared for resulting in mental anguish (a degree of mental pain and suffering that arises from another person's negligence - failure to exercise the care that a reasonably sensible person would exercise in like circumstances). The findings are: A. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE]. B. Record review of R #7's face sheet revealed the following diagnoses: osteomyelitis right ankle and foot (an infection in the bone caused by bacteria or fungi), neuropathy (disease of the nerves that causes weakness, numbness and pain in hands and feet), spina bifida (a birth defect that occurs when the spine and the spinal cord do not develop completely), morbid obesity (a condition of being overweight to a degree that is dangerous to one's health), reduced mobility (ability to move around more difficult due to illness), edema (swelling due to excess fluid in body tissues), muscle weakness, difficulty walking, lack of coordination, right foot abscess (a mass filled with pus due to infection), severe sepsis (infection of the blood stream), respiratory failure with hypoxia (occurs when the body does not get enough oxygen to function), acquired absence of right foot (loss or removal of some or all of the toes on this foot), and acquired absence of left foot (loss or removal of some or all of the toes on this foot) upon admission. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review of R #7's physicians progress notes dated 12/30/21 at 00:00 (12:00 am) revealed This is a [AGE] year-old man who was admitted to [name of hospital] from an outside hospital for a right first metatarsal (bone in the foot just behind the big toe) osteomyelitis. He had a right foot ulcer (open sore on the foot) as well as abscess (mass filled with pus caused due to infection) and cellulitis (a serious bacterial infection of the skin) of the entire right foot. He received IV (Intravenous, which is a thin, plastic tube called a catheter that is put into a vein designed to be deliver medication directly into the bloodstream) and oral (taken by mouth) antibiotics (medication intended to treat and prevent bacterial infections). He underwent a right foot wound debridement (a procedure to remove debris-scattered pieces of waste or remains, infected or dead tissue from a wound) including bone. Cultures of the soft tissue and bone were positive for staph aureus (a germ people carry in their noses or on their skin), Candida (a yeast like fungus that causes fungal infections), and group B strep common bacteria that lives in the body and often carried in the intestines-vita organ that helps digest food and absorb nutrients and vitamins). His hospitalization was complicated by epistaxis (nosebleed) and hyperbilirubinemia (a condition in which there is a build up in the blood of bilirubin - a yellowish pigment that is made during the normal breakdown of red blood cells). He was discharged to [name of the facility] on 12/13/2021 for ongoing wound care with a wound VAC (a treatment vacuum assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap) to the site as well as IV antibiotic treatment. D. Record review of R #7's medical records from [name of infectious disease clinic] revealed R #7 attended appointments at their clinic on 12/28/21 at 3:45 pm and on 01/11/22 at 3:04 pm for follow up of the wound located on his right foot. E. On 03/15/22 at 10:55 am, during an interview, R #7 reported that he left the faciity on two occasions for appointments at the infectious disease clinic. He reported that he could not recall the dates of the appointments, but one was in December (2021) and one was in January (2022). R #7 reported that he attended both appointments in only a hospital gown and would have preferred to have clothes on when leaving the facility for both appointments, because it was very cold outside those two days. R #7 reported No one ever helped me with anything or listened to me over there (at the facility), I would call my mom and tell her to come and get me, because I was all alone. F. Record review of the weather temperatures for [name of city, the facility is located in] listed on the Time and Date website https://timeanddate.com/weather/usa/[NAME]/historic retrieved on 03/16/22 revealed that the weather temperature range for 12/28/21 was 37-48 degrees and the weather temperature range for 01/11/11 was 27-50 degrees. G. Record review of R #7's care plan dated 12/14/21 revealed Resident/Patient requires assistance/is dependent for ADL (Activities of Daily Living, which includes dressing) care. H. On 03/15/22 at 11:52 am, during an interview, the DNP (Doctor of Nursing Practice) at [name of infectious disease clinic] reported to see [first name of R #7] in just a hospital gown in the middle of winter when he (R #7) arrived for his appointments (on 12/28/21 and 01/11/22) was just shocking (awful or horrifying). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. On 03/15/22 at 11:26 am, during an interview, R #7's mother reported that she was upset when she found out R #7 attended offsite appointments in only a hospital gown. She reported that she believes R #7 had a set of clothes with him when he was admitted to the facility (on 12/13/21) and if he didn't the staff should have let the family know, because they could have taken him clothes when they visited him. R #7's mother reported they should have dressed him in clothes (when leaving the facility for appointments), that's like going outside with just your underwear on and it's winter, so it's cold outside. R #7's mother reported He (R #7) still thinks like a child sometimes, people think because he is a big man that he thinks like that and that is not true, he needed help from those people (the staff) that's why he was there (at the facility) and he (R #7) would call me all of the time crying and saying come and get me. J. On 3/17/22 at 1:01 pm, during an interview, the Social Services Director (SSD) reported that when residents do not have clothing to wear, outreach is made to laundry services to ask for donations. K. On 03/17/22 at 2:02 pm, during an interview, the Center Executive Director (CED) reported that if residents leave the facility for appointments in cold weather wearing just a hospital gown, they should at least have a jacket on or a blanket, some kind of coverage to keep them warm. L. On 03/22/22 at 11:43 am, during an interview, Licensed Practical Nurse #3 reported that residents usually wear their own clothing to appointments outside the facility, if they have clothing with them at the facility and if they don't and they are ok with it, they (the staff) check with the laundry services see if there is anything the resident could use. LPN #3 reported that if there is no clothing available then the resident is sent to appointments outside the facility in a hospital gown, but if it's cold outside they (the staff) provide them (residents) a blanket to make sure they stay warm. M. On 03/23/22 at 2:02 pm, during an interview, LPN #4 reported it is my expectation that residents are dressed weather appropriate when going to appointments (outside the facility) and if it's cold outside that includes a jacket and a blanket in addition to socks and full-length bottoms.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review and interview the facility failed to provide resident care that meets acceptable standards of professional practice for 3 (R #'s 3, 5, and 7) of 3 (R #'s 3, 5, and 7) residents by: 1. Failure to follow provider orders to remove a PICC line (Peripherally Inserted Central Catheter - a thin, soft, flexible tube used to inject fluids or medications directly into a vein and or to draw blood samples for testing), complete lab work (blood tests) and administer liquid protein dietary supplement (used to increase the amount of protein in a diet); 2. Failure to conduct weekly skin checks and 3. Failure to conduct weekly skin evaluations. These deficient practices could likely result in residents not receiving all the appropriate care needed to ensure they reach or maintain their optimal well-being. The findings are: Findings related to PICC line: A. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE]. B. Record review of R #7's face sheet revealed the following diagnoses: osteomyelitis right ankle and foot (an infection in the bone caused by bacteria or fungi), neuropathy (disease of the nerves that causes weakness, numbness and pain in hands and feet), spina bifida (a birth defect that occurs when the spine and the spinal cord do not develop completely), morbid obesity (a condition of being overweight to a degree that is dangerous to one's health), reduced mobility (ability to move around more difficult due to illness), edema (swelling due to excess fluid in body tissues), muscle weakness, difficulty walking, lack of coordination, right foot abscess (a mass filled with pus due to infection), severe sepsis (infection of the blood stream), respiratory failure with hypoxia (occurs when the body does not get enough oxygen to function), acquired absence of right foot (loss or removal of some or all of the toes on this foot) and acquired absence of left foot (loss or removal of some or all of the toes on this foot) upon admission. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of R #7's physicians progress notes dated 12/30/21 00:00 (12:00 am) revealed This is a [AGE] year-old man who was admitted to [name of hospital] from an outside hospital for a right first metatarsal (bone in the foot just behind the big toe) osteomyelitis. He had a right foot ulcer (open sore on the foot) as well as abscess (mass filled with pus caused due to infection) and cellulitis (a serious bacterial infection of the skin) of the entire right foot. He received IV (Intravenous, which is a thin, plastic tube called a catheter that is put into a vein designed to be deliver medication directly into the bloodstream) and oral (taken by mouth) antibiotics (medication intended to treat and prevent bacterial infections). He underwent a right foot wound debridement (a procedure to remove debris-scattered pieces of waste or remains, infected or dead tissue from a wound) including bone. Cultures of the soft tissue and bone were positive for staph aureus (a germ people carry in their noses or on their skin), Candida (a yeast like fungus that causes fungal infections), and group B strep common bacteria that lives in the body and often carried in the intestines-vita organ that helps digest food and absorb nutrients and vitamins). His hospitalization was complicated by epistaxis (nosebleed) and hyperbilirubinemia (a condition in which there is a build up in the blood of bilirubin - a yellowish pigment that is made during the normal breakdown of red blood cells). He was discharged to [name of the facility] on 12/13/2021 for ongoing wound care with a wound VAC (a treatment Vacuum Assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap) to the site as well as IV antibiotic treatment. D. Record review of R #7's nursing progress notes dated 12/13/21 21:48 (9:48 pm) revealed he (R #7) has PICC (Peripherally Inserted Central Catheter- a thin, soft, flexible tube used to inject fluids or medications directly into a vein and or to draw blood samples for testing) line to his right upper arm. E. Record review of R #7's medical records from [name of infectious disease clinic] dated 01/11/22 revealed Continue Rocephin (antibiotic medication used to treat a wide variety of bacterial infections) 2 g (grams) every 24 hours through 1/18 (2022) and On 1/18 (2022) may discontinue PICC line. F. Record review of R #7's progress notes dated 01/11/22 17:11 (5:11 pm) revealed patient came back from doctors appointment. Orders stop Rocephin 2 g on 1/18/2022, Discontinue PICC line. G. On 03/15/22 at 11:52 am, during an interview, the Doctor of Nursing Practice (DNP) reported that she sent orders to the facility to remove the PICC line from R #7's right arm as of 01/18/22 due to antibiotics being discontinued and the expectation was that the facility would remove it (the PICC line) on 01/18/22. H. On 03/22/22 at 11:45 am, during an interview, Licensed Practical Nurse (LPN) #3 confirmed an order was received on 01/11/22 to discontinue or remove the PICC line from R #7's right arm on 01/18/22. LPN #3 reported when an order is received (from a provider), we (the nursing staff) enter it into the system (electronic medical record) and get it (the order) done the same day whenever possible, but no more than 2 days (from the order date). I. Record review of R #7's nursing progress notes dated 01/23/22 15:31 (3:31 pm) revealed that R #7 asked a nurse to remove the PICC line due to IV antibiotic ending as of 01/18/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 03/15/22 at 10:55 am, during an interview, R #7 reported I started asking them (the staff) every single day when 01/18/22 (the last day of antibiotics) rolled around to take out my PICC line and they just ignored me, they never listened to me. I did not like having it (the PICC line) in. About a week later, a different nurse that had never been there before listened to me and finally took it (the PICC line) out. Findings related to lab work: K. Record review R #7's [name of infectious disease clinic] DNP progress notes dated 12/28/21 sent to the facility revealed We have not received labs. In order to continue his (R #7's) therapy we need weekly CBC (complete blood count-a blood test that helps evaluate overall health by testing red blood cells and white blood cells), CMP (comprehensive metabolic panel-a panel of 14 blood tests that serves as an initial broad medical screening tool), ESR (erythrocyte sedimentation rate - is a blood test that helps detect inflammation in the body), CRP (C-reactive protein - a blood test that measures inflammation in your body) with results faxed to our office. L. Record review R #7's [name of infectious disease clinic] clinical notes dated 01/06/22 11:19 am revealed A fax has been sent to [name of facility] requesting patient labs. I did write on the fax how important it is for us to get patient labs and if we don't it may impact patients treatment further. M. Record review R #7's [name of infectious disease clinic] clinical notes dated 01/06/22 15:40 (3:40 pm) revealed Reached out to [name of facility] to asked to talk to the director of nursing (DON). I was directed to [first name of DON], but no one picked up and a detailed voice mail was left. I stated that we have been trying to get labs for the last few weeks with no success and this Monday would be the second time we see the patient. I stated that if we do not get labs then this may impact his appointment on 1/10 (1/10/22), we may have to reschedule and or we may not be able to continue treatment. ID clinic number provided and I requested a call back. N. Record review of R #7's nursing progress notes dated 01/10/22 11:57 am revealed Pt (patient) receiving IV ABX (antibiotics) therapy daily, PICC line patent and flushing easily. Pt. has wound vac in place, to Rt (right) foot, no concerns noted. Doctor ordered blood test for CBC, CMP, ESR, CRP. O. On 03/15/22 at 11:52 am, during an interview, the Doctor of Nursing Practice (DNP) reported that she sent orders to the facility to have lab work completed on a weekly basis to ensure that the R #7's renal (kidney) and liver function are not being effected by the antibiotic. She reported It is a safety component while a resident is on therapy and in some cases, we will stop treatment if we don't receive what we need. She reported that they did not receive any lab work results requested prior to R #7's 12/28/21 appointment and they not receive all of the lab work results requested prior to R #7's 01/11/22 appointment. P. On 03/22/22 at 11:51 am, during an interview, LPN #3 reported I see lab orders (requests for blood tests) in the system (electronic medical record) for 12/28/21 and 01/11/22 from Infectious Disease clinic that [first name of R #7] was going to, but I only see them being drawn on 01/10/22 for the appointment R #7 had on 01/11/22; the infectious disease clinic usually requests the lab work weekly for residents that are on IV antibiotics. Findings related to liquid protein supplement: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Q. Record review of R #7's orders dated 12/14/21 revealed protein liquid two times a day for wound healing. R. Record review of R #7's Medication Administration Record (MAR) for the month of December 2021 revealed protein liquid was only administered once on 12/28/21. S. Record review of R #7's MAR for the month of January 2022 revealed protein liquid was only administered one time on 01/21/22. T. On 03/17/22 at 12:52 pm, during an interview, the Center Executive Director (CED) confirmed that protein liquid was supposed to be administered two times a day to R #7 per orders, but it was only administered once on 12/28/21 and on 01/21/22. Findings related to skin checks: U. Record review of R #3's face sheet revealed he was originally admitted to facility on 01/29/21. V. Record review of R #3's nursing progress notes dated 12/13/21 8:56 am entered by the Wound Care Nurse Practitioner (WCNP) revealed Wounds: He had DTI (Deep Tissue Injury) blister eschar (dark, crusty tissue at either the bottom or the top of a wound) on his R (right) lateral malleolus (bony area on the outside of the ankle) and on his right lateral (outer edge) foot. The R (right) malleolus has become a stable eschar and measures 2.8 cm (centimeters) x 2.2 cm x unknown. The R lateral foot is a callus (thickened and hardened area of the skin) crust remains and wound resolved. No drainage from either. Both are stable. The patient had breakdown on his sacrum (large triangular bone at the base of the spine) to right buttock (round fleshy part that forms the lower rear area of a human trunk) from moisture associated dermatitis (skin irritation) that is still superficially (near the surface) open in smaller area of 2.3 cm x 0.9 cm x 0.3 cm depth. He had a small slough (dead skin tissue) wound over an old scar at his L (left) IT (ischial tuberosity - a pair of rounded bones that extends from the bottom of the pelvis) area that has opened. It is 2.1 cm x 2.0 cm x 1.0 cm with only about 25% slough. W. Record review of R #3's skin checks for January 2022 revealed no skin checks were conducted for the weeks of 01/03/22 and 01/10/22. X. Record review of R #5's face sheet revealed she admitted to the facility on [DATE]. Y. Record review of R #5's nursing progress notes dated 01/06/22 revealed Visit Type: Wound. Chief Complaint/Nature of Presenting Problem: Stage 4 pressure injury on her buttocks that is over 1 year old and has been very slow to close. It is now reducing in size and closing. Z. Record review of R #5's skin checks for December 2021 revealed no skin check was conducted for the week of 12/13/21. AA. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BB. Record review of R #7's physicians progress notes dated 12/30/21 00:00 (12:00 am)revealed This is a [AGE] year-old man who was admitted to [name of hospital] from an outside hospital for a right first metatarsal (bone in the foot just behind the big toe) osteomyelitis. He had a right foot ulcer (open sore on the foot) as well as abscess (mass filled with pus caused due to infection) and cellulitis (a serious bacterial infection of the skin) of the entire right foot. He received IV (IV stands for intravenous, which is a thin, plastic tube called a catheter that is put into a vein designed to be deliver medication directly into the bloodstream). and oral (taken by mouth) antibiotics (medication intended to treat and prevent bacterial infections). He underwent a right foot wound debridement (a procedure to remove debris-scattered pieces of waste or remains, infected or dead tissue from a wound) including bone. Cultures of the soft tissue and bone were positive for staph aureus (a germ people carry in their noses or on their skin), Candida (a yeast like fungus that causes fungal infections), and group B strep common bacteria that lives in the body and often carried in the intestines-vita organ that helps digest food and absorb nutrients and vitamins). His hospitalization was complicated by epistaxis (nosebleed) and hyperbilirubinemia (a condition in which there is a build up in the blood of bilirubin - a yellowish pigment that is made during the normal breakdown of red blood cells). He was discharged to [name of the facility] on 12/13/2021 for ongoing wound care with a wound VAC (a treatment vacuum assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap) to the site as well as IV antibiotic treatment. CC. Record review of R #7's skin checks for December 2021 and January 2022 revealed no skin checks were conducted for the weeks of 12/13/21, 01/17/22 and 01/24/22. DD. On 03/17/22 at 12:52 pm, during an interview, the Center Executive Director (CED) reported that skin checks (confirms current status of the skin) and skin evaluations (conducted for all wounds identified includes status of the wound and measurements) should be conducted on a weekly basis. EE. On 03/22/22 at 11:58 am, during an interview, LPN #3 confirmed there were no skin checks on file for R #3 for the weeks of 01/03/22 and 01/10/22, no skin check on file for R #5 for the week of 12/13/21 and no skin checks on file for R #7 for the weeks of 12/13/21, 01/17/22 and 01/24/22. LPN #3 reported that skin checks should have been conducted on a weekly basis for these residents. FF. On 03/23/22 at 1:55 pm, during an interview, LPN #4 reported that skin checks should be conducted once a week and they are conducted by either by CNA's (Certified Nursing Assistants) or nurses. Findings related to weekly skin evaluations: GG. Record review of the facility policy titled Skin Integrity Management revision date 06/01/21 revealed Perform wound observations and measurements and complete Skin Integrity Report (aka Skin & Wound Evaluations and Swift Assessments) upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. HH. Record review of R #3's Skin & Wound Evaluations revealed no evaluations on file for the following weeks: 11/29/21, 12/06/21, 12/13/21, 12/20/21, 12/27/21, 01/03/22 and 01/10/22. II. Record review of R #5's Skin & Wound Evaluations revealed no evaluations on file for the following weeks: 12/27/21, 01/03/22, 01/10/22, 01/17/22, 01/24/22 and 01/31/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	JJ. Record review of R #7's Skin & Wound Evaluations revealed no evaluations on file for the following weeks: 12/27/21, 01/10/22, 01/17/22 and 01/24/22. KK. On 03/17/22 at 12:55 pm, during an interview, the CED reported that Skin & Wound Evaluations should be conducted on a weekly basis. The CED reported that Skin & Wound Evaluations should always include measurements of the wounds. LL. On 03/23/22 at 3:50 pm, during an interview, LPN #3 reported that from November 2021 through the beginning of March 2022 Registered Nurse (RN) #1 was overseeing the Swift (brand name) wound care management program, which allows the user to take images of the wounds in order to measure the wound and better analyze it. LPN #3 reported that RN #1 was not doing a good job of conducting the Skin & Wound Evaluations and was demoted and had also resigned her position with the facility. LPN #3 confirmed no Skin & Wound Evaluations on file for R #3 for the following weeks: 11/29/21, 12/06/21, 12/13/21, 12/20/21, 12/27/21, 01/03/22 and 01/10/22, no Skin & Wound Evaluations on file for R #5 for the following weeks: 12/27/21, 01/03/22, 01/10/22, 01/17/22, 01/24/22 and 01/31/22 and no Skin & Wound Evaluations on file for R #7 for the following weeks: 12/27/21, 01/10/22, 01/17/22 and 01/24/22. MM. On 03/24/22 at 1:49 pm, during an interview, the Wound Care Nurse Practitioner (WCNP) reported that she is assigned to five facilities and therefore visits each facility once a week. She reported that she visits this facility on Thursdays and she is supposed to be accompanied by a Wound Care Nurse at the facility who uses the Swift system to document her visits with the residents and who is ultimately in charge of managing wounds at their facility. The WCNP reported that this facility has been without a good Wound Care Nurse for the last few months and feels that RN #1 was not doing an adequate job as the Wound Care Nurse. She reported that she routinely sees every resident on a monthly basis and then those residents with special wound care needs on a weekly basis; however she was out on leave for 3 weeks in the month of January 2022 and no one was assigned to provide back-up while she was out. The WCNP reported that all of the nurses should have access to the Swift system and they were just trained about two weeks ago, but since there are so many agency nurses coming and going they decided to have once person in charge of the wound care at the facility.

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	325125	A. Building B. Wing	03/23/2022

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Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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F 0660 Level of Harm - Actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review and interview, the facility failed to develop an effective discharge plan for 1 (R #7) of 1 (R #7) resident reviewed for discharge planning (the process of transitioning a resident from one level of care to the next). The facility failed to involve the resident and the residents family in the discharge planning process and accurately identify the residents post discharge needs. This deficient practice likely resulted in R #7 staying at the facility longer than desired and needed, resulting in undue emotional distress (sadness, fear and/or worry). The findings are: A. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE]. B. Record review of R #7's face sheet revealed the following diagnoses: osteomyelitis right ankle and foot (an infection in the bone caused by bacteria or fungi), neuropathy (disease of the nerves that causes weakness, numbness and pain in hands and feet), spina bifida (a birth defect that occurs when the spine and the spinal cord do not develop completely), morbid obesity (a condition of being overweight to a degree that is dangerous to one's health), reduced mobility (ability to move around more difficult due to illness), edema (swelling due to excess fluid in body tissues), muscle weakness, difficulty walking, lack of coordination, right foot abscess (a mass filled with pus due to infection), severe sepsis (infection of the blood stream), respiratory failure with hypoxia (occurs when the body does not get enough oxygen to function), acquired absence of right foot (loss or removal of some or all of the toes on this foot) and acquired absence of left foot (loss or removal of some or all of the toes on this foot). C. Record review of R #7's physicians progress notes dated 12/30/21 00:00 (12:00 am) revealed This is a [AGE] year-old man who was admitted to [name of hospital] from an outside hospital for a right first metatarsal (bone in the foot just behind the big toe) osteomyelitis. He had a right foot ulcer (open sore on the foot) as well as abscess (mass filled with pus caused due to infection) and cellulitis (a serious bacterial infection of the skin) of the entire right foot. He received IV (IV stands for intravenous, which is a thin, plastic tube called a catheter that is put into a vein designed to be deliver medication directly into the bloodstream). and oral (taken by mouth) antibiotics (medication intended to treat and prevent bacterial infections). He underwent a right foot wound debridement (a procedure to remove debris-scattered pieces of waste or remains, infected or dead tissue from a wound) including bone. Cultures of the soft tissue and bone were positive for staph aureus (a germ people carry in their noses or on their skin), Candida (a yeast like fungus that causes fungal infections), and group B strep common bacteria that lives in the body and often carried in the intestines-vita organ that helps digest food and absorb nutrients and vitamins). His hospitalization was complicated by epistaxis (nosebleed) and hyperbilirubinemia (a condition in which there is a build up in the blood of bilirubin - a yellowish pigment that is made during the normal breakdown of red blood cells). He was discharged to [name of the facility] on 12/13/2021 for ongoing wound care with a wound VAC (a treatment vacuum assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap) to the site as well as IV antibiotic treatment. (continued on next page)

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F 0660 Level of Harm - Actual harm Residents Affected - Few	D. Record review of R #7's Post Admission Pt (Patient)/Family Conference notes dated 12/20/21 revealed Patient expectations for length of stay = 15-21 days, IDT (Interdisciplinary Team - group of health care professionals from different fields or departments who work in a coordinated fashion toward a common goal for the resident) determination for projected length of stay = 15-21 days and Additional Comments: This baseline, Person-Centered Care Plan is developed within 48 hours and is reviewed at the Post Admission Patient/Family Conference and given to the resident and/or resident representative and updated as indicated. Social services discussed discharge plan. E. On 03/15/22 at 11:05 am, during an interview, R #7 reported I was always confused and ignored while I was at [name of the facility]. R #7 reported that the staff never kept him informed of his care and when he would be discharging. R #7 reported one nurse said I would be going home after the IV antibiotics were done on January 18th (2022), another nurse told me I would be going home a couple of days after that, the other ones (staff) would poke their head in my room and tell me you are going home tomorrow and I would see them again the next day and they would say oh no you are not going home yet. R #7 reported that he did not participate in any discharge planning meetings even though he asked them every day about going home. R #7 reported I started feeling really depressed (feeling of sadness and loss of interest affecting normal activities) and anxious (feeling worried, uneasy and nervous), it just hit me all at once and I called my parents to come and pick me up (on 01/25/22), because no one (at the facility) was listening to me. R #7 reported that he still had a wound on the bottom of his right foot when he left the faciity on [DATE], but the staff did not provide him or his family with any information about the status of the wound and they only provided about 2 days worth of bandages for the wound so they (R #7 and his family) had to stop at the store on the way out of town for wound care supplies. (continued on next page)

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F 0660 Level of Harm - Actual harm Residents Affected - Few	F. On 03/15/22 at 11:26 am, during an interview, R #7's mother reported that she and other family members made several telephonic attempts on several occasions to reach the facility regarding R #7's discharge and no one ever returned their calls. She reported that the staff was aware that they live over 2.5 hrs away from the facility and that she needed to be involved in the discharge planning process as R #7 could not drive himself home even if he wanted to. She reported I was on the phone with him (R #7) all the time, because he wanted to come home and they would come into his (R#7's) room and he would tell them, I need to let my mom know when I'm going home so she can come pick me up. She reported that he (R #7) wanted to go home, because he was getting depressed and anxious and not sleeping well, because they (the staff) always ignored him when he asked about his progress and when he would be able to go home. She reported he (R #7) would call me and cry and cry and say I want to go home. They caused him emotional distress, he does not deserve that. It's like they wanted to keep him, but they did not want to take care of him. She reported the day we finally just drove there (to the facility) to pick him (R#7) up (on 01/25/22), we let them (the staff) know right away that we were there to pick him up and they (the staff) just let us just sit there in his room for more than 3 hrs. She reported I went up to the nurses station and the male nurse just kept on working like I was not even there and even walked off and left me standing there and the CNA's (Certified Nursing Assistants) kept telling me wait for the nurse, wait for the Social Worker and we kept waiting and no one came so I finally said we need to get home before dark so we are leaving. She reported they told me that he (R #7) can't take the wound vac home and I told them, we don't have electricity where we live so we don't want to take it. She reported the male nurse finally came in to the room and took the bandage off the wound on the bottom of R #7's right foot, applied cream to the wound and put another bandage on the wound and gave them no information about the wound or instruction on what they should do care wise with the wound at home. She reported they made us wait for hours and they still sent us away with no discharge orders and only a couple of supplies for the wound. We had to stop at [name of store] on the way home and buy $130 worth of supplies (for wound care). She reported my son (R #7) is [AGE] years old, but he is still like a child in some ways, because of his learning disability. His mind is still very young. G. Record review of R #7's care plan revealed the following Goal created by Social Services and initiated on 12/14/21: [First name of R #7] will have an ongoing discharge plan that provides for a safe and effective discharge. H. Record review of the facility policy titled Discharge Planning Process revision date 02/01/19 revealed Weekly, and Interprofessional Utilization Management (UM - helps ensure that patients have the proper care and the required services without overusing resources) and Discharge Planning Meeting will be conducted to continue evaluation of discharge potential. I. Record review of R #7's [name of facility] - Short Term Patient notes (also known as UM discharge planning meeting notes) revealed the following: 12/28/21 Keep another week - wound vac needs update and Continues to have IV (Intravenous, which is a thin, plastic tube called a catheter that is put into a vein designed to be deliver medication directly into the bloodstream) antibiotics medication (intended to treat and prevent bacterial infections) and wound vac (a treatment vacuum assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap). Keep until IV are completed. Pt (patient) was d/c (discharged) off therapy on 12/27/21. 01/04/22 On IV anti (antibiotics) until 01/18/21 (year should be listed as 22). (continued on next page)

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F 0660 Level of Harm - Actual harm Residents Affected - Few	01/05/22 Spoke with patient, gave nursing wound sheet to fill out. 01/17/22 Wrong form submitted (for wound vac order) new forms obtained given to nursing. Told pt (patient) center is working on wound vac. J. Record review of R #7's electronic medical record revealed no weekly discharge planning meeting notes for the weeks of 12/13/21, 12/20/21, 01/10/22 and 01/24/22. K. Record review of R #7's nursing progress notes dated 01/25/22 18:45 (6:45 pm) revealed Pt (patient) called his mother and told her he was being discharged from facility. Pt's mother came to facility and was noticeably upset stating she had been trying to get a hold of somebody because she had no information on pt's dc (discharge). Writer stated to pt's mother that the dc planning is still on going and that dc is pending approval of wound vac to be taken home. Mother stated she wanted to take pt home d/t (due to) pt having completed IV ab (antibiotics). Pt and pts mother were notified that if pt left facility today it would be considered AMA (Against Medical Advice). Family stated understanding and decided to take pt home. Social services and pt's Nurse notified. Wound vac was taken off pt and a dressing applied to right foot wound. L. On 03/17/22 at 1:30 pm, during an interview, the SSD confirmed there were no discharge planning meeting notes on file for R #7 for the weeks of 12/13/21, 12/20/21, 01/10/22 and 01/24/22. The SSD reported that the only documented discharge planning meeting that included R #7 and/or his family was held on 12/20/21 at 14:06 (2:06 pm), in which the SSD met in-person with only R #7. The SSD reported I don't write down every interaction that I have with residents regarding discharge planning, because I have these conversations with them (residents) all of the time and I remember speaking to him (R #7) at least twice maybe three or four times about discharge planning. I probably did give him different dates of when he could leave (discharge from the facility), but not every interaction is documented. The SSD reported that they (she & R #7) did not discuss the specific transportation needs R #7 would have upon discharge or the need to involve other family members in the discharge planning process. SSD reported that the length of stay when a resident admits to facility just depends on what is going on with the resident. The SSD reported In this case (R #7's), the wound vac that we needed to order for him was holding up the discharge. Regarding R #7 discharging AMA on 01/25/22, SSD confirmed that he was documented as leaving AMA because he left prior to the wound vac being delivered and she confirmed that R #7 was not provided any discharge information. The SSD reported that she was unaware that R #7 did not have electricity in his home, which is needed to operate a wound vac and that R #7 or the nursing staff should have told her that there was no electricity in R #7's home.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review and interview, the facility failed to provide appropriate foot care for 1 (R #7) of 1 (R #7) resident reviewed by not following orders to schedule an appointment to see a podiatrist (a medical professional who treats disorders of the foot, ankle, and related structures of the leg). This deficient practice could likely result in infection progressing to other parts of the body. The findings are: A. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE]. B. Record review of R #7's physicians history and physical note dated 12/15/21, 10:28 am revealed Follow-up with podiatry. C. Record review R #7's [name of infectious disease clinic] Doctor of Nursing Practice (DNP) progress notes dated 12/28/21 revealed He (R #7) also needs immediate follow-up with his podiatrist [name of podiatrist]. D. Record review of R #7's care plan dated 12/29/21 revealed [R #7's first name has a Dx (diagnosis) of osteomyelitis (an infection in the bone caused by bacteria or fungi located in his right ankle and foot) and is at risk for becoming septic (infection in the blood stream). E. Record review R #7's [name of infectious disease clinic], DNP progress notes dated 01/11/22 revealed Follow-up with podiatry as planned. F. Record review of R #7's progress notes from 12/28/21 through 01/25/22 revealed no follow up appointment with a podiatrist. G. On 03/15/22 at 10:55 am, during an interview, R #7 reported I didn't see a foot doctor (podiatrist) like I was supposed to and I reminded the nurses (at the facility) that [the first name of the DNP at the infectious disease clinic] told me to, but they (staff at the facility) never listened to me. H. On 03/17/22 at 1:35 pm, during an interview, the Social Services Director (SSD) reported that their department does not set up podiatry appointments and that the nursing staff would be responsible for doing that so they (Social Services Department) would have no record of a podiatry appointment for R #7. I. On 03/22/22 at 11:39 am, during an interview, Licensed Practical Nurse (LPN) #3 reported that R #7 was not seen by a podiatrist while at the facility. She reported I remember hearing that they have a podiatrist over at the infectious disease clinic he (R #7) was going to and he probably saw one over there.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37426 Based on record review and interview the facility to ensure that for 3 (R #1, 2, and 3) of 3 (R #1, 2, and 3) residents reviewed for dialysis procedure (removing harmful wastes and surplus salt and water from the blood following kidney failure) reviewed for compliance had: 1. Ongoing communication/collaboration between the facility and the dialysis center; 2. Care planned to identify a hospital for emergency services that has the capacity to provide emergency dialysis care. If the facility is unaware of the residents condition, or complications that may arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: Findings for R #1 A. Record review of R #1's Face sheet: indicated R #1 was admitted on [DATE]. discharged on [DATE]. Diagnosis: acute respiratory failure with hypoxia (not enough oxygen in your blood), orthopedic (bone treatment) aftercare following surgical - amputation (surgical removal of all or part of a limb), acute osteomyelitis (bone infection) - right ankle and foot, reduced mobility (the ability to move or be moved freely and easily), end stage renal (a condition where the kidney reaches advanced state of loss of function) disease, bed confinement status (remains in bed) - weakness muscle weakness, difficulty in walking, lack of coordination, pneumonia (infection of the lungs) due to covid-19 (highly infectious viral disease), type 2 diabetes mellitus (a condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently) with diabetic nephropathy (condition of nerve damage caused due to persistently high blood sugar level (diabetes), type 2 diabetes mellitus with hyperglycemia (high blood sugar), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Payment provider: [name of healthcare program]. B. Record review of R #1's Progress notes dated 01/06/22 at 16:58 (4:58 pm) revealed the following: [name of transportation] to provide stretcher transportation for R #1 to her HD (hemodialysis) (process of purifying the blood of a person whose kidneys are not working normally) on Monday, Wednesday, and Friday. They will pick up at 10:30 am (from the facility). Please ask nursing staff to place the Hoyer (mechanical device for transferring a person i.e., from bed to chair) sling underneath her to assist HD staff in getting her into the HD chair. [name of transportation] will pick her up at 4:30 (from Dialysis Center) and return her to you (the facility). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of R #1's Progress Notes dated 01/10/22 at 11:29 pm revealed, the following, This patient was sent to [name of hospital] emergency roiagnom on [DATE] via ambulance by [name of dialysis center]. [Companies name of transportation] reported that transportation was canceled at 4:17 pm. No report was given to the facility or payment provider [name of healthcare program] about the patient being sent to the hospital. This nurse called [name of hospital] emergency department and spoke with the nurse there who reported that the patient (R #1) had a hypotensive (low blood pressure) crisis and was being admitted to the hospital. [Name of healthcare program representative #1] called back and had spoken with [name of healthcare program representative #2] and reported that [name of hospital] told her the patient (R #1) was Covid positive. [Name of hospital] informed this nurse that they would notify facility and patient, POA (Power of Attorney) of any CIC (change in condition). D. On 02/03/22 at 1:26 pm, during an interview, R #1's Daughter in law, revealed, I had received a phone call at 10:50 pm, on 01/10/22 from [name of nursing facility] stating that my mother-in-law was not at the facility and did not come back from dialysis. I asked why you are calling me so late because 5-6 hours have passed. A woman from the facility who did not give her name informed me that they thought that I may have picked up my mother-in-law and have taking her to dinner or gone shopping. I don't know how that could be possible because my mother-in-law goes to dialysis on a stretcher. [Name of healthcare program] called and they told me that my mother-in-law while at dialysis had low blood pressure, and that she was confused, so they sent her to [name of the hospital]. [name of healthcare program] informed me that my mother-in-law was at [name of hospital]. The [name of nursing facility] never did call back and inform me that she was at [name of hospital]. E. On 02/07/22 at 7:57 pm, during an interview with License Practical Nurse #1 (LPN) confirmed, R #1 was sent out to dialysis on 01/10/22 before my shift began and R #1 did not return when I started my shift at 6:00 pm on 01/10/22. Sometimes when resident's go to dialysis afterwards they are picked up by family, friends, and they are taken out to dinner. I did not initiate looking for R #1 because when I start my shift, I take care of my residents first I have a responsibility to the residents and when it came to 7:30 pm, that evening (01/10/22), I realized R #1 still was not back. I know the daughter-in-law was mad at me for calling her late I cannot remember what time I called her. The note on R #1's progress note dated 01/10/22 was a late entry I called the dialysis center, but they were closed. I found out R #1 is with [name of healthcare program] and called [name of healthcare program] coordinator [name of coordinator] and another person, but I can't remember her name at [name of healthcare program] was assisting me in looking for R #1. [Name of healthcare program] did not know what happened to R #1 was either. I called [name of hospital] emergency room and they confirmed that R #1 was there and that I got report from the nurse at [name of hospital]. The situation of finding R #1 was resolved by 8:30 pm - 9:00 pm and that we (the facility) established that R #1 was safe. F. On 02/08/22 at 11:30 pm, during an interview, Center Nursing Executive (CNE), confirmed that there is a form that is completed for communication purposes between the facility and the dialysis center, and the form goes with the dialysis resident. The nurses put their report (resident assessment performed and completed before resident goes to dialysis) from R #1's on the form. CNE confirmed does not know if residents are signed out and in when going to appointments. CNE also stated that when a resident is late (after residents expected time of arrival) coming back from the dialysis, they call the dialysis center, if dialysis center is closed, then that is a big problem then the family member is contacted. CNE confirmed Facility would initiate the calls to locate the resident immediately after not coming back at the scheduled time. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 02/08/22 at 12:20 pm, during an interview with the Center Executive Director (CED), revealed, she heard about the incident R #1 not returning back to the facility from dialysis the next day (01/11/22) and did receive an incident report from the family member. H. On 02/11/22 at 11:30 am, during an interview with the CED, confirmed, When a resident does not return back to the facility at the scheduled time the nurse would contact dialysis to follow-up. Facility would expect to start looking for the resident within half-an-hour of not returning at the scheduled time to the facility. Also, reaching out to the driver. If the dialysis center is closed follow the missing part of the (elopement) resident policy. I. Record review of facility's Elopement of Patient policy revised date of 02/28/21, revealed for unwitnessed elopement: 1. 3.1 Notify the supervisor that the patient is missing. 2. 3.2 supervisor will alert all staff of missing patient with an announcement to activate missing patient protocol. 3. 3.3 A designee from each unit and department will report to the location tat announced the missing patient to learn of the patient's name, when the patient was last seen, and a description of the patient. 4. 3.4 Staff will search: a. 3.4.1 Room to room and all areas of the center (including occupied and unoccupied spaces): patient rooms, closets, under bed, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen (including walk-in refrigerators and freezers), bathrooms, dayroom/lounges, courtyards, and employee lounges; and b. 3.4.2 Outside building perimeter and grounds. 5. 3. 5 Review Release of responsibility for leave of absence/therapeutic leave record to verify if patient is on leave of absence. 6. 3.6 The supervisor will notify the Center Executive Director (CED) and Center Nurse Executive (CNE) regarding the status of the search. 7. 3.7 If the patient is not found after the search of the center and grounds, notify law enforcement. Center may also, if appropriate, notify local hospitals, public transportation providers, etc. a. 3.7.1 Provide law enforcement and other search party members a copy of the Elopement risk Identification form. b. 3.7.2 If indicated, staff will expand the search beyond the center and ground into the extended community. 8. 3.8 CED, CNE, or designee will notify patient representative. (continued on next page)

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	325125	A. Building B. Wing	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #1's care plan dated 01/05/22 revealed, no documentation containing information for a hospital identified for emergency services that has the capacity to provide emergency dialysis care. Findings for R #2 K. Record review of R #2's Physician Orders revealed the following: Patient will have dialysis on Tuesday, Thursday, and Saturday. L. Record review of R #2's care plan dated 01/04/22 revealed, no documentation containing information for a hospital identified indicating for emergency services that has the capacity to provide emergency dialysis care. Findings for R #3 M. Record review of R #3's Physician Orders revealed the following: Dialysis Tuesday, Thursday, and Saturday. O. Record review of R #3's care plan dated 01/04/22 revealed, no documentation containing information for a hospital identified indicating for emergency services that has the capacity to provide emergency dialysis care. P. On 02/11/22 at 10:42 am, during an interview with the CED confirmed, that R #1, 2, and 3's care plans do not have documentation information for a hospital identified for emergency services that has the capacity to provide emergency dialysis care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	03/23/2022

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41738 Based on record review and interview, the facility failed to ensure resident's medical records were accurate for 1 (R #7) of 1 (R #7) residents reviewed. This deficient practice could likely result in residents not receiving the care and services they need. The findings are: A. Record review of R #7's face sheet revealed he was admitted to the facility on [DATE] and discharged on [DATE] with the following diagnoses: osteomyelitis right ankle and foot (an infection in the bone caused by bacteria or fungi) and right foot abscess (a mass filled with pus due to infection). B. Record review of R #7's nursing progress notes dated 12/13/21 21:48 (9:48 pm) revealed Patient was admitted /readmitted for the following reason(s): Ortho (related to soft tissues or bone) Pain Management, OSTEOMYLETIS (an infection in the bone caused by bacteria or fungi), RESP (respiratory - related to the lungs) FAILURE, HYOPXIA (occurs when the body does not get enough oxygen to function), CELLULITIS (a serious bacterial infection of the skin) Additional details about this note: Newly admitted resident, A/O X 4 (patient is alert and oriented to person, place, time, situation), CAME IN @ 21:48 pm, 12/13/2021. He has a wound on his right foot covered with dressing/bandage with a wound vac (a treatment vacuum assisted device that shrinks the size of the wound and draws the edges of the wound together making it easier for the body to repair the gap connected to it). C. Record review R #7's Skin & Wound Evaluation dated 01/06/22 revealed a wound on the sole of R #7's left foot measuring width of 5.9 cm (centimeters), length of 5.8 cm and area of 27.7 cm. D. Record review of R #7's nursing progress notes dated 01/13/22 9:56 am revealed A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Other Wound(s): Location(s): sole of left Foot. E. On 03/22/22 at 11:27 am, during an interview, Licensed Practical Nurse (LPN) #3 reported that R #7 did not have a wound on his left foot. She reported He (R #7) came to us from the hospital (on 12/13/21) with a wound on the bottom of his right foot and did not acquire any other wounds while at the facility; that was an error made on our (the nursing staff) part, we listed the left foot in a few of our notes by mistake.