STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. Building B. Wing	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on observations, record review, resident and staff interviews, the facility failed to exercise resident rights, failed to provide privacy for 1 of 5 residents (Resident #86) reviewed for resident rights. Findings included: Resident #86 admitted to the facility on [DATE] and with diagnoses that included a history of type 2 diabetes mellitus, hypertension, hypothyroidism, and asthma. A review of Resident #86's quarterly minimum data set (MDS) dated [DATE] revealed Resident was cognitively intact. During an observation on 10/13/22 at 10:23 am Nurse # knocked on Resident #86's room door while NA #3 was providing activities of daily living care (ADL) care. NA #3 stated patient care when heard knock on room door, however Nurse # 12 proceeded to open room door. Resident #86 was lying in bed with lower body exposed and privacy curtain was open and while room door was open. Nurse #12 indicated she was doing covid testing and gestured with hand she was going to roommates' side of the room. NA #3 again stated patient care and Nurse #12 then closed room door. NA #3 pulled privacy curtain at that time. An interview was conducted on 10/13/22 at 10:39 am with Resident #86 and she indicated she did not like it when Nurse walked in room while she was receiving ADL care. She stated, I did not like it, made me feel like I don't have no privacy, me laying here naked. Resident #86 indicated staff do not usually pull the privacy curtain while giving ADL care. An interview was conducted on 10/13/22 at 11:10 am with NA #3 and she indicated she should have had the privacy curtain but forgot to pull it. During an interview on 10/13/22 at 11:20 am with Nurse #12 she indicated she did not hear NA #3 say patient care and she was not aware that Resident #86 was uncovered. She indicated she should have waited for Resident response before she entered room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/13/22 at 1:06 pm an interview was conducted with the Director of Nursing (DON), and she indicated Nurse #12 was a new Nurse and new to the facility. She indicated Nurse # was in orientation, and believed it was a cultural difference and did not understand what was meant when NA #3 said patient care. The DON indicated Nurse #12 she should have knocked on the door and waited to be instructed to come in room before opening room door. She also indicated it was her expectation that the privacy curtain was pulled while providing ADL care. During an interview with the Administrator on 10/13/22 at 5:15 pm, she indicated she was aware of Nurse #12 and NA #3 not providing privacy for Resident #86 while she was receiving ADL care. She indicated Nurse #12 was in training and was doing a task. She further indicated it was her expectation that staff knocked on Residents room doors and waited for response before proceeding and privacy curtains to be pulled while providing ADL care.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on record review, staff and resident interviews, the facility failed to honor a resident's preference for a shower (Resident #92) and failed to allow residents the right to choose to leave their assigned room while the facility was in a Covid-19 outbreak ((Resident #13, Resident #20, Resident #54, and Resident #26) for 5 of 7 residents reviewed for choices. Findings included: 1.Resident #92 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] indicated the assessment was in process. The resident was assessed as cognitively intact. Resident's Activity of Daily Living (ADL) was assessed as requiring total dependence of one person for bathing. The resident did not exhibit rejection of care and had no behavioral symptoms. Review of the Point of Care history documentation from 9/13/22 to 10/11/22 revealed the resident received complete bed baths on 9/14/22, 9/15/22, 9/23/22, 9/28/22, 10/4/22, 10/5/22, and 10/7/22. Resident #92 received partial bed baths on 9/24/22, 9/26/22, 9/27/22, and 10/1/22. There was no documentation of the resident receiving any showers. Review of the shower schedule book revealed Resident #92's scheduled shower days were Thursday during the first shift (7:00 AM- 3:00 PM). During an observation and interview on 10/10/22 at 12:30 PM, Resident #92 was observed sitting in his motorized wheelchair. Resident was observed to be well groomed and clean. Resident indicated he was going out of the facility for a doctor's appointment. Resident #92 stated he did not receive any showers since his admission to the facility (9/13/22). Resident indicated he received bed baths three times a week. Resident #92 stated that when he requested staff for a shower, he was informed that due to COVID-19 outbreak in the facility, the residents were not offered showers. During an interview on 10/12/22 at 10:40 AM, Nurse Aide (NA) #6 stated she was frequently assigned to the resident and worked the first shift (7:00 AM - 3:00 PM). Resident #92 was scheduled for showers every Thursday during first shift. NA #6 indicated the resident was totally dependent for bathing and needed a shower bed. NA #6 stated residents who needed a bariatric shower chair a shower bed for showers needed to be taken to the basement floor for showers in the big shower room that could accommodate the shower bed or the bariatric shower chair. Showers for these residents could not be offered in their rooms as the shower rooms could not accommodate a shower bed or a bariatric shower chair. NA #6 indicated due to COVID -19 outbreak in the facility, NAs were made aware by the management that the residents could not leave their rooms and hence could not be taken downstairs. NA #6 further indicated the resident required 2-person physical assistance for showers and there were not enough staff available to accommodate the resident request. NA stated the resident was offered a complete bed bath or partial bed bath instead. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/13/22 at 2:03 PM, NA #1 indicated she was occasionally assigned to Resident #92 during the first. NA #1 stated due to COVID-19 outbreak in the facility, residents who needed to be taken to the large shower room on the basement floor were not taken. These residents were offered a bed bath instead. During an interview on 10/12/22 at 11:00 AM, Nurse #3 stated she was the unit supervisor. Nurse #3 further stated Resident #92 was offered a complete or partial bed bath almost daily. Nurse #3 indicated to assist the resident to be transferred to shower and offer shower would require 2 NAs to leave the floor. This would mean the floor would be short staff and other residents' care would not be able to be provided. The floor had 3-5 NAs assigned during 1st and 2nd shift but usually the floor had only 3 NA's. Residents who could be provided showers in their rooms were offered showers and other residents were offered bed baths. During an interview on 10/12/22 at 11:15 AM, the Director of Nursing (DON) stated that she was unaware of any policy that indicated that residents would not be offered showers due to the COVID-19 outbreak. The DON further stated there was adequate staff available if needed to offer showers to the resident. DON stated she expected residents to be offered and given showers as scheduled and as requested. During an interview on 10/13/22 at 3:06 PM, the Administrator indicated there was a policy that stated all residents and staff could wear the appropriate personal protective equipment (PPE) and could take the residents to showers as needed. All residents should be offered showers on shower days and as needed when requested. Staff were available to assist the residents with required care as needed. 43332 2. Resident #26 was admitted to the facility on [DATE] with diagnoses of heart failure, diabetes mellitus, and non-Alzheimer's dementia. An interview with Resident #26 was conducted in her room on 10/11/2022 at 9:05 A.M. During the interview, Resident #26 indicated she was told by staff due to the current Covid-19 outbreak in the facility, she was unable to leave her room to sit in the dining room and look out the window. Resident #26 stated she enjoyed being in the dining room and did not like being in her room. Resident #26 further indicated staff indicated they would make her aware when the outbreak was over, and she was able to leave her room. During the onsite survey a Resident Council Meeting, with the surveyor and four residents, was held on 10/12/2022 at 2:30 P.M. During the meeting the residents in attendance (Resident #13, Resident #20, Resident #54, and Resident #26) each confirmed they had been told by all facility staff they were unable to leave their room until two weeks after the last positive Covid-19 test in the facility had been identified. An interview was conducted with Resident #13 in her room on 10/13/22 at 11:30 A.M. During the interview, Resident #13 indicated two weeks ago when the facility had a positive Covid-19 test result, staff told her due to the facility being in a Covid-19 outbreak status they would not be allowed to eat in the dining room, participate in group activities, or leave their rooms. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #9 on 10/13/2022 at 11:42 P.M. During the interview, Nurse #9 indicated when the Covid-19 outbreak began two weeks prior, the Infection Preventionist (IP) spoke with staff when the positive cases of Covid-19 were identified and indicated residents were to stay in their rooms due to the outbreak in the facility. During the interview, she indicated the IP provided staff with all the latest updates and was responsible for telling staff at the conclusion of the outbreak when residents were able to leave their rooms. An interview was conducted with the Infection Preventionist (IP) on 10/12/2022 at 4:36 P.M. During the interview, the IP indicated when the facility was in a Covid-19 outbreak status, such as now, residents had to stay in their rooms to help prevent the spread of the virus An interview was conducted with the Director of Nursing (DON) on 10/13/2022 at 1:15 P.M. The DON indicated if staff told residents to stay in their rooms, the staff had misunderstood the newest Covid-19 guidance. The DON further indicated residents who have tested negative for Covid-19 have no restrictions to their movements and are allowed outside of their rooms. An interview was conducted with the Administrator on 10/13/2022 at 12:15 P.M. During the interview, the Administrator indicated residents were allowed to leave their rooms and eat in the dining room. The Administrator stated there have been no positive cases on second floor and residents who resided on the third floor, where positive Covid-19 cases had been identified, had been asked not to enter the second floor to limit the spread of the Covid-19 outbreak. The Administrator indicated staff needed to explain the risks of exposure to residents and allow the residents to leave their rooms.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review, staff interviews, physician assistant and physician interview, the facility failed to notify the physician of the development of an open wound to a resident's right leg on 7/27/22 that deteriorated in condition through 8/13/22 for 1 of 3 residents (Resident #293) reviewed for notification of change. This failure resulted in no physician evaluation of the wound and no physician ordered treatments to the wound. On 8/12/22 the wound was assessed by Nurse #7 with a foul odor and on 8/13/22 Nurse #7 notified the physician of the wound, a change in the resident's condition, and the physician ordered for the resident to be transferred to the hospital. Resident #293 was treated in the hospital for septicemia (blood poisoning, especially caused by bacteria or their toxins) and osteomyelitis (inflammation of the bone caused by infection) related to right leg wound. Immediate Jeopardy began on 7/27/22 when the facility failed to notify the physician of the open wound found on Resident #293's right leg. The Immediate Jeopardy was removed on 10/22/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems implemented are effective and to complete staff education. Findings included: Resident #293 was admitted to the facility on [DATE]. A review of a nursing progress note dated 7/27/22 at 7:24 pm made by Nurse # 11 read in part Resident #293 had an open wound to his right leg. No treatment orders were found. Wound was packed with normal saline, damp to dry sterile gauze, and covered with sterile gauze secured by kerlix (white gauze dressing). Resident tolerated well. During a telephone interview on 10/11/22 at 5:48 pm with Nurse #11 she indicated, on 7/27/22 she recalled Nursing Assistant (NA) #4 asked for assistance to provide care to Resident #293. She indicated when they went to turn the Resident, she observed an open area on the Resident's right leg that was about 1/2 inch in diameter and 2 inches long. She indicated she cleaned the wound and put a dressing on it and looked at the Resident's skin and did not see any other areas on the Resident's body. She indicated she reported the wound to Nurse #1 who was in the facility at the time, and Nurse #1 informed her she would let the wound Physician know about the wound the next morning. Nurse #11 indicated she asked Nurse #1 if she wanted her to measure the wound or get orders and she stated Nurse #1 informed her she would take care of it and instructed her to put a dressing on the wound. On 10/13/22 at 3:45 pm an interview was conducted with Nurse #1. She denied being notified by Nurse #11 of Resident #293 having any wounds on 7/27/22. She indicated she had no knowledge of the Resident having any wounds in July. Record review from 7/27/22 through 8/12/22 revealed no evidence the physician was notified of Resident #293's right leg wound first identified on 7/27/22, no treatment orders were in place, and no wound assessments or physician evaluations of the wound were completed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Nursing progress note dated 8/12/22 at 10:00 pm by Nurse #7 read in part, Resident # 293 was found to have an open wound on right leg (calf) with a foul-smelling odor, and some bleeding noted. Observations left in wound care and Physician book for evaluation. On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she was the Nurse that worked on 8/12/22. She indicated it was reported by NA #4 who was assigned to Resident #293 that he had blood on his sheets. She indicated she went to check the Resident and observed a bandage wrapped on his right leg. Nurse #7 indicated the bandage had no date on it and when she removed the bandage, she observed wound to right calf that had bloody, greenish drainage. She indicated she observed the wound to be to the bone. Nurse #7 indicated it was the end of her shift and she had to leave and left a written note in Physician book that is left at the nurse's station for further evaluation when Physician returned to facility, and she notified Physician verbally on the phone on 8/13/22. Review of electronic medical record revealed on 8/12/22 a SBAR (situation, background, assessment, resident evaluation) communication form was completed by Nurse #7. The communication form read in part a change in condition identified on 8/12/22 was a wound to right leg. Wound was evaluated to have drainage and foul smell. The responsible party (RP) was notified on 8/13/22 at 4:50 pm, and Physician notified. A review of hospital records read, in part, Resident #293 presented to hospital on 8/13/22 ill-appearing, in acute distress, had diffuse pain, and had a wound to the right lower leg that was covered. On exam it was noted Resident meet SIRS (Systemic Inflammatory Response, an exaggerated defense response of the body to a noxious stressor like infection and/or inflammation) criteria and was started on intravenous fluids and antibiotics. On 8/15/22 MRI (magnetic resonance imaging) of Resident #293's right lower leg was done, and results revealed MRI along posterolateral (situated on the side and toward the posterior aspect) upper leg with sinus tract to bone with osteomyelitis. A telephone interview was conducted on 10/12/22 at 10:15 am with the Physician Assistant (PA) and it was indicated she no longer worked in the facility and did not have access to her notes. She indicated she did not recall personally seeing any wounds on Resident #293 or being informed of any. On 10/12/22 at 10:28 am a telephone interview was conducted with the primary Physician of Resident #293, and he indicated as of 9/17/22, he no longer worked at the facility and no longer had access to Resident #293's records. He indicated he was not aware of Resident #293 having any wounds in July and was not able to access the records for the Resident. During an interview on 10/13/22 at 1:06 pm with the Director of Nursing (DON) she indicated the process to be followed when a wound was identified was to notify the Physician and Responsible party (RP), get an order for treatment of the wound from the Physician and transcribe the order in the computer. She also indicated the nursing staff should put any new wounds identified in the wound communication book to notify the wound nurse. She indicated she reviewed the activity report in the computer and 24-hour report to see if any report included abnormal findings. She indicated she was not aware Resident #293 had any wounds in July. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/13/22 at 5:10 pm with the Administrator it was indicated her expectation when a new wound was identified was to notify the Physician, get orders to treat the wound, and notify the family. She further indicated it was her expectation skin observations were to be done weekly and documented in the computer. The Administrator was notified of immediate jeopardy on 10/21/22 at 11:11 am. On 10/21/22 the facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance. Resident #293 no longer resides in the facility. On 7/27/22 Nurse #11 noted wound to posterior right lower leg, applied dressing but failed to notify physician. On 8/12/22 Nurse noted open wound to posterior right lower leg with foul odor and placed in physician and wound care notification books without verbal notification to the physician. On 8/13/22 nurse spoke with physician and new orders were obtained for antibiotics, wound care orders and an x-ray to right lower leg. X-ray dated 8/13/22 identified lytic lesion to distal femoral shaft. Upon the Nurse's notification to the Physician regarding the Right leg X-ray results the Physician transferred the resident #293 to the emergency room . The Residents admitting diagnosis to Hospital was rule out osteomyelitis to the right lower leg. Nurse #11 is no longer employed by this facility. The Director of Health Services initiated 100% body audits on all residents within the facility on 10/20/22 to be done by the Nurses. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed on 10/20/2022. Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed. The Director of Health Services and/or Nurse Managers have reviewed the wound body audit completed by the Nurses, conducted on 10/20-21/22, and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas and Physician notification. The Director of Health Services and Nurse Managers reviewed residents with skin integrity impairments to ensure weekly documentation including notification to the physician of any changes in their skin integrity impairment status. The Director of Health Services and/or Nurse Managers began education to the Nurses, on 10/20/22 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Clinical Competency Coordinator was notified on 10/21/22 by the Licensed Nursing Home Administrator to add the skin observations and documentation in the electronic health record education to the Nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order for changes in skin integrity. Any Nurse will not be allowed to work after 10/21/22 until they receive the education. The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. On 10/20/22 and 10/21/22 the Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing Assistant will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Nursing assistant will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify nurse regarding skin integrity issue. The Nurse will complete body observation on residents the certified nursing assistance have identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator was notified on 10/21/2022 by the Licensed Nursing Home Administrator, to add the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant. Any Certified Nursing Assistant will not be allowed to work after 10/21/22 until they receive the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues. The Clinical Competency Coordinator/RN was notified by the Licensed Nursing Home Administrator on 10/21/22, that they are responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/21/22. On 10/21/22 The Licensed Nursing Home Administrator notified the Director of Health Services and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. Alleged date of immediate jeopardy removal: 10/22/22 On 10/27/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed. Interview with the Minimum data set (MDS) Nurse revealed skin assessments were completed daily. Nurse Assistants (NA) complete a skin audit daily and if there is an issue with a resident's skin, the NA notifies the charge nurse who then documents, notifies the Physician, and obtains order if needed. MDS Nurse also indicated they notify the responsible party (RP)/family. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the audits revealed all residents' orders were reviewed and any discrepancies were corrected. A review of the education training revealed education was provided to staff as stated in the credible allegation. Interviews with staff indicated they had been educated by facility that NAs are to report any issues with skin to charge nurse. The Nurse then assesses resident's skin and documents, notifies wound nurse, Physician and RP/family. Interviews further indicated knowledge of completing a daily body audit sheet for any issues with a resident's skin and notifying the charge nurse if observes any skin issues. Interview was conducted with Wound Nurse on 10/27/2022 at 11:12 am who indicated NAs had to do full skin audits on every shift. If identified any areas, including redness, they notify the nurse and audits were turned into the nurse who reviews and signs off the skin audit and skin audit given to DON. Nurses review audit sheets and if anything observed, they are to do a SBAR, assess wound, inform Physician and RP, and transcribe any order in computer. Nurses put information in wound communication book and treatment nurse checks the book every day for any new areas on skin that were identified. Interviews with staff revealed that education was provided. The immediate jeopardy removal date of 10/22/2022 was validated on 10/27/22.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on observations, staff interviews and record review the facility failed to assure resident's fingernails were trimmed for 1 of 7 residents dependent on staff for Activity of Daily Living (ADL) care (Resident #91). Findings included: Resident #91 was admitted to the facility on [DATE] with diagnoses that included Subluxation (an injury) of C1/C2 cervical (the neck) vertebrae (bone(s) in the spinal column), Chronic respiratory failure with hypoxia, Chronic obstructive pulmonary disease, and Cervical disc degeneration. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 was assessed as cognitively intact. Resident #91 was assessed as requiring limited assistance with one-to-two-person assistance Activities of Daily Living (ADL) care. Review of the care plan dated 9/15/22 revealed Resident #91 was care planned for potential for ADL decline. Goal indicated the resident's ADL needs would be met and independence potential maximized within constraints of the disease. Interventions included providing assistance with ADL care as needed and encouraging the resident to do as much as possible. During an observation on 10/10/22 at 10:51AM, Resident #91 was observed lying in bed. Observation of resident's fingers revealed resident with approximately one-inch-long fingernails (10 of 10 fingernails). There was black color debris under the nails. When the resident was asked if he liked his fingernails trimmed, Resident # 91 did not respond to surveyor's question. On 10/10/22 at 1:08 PM, Resident #91 was observed during lunch. Resident was eating his lunch in his room and was able to feed self. The lunch tray consisted of corn bread and fried okra as part of his meal. The resident was observed eating these foods with his hands. The resident's fingernails (10 of 10 fingernails) were observed with black color debris and had food particles under them. During an interview on 10/12/22 at 10:28 AM, Nurse Aide (NA) #6 indicated she was assigned to the resident. NA #6 further indicated Resident #91 required extensive to total assistance with one-person physical assist for ADL care. NA #6 The NA stated the residents' fingernails and toenails were trimmed after a shower or a bed bath. Unless the resident was a diabetic patient, when the assigned nurse would trim the fingernails and toenails of the resident. NA #6 further stated she had provided a bed bath to the resident and had not noticed the resident's fingernails to be long and dirty. NA #6 indicated the resident did not refuse care. She added the resident returned to the facility after hospitalization over the weekend. On 10/12/22 at 10:44 AM, Nurse #3 upon observation of resident's fingernails stated the resident's nails should have been trimmed when the resident was offered a bed bath or when offered a shower. Nurse #3 then asked the resident if he would like his fingernails to be trimmed and the resident responded sure. Nurse #3 indicated she would ensure the resident's fingernails were trimmed and cleaned. Nurse #3 stated the resident was readmitted to the facility on [DATE] from the hospital. The resident had a decline in health and was placed under hospice care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/12/22 at 11:00 AM, The Director of Nursing (DON), she indicated the resident's fingernails and toenails should be trimmed as needed, when the resident was offered a shower or a bed bath. She indicated unless the resident was a diabetic resident, the NA could trim residents' fingernails or toenails. If the resident was a diabetic, then the assigned nurse was responsible for trimming both fingernails and toenails. The DON stated the resident's fingernails should have been trimmed and cleaned by staff as needed. The resident could also be placed on the podiatrist list so that his toenails could be trimmed.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review, staff interviews, physician assistant and physician interviews, the facility failed to identify/assess a wound for 1 of 3 residents (Resident #293). Nurse #11 identified a wound on Resident's right leg on 7/27/22. There were no orders for wound care. From 7/27/22 to 8/12/22 Nurses failed to complete the weekly body observations that included wound observations and measurements. On 8/12/22 Nurse # 7 noted an open wound to posterior right leg with foul smelling odor with some bleeding and, Nurse #7 failed to address/communicate/report/document the condition/status/size/appearance of the wound. On 8/13/22 Resident #293's condition changed, and Resident #293 was hospitalized . Resident #293 required treatment for septicemia and osteomyelitis related to the right leg wound. Immediate Jeopardy began on 7/27/22 when Nurse #11 identified a wound to Resident's posterior right leg, and necessary care and services were not provided. The Immediate Jeopardy was removed on 10/22/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. Findings included: Resident #293 admitted to the facility on [DATE]. A review of admission observation for Resident #293 dated 6/8/22 revealed no skin alterations. A review of Resident #293's June electronic medication record (EMAR) revealed no order for skin observations for the month of June. A review of the medical record revealed no documented weekly skin observations from July 2022 to August 2022. A review of Resident #293's July EMAR revealed an order dated for 7/15/22 to observe and examine Resident's skin from head to toe and complete accompanying observations. It was noted on the EMAR for 7/15/22 it was initialed by Nurse #7, on 7/22/22 by Nurse #10, and on 7/29/22 by Nurse #7, however there was no documentation to verify they were complete. During an interview with Nurse #10 on 10/13/22 at 12:45 pm, it was indicated she did not remember doing a skin observation on Resident #293 on 7/22/22. She indicated the skin observations should be documented in the computer. An interview with Nurse #7 was conducted on 10/13/22 at 1:43 pm, it was indicated she did not recall doing skin observations on Resident # 293 on 7/15/22 and 7/29/22. She further indicated when she did skin observations, she would sign off she completed the skin observation on the EMAR and document the skin observation in the computer. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Nursing progress note dated 7/27/22 at 7:24 pm by Nurse #11 read in part Resident #293 had an open wound to his right leg. No treatment orders were found. Wound was packed with normal saline, damp to dry sterile gauze, and covered with sterile gauze secured by kerlix. Resident tolerated well. Repositioned off right side following cleaning and linen change after bowel movement. An interview was made on 10/11/22 at 4:33 pm with NA #4, and she indicated she recalled working one night, (however could not recall the exact date) with Nurse #11 and reported to her about the wound to Resident's right leg and Nurse #11 put a bandage on it. During a telephone interview on 10/11/22 at 5:48 pm with Nurse #11 it was indicated on 7/27/22 she assisted NA #4 provide activities of daily living (ADL) care on Resident #293 and when they went to turn the Resident, she observed an open wound on Resident's right leg that was about 1/2 inch in diameter and 2 inches long. She indicated she cleaned the wound and put a dressing on it. She indicated she observed Resident's skin and did not see any other wounds on Resident. Nurse #11 indicated she reported the wound to Nurse #1 who was in the facility at the time, and Nurse #1 stated she would let the wound Physician know about the wound the next morning. Nurse #11 indicated she asked Nurse #1 if she wanted her to measure the wound or get orders and she stated Nurse #1 informed her she would take care of it and instructed her to put a dressing on the wound. On 10/11/22 at 3:21 pm an interview was conducted with Nurse #1, and she indicated Resident #293 had no skin concerns on admission. She indicated the floor nurses were responsible for performing skin assessments weekly on the residents and to document any abnormal findings in the wound communication books located at each nurse's desk. Nurse #1 indicated she did not recall the conversation with Nurse #11. Resident #293's Quarterly minimum data set (MDS) dated [DATE] revealed cognition assessment was not assessed. Further review of the MDS revealed Resident #293 was able to make needs known and required extensive assistance with 1-person physical assist with bed mobility, toilet use, personal hygiene, bathing, and supervision with setup help with eating. Resident #293 had no wounds identified on this assessment. A review of August EMAR for Resident #293 revealed on 8/5/22 it was initialed by Nurse #2 Resident's skin observation was completed; however, no documentation was found to verify it was complete. On 10/13/22 at 3:30 pm an interview was conducted with Nurse #2, and it was indicated he did not remember doing a skin observation on Resident #293 on 8/5/22. He indicated he did not recall Resident having a wound. A review of care plan last revised on 8/12/22 revealed Resident #293 had a potential for impaired skin integrity related to decreased mobility, incontinence, and obesity. A goal was for Resident to remain free from development of pressure injury. The interventions included observe skin with daily care, report open, reddened, excoriated, sore areas to nurse, diet as ordered, report meal refusals to nurse, moisture barrier cream if indicated, provide peri care following incontinent episodes, provide turning/positioning assistance with care rounds and as needed, use pillows as tolerated/indicated for offloading. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was made on 10/11/22 at 4:33 pm with NA #4 and she indicated she was assigned to Resident # 293 on 8/12/22. She indicated when she came to work on the 11pm shift on 8/12/22 and while doing her rounds she went to check Resident and saw drainage on his sheets and noted a bandage on his right leg. She indicated she reported her findings to Nurse #7. A review of Nursing progress note dated 8/12/22 at 10:00 pm by Nurse #7 read in part Resident # 293 was found to have an open wound on right leg (calf) with a foul-smelling odor, and some bleeding noted. Observations left in wound care and Physician book for further evaluation. On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she was the Nurse that worked on 8/12/22. She indicated it was reported by the NA #4 assigned to Resident # 293 that he had blood on his sheets. She indicated she went to check Resident and observed a bandage wrapped on his right leg. Nurse #7 indicated the bandage had no date on it and when she removed the bandage, she observed wound to right calf that had bloody, greenish drainage. She indicated she observed the wound to be to the bone. Nurse #7 indicated it was the end of her shift and she had to leave. During a follow up interview with Nurse #7 it was clarified that on 8/12/22 she found Resident #293 with a dressing on Resident's right calf area, and it had no date, the dressing was soiled, and a foul smelling bloody greenish colored drainage was on the sheet. Review of electronic medical record revealed on 8/12/22 a SBAR (situation, background, assessment, resident evaluation) completed by Nurse #7 communication form read in part a change in condition symptoms or signs observed was wound to right leg, and it started on 8/12/22. Wound was evaluated to have drainage and foul smell. The responsible party (RP) was notified on 8/13/22 at 4:50 pm, and Physician notified. A review of Nursing progress note dated 8/13/22 at 1:28 pm by Nurse #7 read in part, Spoke to Physician, and received an order for x-ray of wound to right leg due to pain and to rule out osteomyelitis. The orders were transcribed for Doxycycline (an antibiotic to treat bacterial infections) 200 milligrams (mg) by mouth twice a day for 7 days, and wound care orders for Dakin's solution and Santyl ointment daily. Also received lab orders for a Complete blood count and basic metabolic panel for Monday 8/15/22. The RP was notified. A review of Nursing progress note dated 8/13/22 at 6:37 pm by Nurse #7 read in part Resident #293 sent to emergency department for further evaluation due to wound on right leg and uncontrolled pain per Physician request. Director of Nursing (DON) and RP notified. Temperature (T) was 97.3, pulse (P) was 134, respirations (R) was 18, blood pressure (B/P) was 120/72, and oxygen level was 100% on room air. X-ray was done and results of right leg findings suggest further assessment with a computerized tomography (CT)/magnetic resonance imaging (MRI). The results were left in the Physician book and reported to floor nurse. A review of physician orders revealed on 8/13/22 orders received to clean right leg with normal saline pat dry, apply Dakin's solution, moistened gauze, and cover with calcium alginate and dry dressing once daily. On 10/11/22 at 3:21 pm an interview was conducted with Nurse #1, and she indicated she was called on 8/13/22 and Nurse #7 informed her of Resident #293's wound to right leg. She indicated she informed Nurse #7 to call the Physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she returned to work on 8/13/22 and went to check on the Resident and then went and called the Physician. She indicated she received orders for x-ray of right leg, antibiotics, and blood work. She stated she went back into Resident's room later in the shift and Resident was in pain despite receiving pain medication and she called the Physician back and received orders to send Resident to hospital for evaluation of wound to rule out osteomyelitis. She further indicated she called the DON and RP to inform them of the above information. During an interview on 10/12/22 at 1:38 pm with Nurse #9, it was indicated she was the Nurse assigned to Resident #293 on 8/13/22 and helped Nurse #7 send Resident #293 to the hospital. Nurse #9 also indicated she was assigned to Resident #293 on 8/12/22. She indicated she received report of the wound from Nurse #7 and Nurse #7 stated she had worked with the Resident the night before and she was going to notify the Physician because she had found the wound the evening before. She indicated she was informed by Nurse #7 she had received an order on 8/13/22 to send Resident to the hospital for evaluation. Nurse # 9 indicated she had not seen a wound on the Resident prior to 8/13/22 and had only observed the wound on 8/13/22 with Nurse #7 while she did the treatment to the wound. She indicated she observed the wound on Residents right calf, and she could see the muscle. She indicated it had a small amount of bloody drainage on the bandage. She indicated she did not recall doing a skin observation on Resident #293. She indicated the skin observation was on the EMAR and was to be completed weekly. She also indicated they were supposed to sign off on the EMAR once the observation of the skin was completed and document in the observation section in the computer. Nurse #9 indicated she did not recall Resident #293 having any wounds. On 10/12/22 at 10:28 am a telephone interview was conducted with the primary Physician of Resident #293, and he indicated as of 9/17/22, he no longer worked at the facility and no longer had access to Resident #293' s records. He indicated he recalled the call from Nurse #7 on 8/13/22 concerning Resident's wound. He indicated he gave Nurse #7 orders, (however did not remember exactly what orders), and eventually sent Resident to the hospital for further evaluation. He indicated he did not recall anything further about Resident #293. During an interview on 10/11/22 at 4:04 pm with NA #10 it was indicated she worked with Resident #293 on occasion and last worked with Resident in July. She indicated Resident would barely let anyone touch him, was difficult to turn, would often refuse to be turned, bathed, or touched. She indicated she notified the nurses when Resident refused care. NA #10 indicated Resident #293 had a bandage on back of his leg and buttocks. She indicated she did not know what was under the bandages. A telephone interview was conducted on 10/12/22 at 10:15 am with the Physician Assistant (PA) and it was indicated she longer worked in the facility and did not have access to her notes. She indicated she did not recall personally seeing any wounds on Resident #293. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/13/22 at 1:06 pm with the DON she indicated the process for when a wound was identified was to notify the Physician and RP, get an order for treatment of the wound from the Physician and transcribe the order in the computer. She also indicated the Nursing staff should put any new wounds identified in the wound communication book to notify the wound nurse. She indicated she reviews the activity report in the computer and 24-hour report to see if anything was reported of any abnormal findings. She indicated she was not aware of this incident until 8/13/22 and after this occurred, she did a performance improvement plan (PIP) which included education to Nursing staff on completing body audits, skin assessments in a timely manner, to ensure residents are provided quality care to promote optimum outcomes and decrease the occurrence of new acquired wounds, education of doing skin observations, and they did wound checks on the residents on 8/24/22 as part of the PIP. During an interview on 10/13/22 at 5:10 pm with the Administrator it was indicated it was her expectation when a new wound was identified was to notify the Physician, get orders to treat the wound, and notify the family. She further indicated it was her expectation skin observations were to be done weekly and documented in the computer. A review of hospital emergency department records read in part Resident #293 presented to hospital on 8/13/22 ill-appearing, in acute distress, had diffuse pain, and had a wound to the right lower leg, that was covered. Resident's vital signs were as follows T-99.6, P-119, R-20, B/P-105/63. On exam it was noted Resident meet systemic inflammatory response (SIRS)criteria and was started on intravenous fluids and antibiotics. On 8/15/22 MRI of Resident #293's right lower leg was done, and results revealed MRI along posterolateral upper leg with sinus tract to bone with osteomyelitis. The Administrator was notified of immediate jeopardy on 10/20/22 at 6:07 pm. On 10/22/22 the facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance. Resident #293 no longer resides in the facility. On 7/27/22 Nurse #11 noted wound to posterior right lower leg, applied dressing but failed to notify physician, her supervisor and did not report off to on-coming nursing staff. From 7/27/22 to 8/12/22 Nurses failed to complete the weekly body observations that included wound observation and measurements of the resident's skin integrity status for this same period of time. On 8/12/22 Nurse noted an open wound to posterior right lower leg with foul smelling odor with some bleeding noted, the Nurse placed a written communication in the Physician and Wound Care book for further evaluation and failed to address/communicate/report/document the condition/status/size/appearance of the wound. On 8/13/22 nurse spoke with physician and new orders were obtained for antibiotics and wound care orders with an x-ray to right leg. X-ray dated 8/13/22 identified lytic lesion, and resident #293 was transferred to the Hospital emergency room . The Residents admitting diagnosis to the Hospital was rule out osteomyelitis. Nurse #11 is no longer employed by this facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Health Services initiated 100% body audits on all residents within the facility on 10/20/22. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed by the nurses on 10/20-21/2022. All residents have the potential to suffer a serious adverse outcome as a result of the failure to address/communicate/report/document the identification/condition/status/size/appearance of the wound on a weekly basis. Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/20-21/22 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services and Nurse Managers reviewed residents with skin impairments identified on their 10/20/22 and 10/21/22 body audits to ensure the resident had a treatment order in place, physician notification, and document of the condition/status/size/appearance of the wound. The Director of Health Services and/or Nurse Managers began education to the Nurses on 10/20/22 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. The Clinical Competency Coordinator was notified on 10/21/22 by the Licensed Nursing Home Administrator to add the skin observations and documentation in the electronic health record education to the Nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order for new / changes in skin integrity. Any Nurse will not be allowed to work after 10/21/22 until they receive the education. On 10/21/22 The Director of Health Services notified the Wound Nurse and the Nurse Practitioner to meet weekly to discuss and review all residents with wounds. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/22 and 10/21/22 the Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing Assistant will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Nursing assistant will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify nurse regarding skin integrity issue. The Nurse will complete body observation on residents the certified nursing assistants have identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator was notified on 10/21/2022 by the Licensed Nursing Home Administrator, to add the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant. Any Certified Nursing Assistant will not be allowed to work after 10/21/22 until they receive the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues. The Clinical Competency Coordinator/RN was notified by the Licensed Nursing Home Administrator on 10/21/22, that they are responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/21/22. On 10/21/22 The Licensed Nursing Home Administrator notified the Director of Health Services and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. Date when corrective action will be completed: 10/22/22. On 10/27/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed. Interview with the Minimum data set (MDS) Nurse revealed skin assessments were completed daily. Nurse Assistants (NA) complete a skin audit daily and if there is an issue with a resident's skin, the NA notifies the charge nurse who then documents, notifies the Physician, and obtains order if needed. MDS Nurse also indicated they notify the responsible party (RP)/family. A review of the audits revealed all residents' orders were reviewed and any discrepancies were corrected. A review of the education training revealed education was provided to staff as stated in the credible allegation. Interview was conducted with staff on 10/27/2022 at 10:18 am who indicated they had been educated by facility that NAs are to report any issues with skin to charge nurse. The Nurse then assesses resident's skin and documents, notifies wound nurse, Physician and RP/family. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview was conducted with staff on 10/27/2022 at 10:22 am who indicated knowledge of completing a daily body audit sheet for any issues with a resident's skin and notifying the charge nurse if observes any skin issues. Interview was conducted with Wound Nurse on 10/27/2022 at 11:12 am who indicated NAs had to do full skin audits on every shift. If identified any areas, including redness, they notify the nurse and audits were turned into the nurse who reviews and signs off the skin audit and skin audit given to DON. Nurses review audit sheets and if anything observed, they are to do a SBAR, assess wound, inform Physician and RP, and transcribe any order in computer. Nurses put information in wound communication book and treatment nurse checks the book every day for any new areas on skin that were identified. Interviews with staff revealed that education was provided. The immediate jeopardy removal date of 10/22/2022 was validated on 10/27/22.

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Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

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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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44889 Based on observations, staff interviews, Nurse Practitioner interview, and record review, the facility failed to provide the necessary care and services for a pressure ulcer including failure to complete weekly skin assessments and treatments as ordered. The facility failed to identify a pressure ulcer before it was significant enough to have depth (7/10/22). Three days later the wound was with slough, debris, and necrosis. On 8/3/22, the wound was assessed to be deteriorated and a stage three. The wound continued to deteriorate. On 10/11/22, a nurse detected odor in the wound and did not seek medical attention. This was for 1 of 3 residents reviewed for pressure ulcer prevention and treatment (Resident #83). The findings included: Resident #83 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Diagnoses included sacral pressure ulcer, type two diabetes mellitus without complications, left and right leg above knee amputations, and muscle weakness. The quarterly minimum data set (MDS) dated [DATE] revealed Resident #83 was at risk for pressure ulcer development. She had no pressure ulcers at the time of assessment. Weekly skin assessment documentation was not provided. A wound note by Nurse #1 dated 7/10/22 revealed Resident #83 had a new sacral wound, and she was started on supplements to promote wound healing. The wound had a light amount of exudate (drainage) and was noted to have the following measurements: length 2.5 centimeters (cm), width 4.5 cm, and depth 0.3 cm. A physician order for wound treatment dated 7/10/22 stated clean sacral wound with normal saline or wound cleanser and pat dry. Apply Medi honey to the wound bed and cover with a dry dressing once daily. Review of a wound note by Nurse Practitioner (NP) #1 dated 7/13/22 revealed Resident #83 was assessed for a new sacral wound. Resident #83 required extensive staff assistance with mobility, followed some commands, and was not combative. NP #1 indicated the wound exhibited some yellow slough and debris. Therefore, depth of the wound was estimated to be 0.4 cm. The length was measured to be 2.2 cm and the width was 5.8 cm. There was a presence of necrotic tissue (tissue death) and a mild amount of drainage noted. The plan was to apply topical Medi honey gel that would promote debridement. NP #1 recommended use of an air mattress to promote optimal offloading of the resident's weight on her sacrum, as well as repositioning. The NP indicated the origin of the pressure ulcer as in-house and marked no for unavoidable. Review of a wound note by NP #1 dated 8/3/22 indicated the sacral wound had a slight deterioration in appearance. It was noted to be a stage three pressure injury and measured length 1.5 cm, width 3.5 cm, and depth 0.2 cm. There was a mild amount of exudate, and a debridement was performed. It was noted that offloading weight should continue as well as nutritional support measures. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #83's care plan, revised on 8/4/22, revealed a focus area for pressure ulcers. The goal was for Resident #83's pressure ulcer to heal without complications. Interventions included monitored pressure ulcer for signs and symptoms of infection, informed the physician or nurse practitioner of any changes, and provided treatments as ordered. A wound note by NP #1 dated 8/10/22 indicated Resident #83's wound was deteriorating. The was a mild amount of exudate and measurements were as follows: length 6cm, width 5 cm, and depth 0.2 cm. The resident was noted to be dependent for transfers and urinary diversion with catheter placement was addressed. A wound note by NP #1 dated 8/24/22 indicated Resident #83's wound healing demonstrated slight deterioration from previous assessments. There was a mild amount of exudate, and the wound measurements were as follows: length 6.5 cm, width 5 cm, and depth 0.2 cm. NP #1 indicated Resident #83 remained dependent for positioning and transfers. Review of MDS documentation revealed Resident #83 was hospitalized from 9/1/22 - 9/5/22. A physician's order dated 9/5/22 revealed Resident #83 was ordered a low air loss mattress for her stage three pressure ulcer. The quarterly MDS dated [DATE] revealed Resident #83 was severely cognitively impaired. She required extensive staff assistance with bed mobility and had a stage three unhealed pressure ulcer. She was noted to receive pressure ulcer care and a pressure reducing device for the bed. The resident weighed 179 pounds. Review of a wound note by NP #1 dated 9/14/22 indicated the wound was again deteriorating, but stable in appearance. There was a mild amount of exudate, and the measurements were as follows: length 6.5 cm, width 7 cm, and depth 0.2 cm. It was noted that there was a lack of significant improvement and treatments were changed. A physician's order dated 9/14/22 for wound care revealed cleanse sacral wound with wound cleanser, pat dry, apply two hydrocolloid dressings, and secure with bordered gauze three times a week. A wound note by Nurse #1 dated 9/21/22 revealed Resident #83 had a stage three pressure ulcer, and treatments would be continued. There was a moderate amount of drainage and measurements were as follows: length 4.5 cm, width 3 cm, and depth 0.3 cm. A Physical Therapy (PT) progress note dated 9/26/22 revealed Resident #83 was noted to be supine in bed. She participated in rolling to her side and was repositioned with pillows to promote offloading of weight. There was a large red patch surrounding the sacral wound and the resident had a soiled brief. The area was assessed by applying pressure with the nail tip to surrounding tissues with no response from the resident. It was unable to be determined if this was due to confusion or poor sensitivity. A PT progress note dated 9/27/22 revealed Resident #83 was noted to be supine in bed. The resident participated in rolling to her side and was repositioned with pillows to promote offloading of weight. There was increased redness around the sacral wound and the therapist questioned Resident #83's sensation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A physician's order dated 9/28/22 revealed sacral wound care daily and as needed for soiled or loose dressing. The order further indicated to cleanse the wound with wound cleanser, pat dry, and pack the cavity with Dakin's solution moist gauze. The wound was to be covered with a dry dressing. There was not an order for calcium alginate. Review of a wound note by NP #1 dated 9/28/22 indicated the sacral wound was larger when assessed and it was deteriorating. It was evaluated to have changed from a stage three to stage four pressure ulcer. NP #1 suggested nurses utilized a wedge pillow to optimize offloading considering Resident #83's immobility and body habitus. There was a mild amount of drainage and an increase in necrotic tissue was present. A debridement was performed, and the wound measurements were as follows: length 5 cm, width 4cm, and depth 1 cm. A PT progress note dated 9/28/22 revealed Resident #83 was noted to be supine in bed. She complained of back pain and participated in the PT session. Resident #83 stated she felt better after she was repositioned with a pillow to promote offloading of weight. A wound note by Nurse #1 dated 9/28/22 revealed Resident #83 had a stage four pressure ulcer with moderate drainage. There was necrotic tissue present, and the following measurements were documented: length 5cm, width 4 cm, and depth 1 cm. Treatment orders included Dakin's solution daily. A PT note dated 9/29/22 revealed Resident #83 was repositioned to her side at the end of the session for optimal wound pressure relief. Skin around the wound was noted to be red. Review of documentation revealed Resident #83 was hospitalized from 10/1/22 - 10/6/22. The medication administration record (MAR) dated 10/1/22 - 10/12/22 revealed Resident #83 was in the facility 10/7/22 - 10/12/22. Wound care was not documented on 10/8/22. An observation on 10/10/22 11:42 AM revealed Resident #83 was in bed lying on her back. An observation on 10/10/22 1:20 PM revealed Resident #83 was in bed with a pillow under her right hip. An observation on 10/10/22 at 4:00 PM revealed the resident was in bed lying on her back. An interview was conducted with Nurse #8 on 10/11/22 at 3:17 PM. Nurse #8 stated Resident #83 developed a pressure ulcer in July 2022 and received dressing changes daily, unless she refused care. The treatment nurse typically performed wound care, but nurses were responsible when the treatment nurse was absent. During an observation on 10/11/22 at 3:55 PM, Nurse #7 was observed providing pressure ulcer care for Resident #83. The resident had a pillow under her right hip. Dressing supplies and cleansing solution were placed on the resident's bedside table. Resident #83's sacral dressing had an unreadable (smeared) date and was wet with brown exudate. Nurse #7 removed the dressing and commented on the strong presence of an odor from the wound. Nurse #7 cleansed the wound with Dakin's solution-soaked gauze, packed the wound with calcium alginate, and applied a foam dressing. Resident #83's air mattress was set to normal pressure for a weight of 350 pounds. Resident #83 did not have a catheter at the time of the observation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with Nurse #7 on 10/11/22 at 3:55 PM, she stated she checked physician's orders before providing pressure ulcer care. She did not know who was responsible for setting up Resident #83's air mattress and was not sure of the last time she provided pressure ulcer care for Resident #83. There was no odor when she last performed wound care. An interview was conducted with NA#9 on 10/11/22 at 3:55 PM. He stated Resident #83 was mostly calm. She received incontinence care as needed. If the resident's dressing was loose or soiled, he would notify the nurse. An interview was conducted with Nurse #1 on 10/11/22 at 4:03 PM. She stated Resident #83 developed a pressure ulcer in July 2022 after going to the hospital. At the time of the resident's return, she had a small red area on her back. About a week later, the area was open, it was assessed, and treatments were ordered including dressing changes and an air mattress. Nurse #1 further explained nurses should adjust the settings on the air mattress. Nurse #1 indicated the air mattress should not be set at 350 pounds for Resident #83. Resident #83 has been hospitalized several times causing interruptions in treatments. Nurse #1 last saw Resident #83 two weeks ago. During an interview with NA #4 on 10/11/22 at 4:32 PM, she stated Resident #83 did not like to lie flat. The NA stated Resident #83 was turned and repositioned every 2 hours. An observation on 10/12/22 at 7:34 AM revealed Resident #83 was in bed lying on her back. Appeared calm when staff were engaging with her. The air mattress was set to 160/200-pound setting, normal pressure. An interview and observation of care were conducted with NP #1 on 10/12/22 at 8:05 AM. NP #1 stated Resident #83 had recently been hospitalized . She indicated pressure settings on the air mattress should reflect the resident's weight to promote optimal wound healing. NP #1 assessed the wound and determined the treatment with Dakin's solution should continue. Nurse #1 was present and noted there was some odor when the dressing was removed. NP #1 had not been notified of an odor from the previous day. The NP was unsure if the wound had deteriorated and stated she would need to review previous notes. NP #1 indicated physical therapy would see the resident to help keep her off her back and to reduce pressure. Resident # 83 was cooperative with the care that was provided and positioned on her back after the pressure ulcer assessment and treatment was completed. An observation on 10/12/22 at 10:50 AM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated. During a follow up interview on 10/12/22 at 12:45 PM, NP #1 stated she was unsure if the wound had deteriorated since her last assessment, and she would need to review previous notes. NP #1 indicated Resident #83's pressure ulcer had been assessed by the hospital's general surgeon and infection preventionist during her recent hospitalization (10/1/22 - 10/6/22). It was not infected at the time of that assessment and surgical debridement was not needed. An observation on 10/12/22 at 1:17 PM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated. An observation on 10/12/22 at 3:00 PM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with nurse aide (NA) #2 on 10/12/22 at 3:00 PM, she stated she turned resident #83 during a bath before lunch and returned her to her back. NA #2 stated Resident #83 did not want a pillow under her. An observation on 10/13/22 at 9:58 AM revealed Resident #83 was lying on her back with the head of the bed slightly elevated. An interview was conducted with Physical Therapist (PT) #1 on 10/13/22 at 11:30 AM. She stated she received a referral to evaluate Resident #83's stage four pressure ulcer. She would assess the resident for wound healing modalities and bed mobility for optimal relief of pressure area. PT #1 indicated she had seen the pressure ulcer earlier in the day and stated it appeared worse than the last time she saw it. Resident #83 had not rejected any treatments that were provided in the past. An observation on 10/13/22 at 12:15 PM revealed Resident #83 was lying in bed on her back. During an interview with the Director of Nursing (DON) and a follow up interview with Nurse #1 on 10/13/22 at 12:23 PM, the DON stated nurses should provide pressure ulcer care as ordered. The DON and Nurse #1 confirmed nurses should verify settings on air mattress beds. During an interview with the Administrator on 10/13/22 at 5:07 PM, she stated wound care should be provided as ordered and bed settings should be correct and accurate.