STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. Building B. Wing	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Trent	836 Hospital Drive New Bern, NC 28560

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 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** 37468 Based on staff, physician, nurse practitioner, and police officer interviews, and record review the facility failed to notify the physician of an open wound that progressively deteriorated from [DATE] through [DATE]. This failure resulted in the resident receiving no physician evaluation of the wound and no physician ordered treatments to the wound. Resident #200 was identified by Emergency Medical Services (EMS) and police on [DATE] to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on [DATE] when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse failed to notify the physician or nurse practitioner. Immediate jeopardy was removed on [DATE] when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #200 was admitted to the facility on [DATE] with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands). Resident #200's quarterly minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments. Review of Resident #200's Treatment Orders and Treatment Administration Records from [DATE] through [DATE]th, 2021 revealed on [DATE] the physician ordered to have Resident #200's left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on [DATE] by Physician #1 and was transcribed by the Wound Care Nurse. (continued on next page)

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician note dated [DATE] by Physician #1 revealed Resident #200's hidradenitis had improved with a course of antibiotics and they would resume antibiotics if the inflammation reoccurred. Review of physician and nurse practitioner notes from [DATE] through [DATE] revealed no mention of any wound to Resident #200's left armpit. Review of Resident #200's chart revealed between the time of [DATE] through [DATE] no communication was documented between the facility staff and Physician #1 or Nurse Practitioner #1 related to a wound to Resident #200's left armpit. The EMS record dated [DATE] indicated EMS was dispatched to the facility for Resident #200. He was observed with a large gaping hole in his left armpit that was bleeding. The police case narrative dated [DATE] revealed Police Officer #1 arrived at the facility in response to a death in the facility on [DATE]. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased 's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was several inches wide and extended up inside his body. The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced. During an interview on [DATE] at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on [DATE] and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. Review of the police report photographs taken on [DATE] at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.). (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 the Wound Care Nurse on [DATE] at 9:43 AM stated she remembered Resident #200. She stated she was the Wound Care Nurse at the time he was at the facility, and he was on her caseload. She further stated on [DATE] the treatment was discontinued to the wound in his left armpit. The Wound Care Nurse stated she informed Nurse Practitioner (NP) #1 Resident #200's wound was not healed, that she was completing the treatment without an order, and that the dressing she was using on the wound would not stay on due to the drainage from the wound. This information was from her recollection and she could not recall the exact timeframe she notified NP #1 of this information. The Wound Care Nurse indicated NP #1 informed her (unable to recall a specific date) to keep an eye on the wound and keep her up to date with any changes, but she had not ordered any treatment. She stated that she recalled notifying NP #1 at some point in [DATE] that the wound continued to not heal. The Wound Care Nurse reported she observed Resident #200's wound and provided the non-ordered treatment to his left armpit up until his death ([DATE]) and it progressively deteriorated. She indicated that a couple of days before Resident #200's death, his left armpit wound had developed an odor. She indicated the wound was the size of a nickel and was about 0.1 centimeters deep. The Wound Care Nurse reported that she told NP #1 about the size and the odor that had developed. She stated it was concerning to her that the wound had deteriorated in size and developed an odor, yet NP #1 had not ordered any care for the wound. She indicated she had not shared this concern with any other staff at the facility. The Wound Care Nurse revealed she had no documentation of any communication with NP #1 related to Resident #200's left armpit wound from [DATE] through [DATE], and she was unable to provide a date of the last time she visualized the wound. During an interview on [DATE] at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She further stated she remembered he had hidradenitis suppurativa especially under his arms. She stated Resident #200 had been given antibiotics a couple of different times when the lesions were infected. She further stated these areas did not typically open very much and were usually raised with a small area that was draining. She continued to state in [DATE] at the conclusion of his antibiotic treatment she had been told the wounds had gotten better. The Wound Care Nurse's interview that indicated she informed Nurse Practitioner #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with Nurse Practitioner #1. Nurse Practitioner #1 denied ever being notified after [DATE] by the Wound Care Nurse or any other staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. She stated if the resident's wound under his left arm had opened, she should have been notified and she would have ordered another round of antibiotic treatment and possible referral to surgery for treatment. She also stated she should have been notified the treatments were being done without an order. Nurse Practitioner #1 provided a signed statement dated [DATE] which again attested Nurse Practitioner #1 was not aware or notified by any staff that [Resident #200's] wound had opened up or gotten worse since the completion of antibiotics in [DATE]. During an interview on [DATE] at 8:58 AM Physician #1 stated Resident #200 had a condition of hidradenitis which was a chronic problem that was very difficult to control. He further stated the areas to Resident #200's underarms would close and then would rupture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the area open to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left armpit and did not know there was a wound to Resident #200's left armpit after [DATE]. (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 [DATE] at 1:35 PM the Director of Nursing stated if a wound was open or required treatment the wound should be reported to the nurse practitioner or doctor. She further stated if the Wound Care Nurse had concerns about wound treatments, lack of response from the nurse practitioner or physician, or concerns about wound care in general the Wound Care Nurse could and should inform the Director of Nursing and escalate her concerns with the wound in question. She further stated to her knowledge, Resident #200 was admitted with wounds to his right underarm which eventually closed in September of 2020. He also developed an area under his left arm during his stay that to her knowledge was closed and treatment was completed in September of 2020. She further stated up until his death on [DATE] she was not made aware of any concerns about the skin status of his left armpit. Upon viewing the photographs of Resident #200 supplied by the local police department the Director of Nursing stated a wound of the severity pictured should have been reported to herself as well as the physician or Nurse Practitioner and she was not made aware of the presence of that wound. During an interview on [DATE] at 4:17 PM the Administrator stated she was not aware of any wounds to Resident #200's left armpit. She further stated the Wound Care Nurse was to notify the physician or nurse practitioner of changes to wounds or the presence of new wounds. She stated if the Wound Care Nurse had concerns that a wound was not receiving attention from the physician or nurse practitioner, she should have escalated her concerns to the Administrator and Director of Nursing. She stated the Wound Care Nurse never shared such concerns nor documented such concerns with Resident #200. The Administrator was notified of the immediate jeopardy on [DATE] at 11:03 AM. On [DATE] at 2:02 PM the facility provided the following credible allegation of immediate jeopardy removal. The Removal Plan: F580 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On [DATE] the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired [DATE]) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from [DATE] through [DATE]. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from [DATE] through [DATE]. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from [DATE] through [DATE] for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from [DATE] through [DATE]. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Upon arrival to facility on [DATE] the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on [DATE]. All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be. The Director of Health Services initiated 100% body audits on all residents within the facility on [DATE]. This audit reveals no wounds without physician/physician extender notification. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders or all change in conditions (utilizing the Situation, Background, Assessment, Recommendation form when a change in skin impairment or change of condition is noted. This education has been added the Licensed Nurse general orientation upon hire. License Nurses not educated by [DATE] will be educated prior to their next scheduled shift. 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 utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Certified Nursing Assistants not educated by [DATE] will be educated prior to their next scheduled shift. Alleged date of IJ Removal [DATE] The credible allegation for Immediate Jeopardy removal was validated on [DATE] which removed the Immediate Jeopardy on [DATE], as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on notifying the physician about newly identified skin concerns and worsening of known wounds. The facility's Immediate Jeopardy removal date of [DATE] was validated.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 37468 Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility neglected to provide necessary care and services to a resident by failing to effectively assess and monitor an open wound, failing to obtain physician's orders prior to treating the wound, and failing to notify the physician of an open wound that progressively deteriorated from [DATE] through [DATE]. Resident #200 was observed by Emergency Medical Services (EMS) on [DATE] with a large tunneling wound under his left arm at the time of death. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on [DATE] when the Wound Care Nurse failed to notify the physician of the presence of an open wound to Resident #200's left axillary (armpit), administered a discontinued treatment to the wound, and failed to assess and document the status of the wound. Immediate jeopardy was removed on [DATE] when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #200 was admitted to the facility on [DATE] with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands). Resident #200's quarterly minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments. Resident #200's care plan dated [DATE] revealed he was care planned to have a pressure ulcer to his sacral area, right axilla, and left and right buttock. There was no mention of a wound to his left armpit. He was also care planned to resist wound treatment care. The interventions included to reiterate the purpose and advantages of treatment for the resident as well as assess his resistance to care. Review of Resident #200's Treatment Orders and Treatment Administration Records from [DATE] through [DATE]th, 2021 revealed on [DATE] the physician ordered to have Resident #200's left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. The treatments were performed per orders and he refused on ,d+[DATE] through ,d+[DATE] of 2020 and again on ,d+[DATE] through ,d+[DATE] of 2020. This order was discontinued on [DATE] by Physician #1 and was transcribed by the Wound Care Nurse. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician note dated [DATE] by Physician #1 revealed Resident #200's hidradenitis had improved with a course of antibiotics and they would resume antibiotics if the inflammation reoccurred. Review of physician and nurse practitioner notes from [DATE] through [DATE] revealed no mention of any wound to Resident #200's left armpit. Review of Resident #200's chart revealed between the time of [DATE] through [DATE] no communication was documented between the facility staff and Physician #1 or Nurse Practitioner #1 related to a wound to Resident #200's left armpit. A review of Resident #200's weekly skin assessments from [DATE] to his time of death ([DATE]) revealed no documentation of a wound to his left armpit. There was no documentation of skin check refusals during this time on the skin check assessments. A nursing note dated [DATE] revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility. The EMS record dated [DATE] indicated EMS was dispatched to the facility and when they arrived on the scene, they found Resident #200 in bed with caregiver providing CPR. He was pulseless and apneic (cessation of breathing) and was warm to the touch. The nurse (Nurse #5) indicated she found Resident #200 not breathing but with a weak pulse. She called another nurse (Nurse #6) from the downstairs unit (the facility had two stories) to stay with Resident #200 while she called 911. Prior to EMS arrival the resident lost his pulse and CPR was initiated by the staff. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified. During an interview on [DATE] at 1:03 PM Emergency Medical Technician (EMT) #1 stated he was at the facility on [DATE] for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was wide open. He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:00 PM EMT #2 stated he was dispatched to the facility on [DATE] for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound's tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound. During an interview on [DATE] at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of [DATE]. EMT #3 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time. The police case narrative dated [DATE] revealed Police Officer #1 arrived at the facility in response to a death in the facility on [DATE]. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased 's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was several inches wide and extended up inside his body. The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced. During an interview on [DATE] at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on [DATE] and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the police report photographs taken on [DATE] at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.). During an interview on [DATE] at 4:46 PM Nurse #6 stated she remembered Resident #200. She stated he refused a lot of care, but she did not have him on her caseload often. She further stated she did not really remember the morning when she initiated CPR ([DATE]) on Resident #200 or him passing away. She stated she did not remember lesions under his arms or if they started bleeding while she provided CPR. During an interview on [DATE] at 3:17 PM Nurse #5 stated she remembered Resident #200. She further stated he was a very quiet gentleman who did not like to be bothered. She further stated she did not specifically remember him passing away on her shift or details of that night ([DATE]). She further stated Resident #200 had open wounds under his arm but could not remember if it was both arms or one arm. She concluded she could not remember the wound's appearance under his arm or arms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview the Wound Care Nurse on [DATE] at 9:43 AM stated she remembered Resident #200. She stated she was the Wound Care Nurse at the time he was at the facility, and he was on her caseload. She indicated he refused care at times, explaining he would not allow them to do anything on certain days and other days he would allow treatment to be provided. She indicated she was providing wound care to his left underarm and on [DATE] the treatment was discontinued. She revealed she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner as the wound had not improved and had not healed at that time. She further revealed that until Resident #200's death ([DATE]) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the left armpit wound in the medical record from [DATE] through [DATE]. The Wound Care Nurse spoke about the treatment she provided. She indicated she cleaned the wound with skin integrity wound cleanser and patted dry and applied a dry dressing. She placed an adhesive foam dressing over this due to the fact it drained a lot. She explained he had purulent drainage and weeping from the wound under his left arm. She further explained the dressing would not stay on due to the drainage from the wound. She revealed she had not completed any assessments or wound measurements of the left armpit wound for Resident #200 from [DATE] through [DATE]. The Wound Care Nurse stated she informed Nurse Practitioner (NP) #1 Resident #200's wound was not healed, that she was completing the treatment without an order, and that the dressing she was using on the wound would not stay on due to the drainage from the wound. This information was from her recollection and she could not recall the exact timeframe she notified NP #1 of this information. The Wound Care Nurse indicated NP #1 informed her (unable to recall a specific date) to keep an eye on the wound and keep her up to date with any changes, but she had not ordered any treatment. She stated that she recalled notifying NP #1 at some point in [DATE] that the wound continued to not heal. She reported NP #1 saw the resident in [DATE] but had not visualized the wound to his left armpit as it had a dressing over it. The Wound Care Nurse reported she observed Resident #200's wound and provided the non-ordered treatment to his left armpit up until his death ([DATE]) and it progressively deteriorated. She indicated that a couple of days before Resident #200's death, his left armpit wound had developed an odor. She indicated the wound was the size of a nickel and was about 0.1 centimeters deep. The Wound Care Nurse reported that she told NP #1 about the size and the odor that had developed. She stated it was concerning to her that the wound had deteriorated in size and developed an odor, yet NP #1 had not ordered any care for the wound. She indicated she had not shared this concern with any other staff at the facility. The Wound Care Nurse revealed she had no documentation of any communication with NP #1 related to Resident #200's left armpit wound from [DATE] through [DATE], and she was unable to provide a date of the last time she visualized the wound. This interview with the Wound Care Nurse ([DATE] at 9:43 AM) continued. The Wound Care Nurse indicated she worked every Monday through Friday and every other weekend. Nurses for the unit would do the wound care when she was not working. She revealed because there was no physician's order for treatment to Resident #200's open left armpit wound from [DATE] through [DATE], the staff working when she was not in the facility would not have provided him with treatment. She explained she had not verbally gone to the nurses and informed them of the dressing change she was doing for Resident #200's left armpit wound that was not ordered by the physician. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She further stated she remembered he had hidradenitis suppurativa especially under his arms. She stated Resident #200 had been given antibiotics a couple of different times when the lesions were infected. She stated he had some scarring which she believed had been from a past surgery for the areas under his arm and she offered to refer him for surgical interventions which he refused. She stated when he first arrived at the facility in June through September of 2020, he always had an odor from those wounds under his arms and the times he did allow her to visualize the wounds, they had drainage. She stated at those times she had put him on antibiotics. She stated he received clindamycin [DATE] through [DATE]. He had Bactrim [DATE] through [DATE]. Bactrim [DATE] through [DATE]. Keflex [DATE] through [DATE]. Keflex [DATE] through [DATE]. She further stated these areas did not typically open very much and were usually raised with a small area that was draining. She stated she did not order the wound treatment to be discontinued due to his refusals. She stated even if a resident refused something every day, she would ensure staff were offering the treatment and would not discontinue it. She continued to state in [DATE] at the conclusion of his antibiotic treatment she had been told the wounds had gotten better. The Wound Care Nurse's interview that indicated she informed Nurse Practitioner #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with Nurse Practitioner #1. Nurse Practitioner #1 denied ever being notified after [DATE] by the Wound Care Nurse or any other staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. She stated if the resident's wound under his left arm had opened, she should have been notified and she would have ordered another round of antibiotic treatment and possible referral to surgery for treatment. She also stated she should have been notified the treatments were being done without an order. Nurse Practitioner #1 provided a signed statement dated [DATE] which again attested Nurse Practitioner #1 was not aware or notified by any staff that [Resident #200's] wound had opened up or gotten worse since the completion of antibiotics in [DATE]. During an interview on [DATE] at 8:58 AM Physician #1 stated Resident #200 had a condition of hidradenitis which was a chronic problem that was very difficult to control. He further stated the areas to Resident #200's underarms would close and then would rupture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the area open to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left armpit and did not know there was a wound to Resident #200's left armpit after [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on [DATE] at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left armpit that he or his nurse practitioner should have been made aware of the presence and severity of such a wound. He further indicated he could not say how quickly a wound such as the one in the photograph could take to develop. He further stated he did not recall discontinuing Resident #200's orders for treatment to his wound on his left armpit but if the nurse had made the recommendation to discontinue the treatment he would have signed off on their recommendation. He further stated he would not have told the Wound Care Nurse to continue administering a discontinued treatment and did not believe Nurse Practitioner #1 would have requested the Wound Care Nurse to continue administering a discontinued treatment as well. He further stated he did not understand why the Wound Care Nurse would not have gotten an order for treatment of a wound if she had asked. He stated he was unsure if the wound could have developed after his death or how long it would have taken to develop such a wound. The Physician stated he felt the wound had a severe appearance in the photographs and did not know why the Wound Care Nurse did not have measurements, treatment records, and weekly wound assessments if she was following the wound. He stated due to the lack of documentation it was impossible to know if or when the wound was or was not present or the severity of the wound until the time of the photographs by the police department. He stated wounds should be documented and reported to him or the nurse practitioner if there was a need for wound treatment. He expressed he was at a loss as to why the Wound Care Nurse did not request an order for treatment because neither he nor the nurse practitioner would ever deny an order for a wound to be treated. He concluded he would not discontinue wound treatment to a resident even if the resident continually refused treatment except in extenuating circumstances such as hospice and Resident #200 did not meet that criteria at the time. During an interview on [DATE] at 11:34 AM Nurse Aide #5 stated she remembered Resident #200. She stated he required total care, and he did not speak much but he was able to make his needs known when he wanted to. She further stated he would let staff provide activities of daily living care, but he did not like to be bothered most of the time. She continued to state he did have open wounds in one or both underarms and nursing was aware of those wounds. She stated during morning care she was aware of those wounds because she had to take care while cleansing around the wound area. She could not remember if there were ever dressings on his wound under his arm or not. During an interview on [DATE] at 8:42 AM Nurse Aide #1 stated she remembered caring for him leading up to his death. She recalled a wound to one of his armpits that was oozing something like pus. The nurse aide reported she notified Nurse #5 on multiple occasions (unable to recall specific dates) of the oozing and the nurse went and looked at the wound when notified. She reported she had not recalled seeing the left arm pit wound with a dressing on it at any point in the weeks leading up to his death. During an interview on [DATE] at 11:56 AM Nurse Aide #2 stated she remembered Resident #200 had a wound under one of his arms. She did not remember if there were ever any dressings to the wound she noted under his arm. She stated the area was about the size of a dime with no depth and it had some drainage that was like pus. This wound was present through the end of his stay in the facility to her knowledge. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:35 PM the Director of Nursing stated if a wound was open or required treatment the wound should be reported to the nurse practitioner or doctor. The doctor had to sign off on all treatments so he would be made aware of treatments. She further stated wound treatment should not be done without an order and if the Wound Care Nurse deemed a wound needed to have continued treatment, she should request the order be continued or changed depending on the situation. She further stated if the Wound Care Nurse had concerns about wound treatments, lack of response from the nurse practitioner or physician, or concerns about wound care in general the Wound Care Nurse could and should inform the Director of Nursing and escalate her concerns with the wound in question. She stated to her knowledge, Resident #200 was admitted with wounds to his right underarm which eventually closed in September of 2020. He also developed an area under his left arm during his stay that to her knowledge was closed and treatment was completed in September of 2020. She further stated up until his death on [DATE] she was not made aware of any concerns about the skin status of his left armpit. She stated the Wound Care Nurse according to the records had discontinued the order to the left armpit as of [DATE] and did not document a reason. Upon viewing the photographs of Resident #200 supplied by the local police department the Director of Nursing stated a wound of the severity pictured should have been reported to herself, the physician or Nurse Practitioner, and responsible party and she was not made aware of the presence of that wound. She stated that identified wounds were to be assessed, monitored, and documented. She concluded wound measurements were part of the assessments to follow the wound progress. During an interview on [DATE] at 4:17 PM the Administrator stated she was not aware of any wounds to Resident #200's left armpit. She further stated the Wound Care Nurse should not provide treatments without orders. She stated the Wound Care Nurse should acquire wound care orders when she deemed wound treatment was needed. She stated if the Wound Care Nurse had concerns that a wound was not receiving attention from the physician or nurse practitioner, she should have escalated her concerns to the Administrator and Director of Nursing. She stated the Wound Care Nurse never shared such concerns nor documented such concerns about Resident #200. The Administrator was notified of the immediate jeopardy on [DATE] at 9:21 AM. On [DATE] at 2:09 PM the facility provided the following credible allegation of immediate jeopardy removal. The Removal Plan: F600 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired [DATE]) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from [DATE] through [DATE]. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from [DATE] through [DATE]. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from [DATE] through [DATE] for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from [DATE] through [DATE]. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. Weekly skin assessments from [DATE] through [DATE] failed to identify Resident #200's open wound to the axilla area. The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. The facility was unaware of the failure of nurses to identify the open wound during weekly skin assessments from [DATE] through [DATE]. Upon arrival to facility on [DATE] the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on [DATE]. All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be The Administrator completed a 24-hour report to the State Agency regarding neglect on [DATE] when she was notified of the concern regarding the axilla (armpit) wound and no documentation of same. The Wound Nurse was suspended pending investigation on [DATE] and terminated on [DATE]. The wound Nurse was reported to the North Carolina Board of Nursing on [DATE] for professional standards violations. The Clinical Competency Coordinator and/or Nurse Management began education on [DATE] for Licensed Nurses regarding abuse and neglect with emphasis on provision of care and services, wound care including assessment, measurement, and notification to physician/physician extender. This education included that treatments were not to be provided without a physician's order and that all provided treatments were to be documented. This education included that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Licensed Nurses not educated by [DATE] will be educated prior to their next scheduled shift. This education has been added to the general orientation upon hire. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Clinical Competency Coordinator and/or Nurse Managers began educating the Certified Nursing Assistants that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Certified Nursing Assistants not educated by [DATE] will be educated prior to their next scheduled shift. This education has been added to the general orientation of certified Nursing Assistants. The Director of Health Services initiated 100% body audits on all residents within the facility on [DATE]. This audit reveals no wounds without orders or without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on [DATE] and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by [DATE] will be educated prior to their next scheduled shift. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by [DATE] will be educated prior to their next scheduled shift. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding notification to Resident responsible party regarding newly identified skin impairments and/or worsening skin impairments and new wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by [DATE] will be educated prior to their next scheduled shift. 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 note [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on staff, physician, nurse practitioner, police officer, and emergency medical technician (EMT) interviews, and record review the facility failed to implement their abuse policy in the areas of identifying, reporting and investigating neglect for 1 of 1 resident reviewed for abuse and neglect (Resident #200). Findings included: A review of the abuse prevention and reporting policy and procedure of the facility dated ,d+[DATE] revealed neglect was the failure to provide goods and services necessary to avoid harm, mental anguish, or mental illness. Anyone witnessing, suspecting, or hearing an allegation of neglect of any resident was to immediately report this to the administrator whether the administrator was on the premises or not. The Administrator would begin an investigation and implement measures necessary to assure the safety and protection of the residents from the actual or alleged perpetrator. In the event the administrator had knowledge that the resident had been neglected, the administrator would report to the department of community health and appropriate law enforcement agency. A 24-hour report was to be completed and faxed to the appropriate health facility regulation department complaint division. Resident #200 was admitted to the facility on [DATE] with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands). Resident #200's quarterly minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He had two stage II pressure ulcers present upon admission. Review of Resident #200's Treatment Orders and Treatment Administration Records indicated Resident #200 had a treatment order for a left inner armpit cyst that was discontinued on [DATE]. There were no orders after [DATE] related to his left armpit wound. Further review of the medical record revealed no documentation of the wound to his left armpit from [DATE] through [DATE]. There were no assessments or measurements of the wound and no reference was made to the wound in the physician or Nurse Practitioner (NP) notes. A nursing note dated [DATE] revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility. The EMS record dated [DATE] indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:03 PM Emergency Medical Technician (EMT) #1 stated he was at the facility on [DATE] for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was wide open. He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer. During an interview on [DATE] at 2:00 PM EMT #2 stated he was dispatched to the facility on [DATE] for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound's tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound. During an interview on [DATE] at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of [DATE]. EMT #3 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time. The police case narrative dated [DATE] revealed Police Officer #1 arrived at the facility in response to a death in the facility on [DATE]. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased 's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was several inches wide and extended up inside his body. The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on [DATE] and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. Review of the police report photographs taken on [DATE] at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.). During an interview on [DATE] at 3:17 PM Nurse #5 stated she remembered Resident #200. She further stated she did not specifically remember him passing away on her shift or details of that night. She further stated Resident #200 had open wounds under his arm but could not remember if it was both arms or one arm. Nurse #5 could not remember the wound appearance under his arm or arms or if they were present when he died , and she did not have concerns with neglect. She concluded the police came and asked for a few things and left and it was not unusual for police to be called following a code and death. She indicated she was unaware of the EMT and police concerns with neglect for Resident #200. During an interview on [DATE] at 4:46 PM Nurse #6 stated she remembered Resident #200. She further stated she did not really remember the morning when she initiated CPR on Resident #200 or him passing away. She stated she could not remember him having wounds under his arms that she was able to visualize or see how deep the wounds were. She was unaware the police came to the facility on [DATE] for Resident #200 and was not made aware the EMT and police concerns of neglect for the resident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:55 AM the Director of Nursing stated she was not made aware by EMS, police, or her staff about concerns of neglect with Resident #200 after his death. She further stated after review of the EMS report and police photographs that it was her own opinion at the time prior to his initiation of CPR the area to Resident #200's left armpit was not open because she felt her staff would have reported something to the severity pictured in the police photograph. She stated this was the reason she believed the staff did not report any concerns of neglect for Resident #200. She stated what the staff saw versus what the photos from the police report showed were very different, so she believed the wound had not opened prior to CPR. During an interview on [DATE] at 9:32 AM the Administrator stated staff were trained to identify and report abuse and neglect and upon being made aware of Resident #200's status and the concerns identified by EMS and the Police Department, her staff should have identified and reported these concerns and she did not know why staff did not have concerns with neglect. She further stated based on the information provided to her by the Director of Nursing, following her interview with the state, she had suspended the wound care nurse, was currently submitting a 24-hour report for resident neglect, and initiated a 100% head to toe skin audit on all residents. A wound going any length of time untreated, not reported, and not documented was unacceptable.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41240 Based on observations, resident and staff interviews, and record review the facility failed to develop comprehensive individualized plans of care in the areas of advance directives (Resident #52), behaviors (Resident #98), epilepsy/seizures (Resident #65), pressure ulcers (Resident #79), pacemaker (Resident #74), activities of daily living (Resident #95), and contracture (Resident #80) for 7 of 25 residents reviewed for comprehensive care plans. Findings included: 1. Resident #74 was admitted to the facility on [DATE] with diagnoses that included acute congestive heart failure. A review of a physician order dated 4/29/2021 revealed pacemaker take apical pulse (the part of the heart where the beat is heard the loudest) daily for one full minute. Report irregularities in rate and rhythm, and observe pacemaker site for redness, swelling or pain as needed. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #74 was severely cognitively impaired. Per MDS he had an active diagnosis of heart failure. The active care plan, last reviewed on 8/29/2021, revealed there was no care plan that addressed Resident #74's pacemaker. A review of the Medication Administration Record for the month of October 2021 revealed Resident #74's physician's order for apical pulses remained active and were completed as ordered. During an interview with the MDS Nurse on 10/28/2021 at 2:00 pm, she stated she was aware Resident #74 had a pacemaker. The MDS Nurse acknowledged Resident #74's pacemaker was not mentioned on his care plan and that this should have been addressed. On 10/29/2021 at 11:14 am during an interview the Director of Nursing (DON) stated Resident #74's pacemaker should have been addressed on the care plan. 2. Resident #95 was admitted on [DATE] to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #95 was severely cognitively impaired. He required extensive assistance of 1 with all activities of daily living (ADL) except was independent with meals. The active care plan, initiated on 9/29/2021, revealed there was no plan of care that addressed Resident #95's ADL needs. During an interview with the MDS Nurse on 10/28/2021 at 2:00 pm, she stated she thought she had a care plan for Resident #95' s ADL care. She stated it was an oversite and there should have been a care plan to address his needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/28/2021 at 11:14 am the Director of Nursing stated the MDS Nurse was responsible for the care plans. She then stated she had not known how he was missed for an ADL care plan. She further stated there should have been a care plan to address Resident #95's daily ADL needs. 3. Resident #80 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease affecting the left non-dominant side. A record review revealed a diagnosis of left hand contracture on 2/19/2019. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. Per MDS she had a functional limitation on one side of the upper and lower extremity. The active care plan, last reviewed on 8/29/2021, revealed no plan of care that addressed Resident #80's left hand contracture. During an observation and interview with Resident #80 on 10/27/2021 at 10:00 am, she was resting in bed with her left arm outside of the covers. Her left hand was noted to be in a closed position. She stated she could not open her left hand or use the left arm. She then stated her hand and arm have been in that condition for a long time. The MDS Nurse stated on 10/28/2021 at 2:00 pm during an interview she was aware Resident #80 had a left hand contracture. She said she thought it was addressed on the care plan. The care plan was reviewed with the MDS Nurse and she verified it was not on the care plan and that it should have been. During the interview with the Director of Nursing on 10/28/2021 at 11:14 am she stated the MDS Nurse was responsible for the care plans. She said Resident #80's care plan should have included her left hand contracture. 40200 4. Resident #98 was admitted to the facility on [DATE] with diagnoses which included epilepsy disorder and schizophrenia. Resident #98's quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and was independent or supervision for most activities of daily living. Review of the comprehensive care plan for Resident #98 last revised 10/15/21 revealed no care plan intervention or focus for schizophrenia behaviors or epilepsy. An interview on 10/27/21 at 8:13 AM with the MDS Nurse revealed she was responsible for entering the care plan information. She stated Resident #98 should have been care planned for behaviors and potential for seizures and she had just missed it. An interview on 10/29/21 at 11:51 AM with the Administrator revealed it was her belief that care plans should be accurate. 5. Resident #79 was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus and a stage 2 sacral pressure ulcer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #79's admission Minimum Data Set (MDS) dated [DATE] revealed he had severe cognitive impairment and was totally dependent on staff for activities of daily living. He was coded to have had a stage 2 sacral pressure ulcer that was present on admission. Review of the comprehensive care plan for Resident #79 last revised 10/09/21 revealed no care plan intervention or focus for pressure ulcers. An interview on 10/27/21 at 8:13 AM with the MDS Nurse revealed she was responsible for entering the care plan information. She stated Resident #79 should have been care planned for pressure ulcers and she had just missed it. An interview on 10/29/21 at 11:51 AM with the Administrator revealed it was her belief that care plans should be accurate. 32503 #6 Resident #52 was admitted to the facility on [DATE]. Her diagnoses included Diabetes, hypertension, and cardiovascular accident (CVA). A progress note dated 8/17/21 written by the Social Worker documented Resident #52 continued to have a Do Not Resuscitate status. The October 2021 Physician orders indicated Resident #52 had a Do Not Resuscitate status. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #52 was readmitted from the hospital on 7/28/21. She was severely cognitively impaired. She required extensive or total assistance with activities of daily living. The current care plan revealed Resident #52 had two different code statuses. One care plan had been initiated on 6/5/19 and noted Resident #52 wishes to be a full code. Another care plan which had been initiated on 7/22/21 noted Resident #52 had wishes to be a DNR (Do Not Resuscitate), allow natural death, do not attempt resuscitation. Both had been edited by the MDS nurse on 9/4/21 and continued to be active care plans. On 10/28/21 the MDS nurse stated Resident #52 was a DNR and not a full code. The MDS nurse added the care plan had an error because the full code problem should not be on the current care plan. She said the care plan should not have both DNR and full code. 41009 7. Resident #65 was admitted to the facility on [DATE] a diagnosis of seizures. The annual Minimum Data Set assessment (MDS) for Resident #65 dated 07/30/2021 revealed his cognition was moderately impaired. Seizure disorder or epilepsy was listed in the active diagnoses. A review of the physician's orders for Resident #65 revealed a current order for levetiracetam (an anticonvulsant medication to treat seizures) 500 milligrams by mouth twice daily last initiated on 12/09/2019. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current care plan for Resident #65 dated 10/15/2021 revealed no identification or incorporation of his seizures. On 10/28/2021 1:13 PM an interview with the MDS nurse indicated Resident #65 had a diagnosis of seizures. She stated this should have been incorporated in his comprehensive plan of care. On 10/29/2021 at 9:51 AM an interview with the Director of Nursing (DON) indicated she would expect Resident #65's diagnosis of seizures to be incorporated in his comprehensive plan of care.

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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** 41009 Based on observations, record review and resident and staff interviews the facility failed to provide nail care for 2 of 6 residents reviewed for activities of daily living (ADL). (Resident #90 and Resident #80) Findings included: 1. Resident #90 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) following non-traumatic intracranial hemorrhage (bleeding into the brain), muscle weakness, contracture (tightening of the muscle and tendon that causes joints to become very stiff and prevents normal movement) of the left hand and wrist, and diabetes mellites type 2. A review of the annual Minimum Data Set (MDS) assessment for Resident #90 dated 10/10/2021 revealed he was cognitively intact. Resident #90 had no behaviors or rejection of care during the 7 day look back period of the assessment. He required the extensive assistance of one person for bathing and personal hygiene. He had functional limitation in range of motion to his upper and lower extremity on one side. A review of the current care plan for Resident #90 last revised on 09/21/2021 revealed a focus area dated 10/03/2020 of ADL decline requires assistance due to hemiplegia and hemiparesis. The goal was for Resident #90 to have his ADL needs met with the required assistance from staff. An intervention was to set-up Resident #90 for ADL. On 10/25/2021 at 2:27 PM an observation of Resident #90 revealed his left hand was contracted. The fingernails of his left hand were not visible. A review of Resident #90's medical record from 07/01/2021 through 10/25/2021 did not reveal any information regarding when Resident #90 had his fingernails last trimmed. On 10/26/2021 at 2:45 PM an observation of Resident #90 revealed his left hand was contracted. The fingernails of his left hand were not visible. An interview with Resident #90 at that time indicated he received his bath that morning. He stated the nursing assistant (NA) washed his left hand. He further indicated she had not trimmed the fingernails of his left hand as a nurse had to do that. Resident #90 went on to say his family member trimmed the fingernails of his right hand but could not trim the fingernails of his left hand because it was contracted. He stated he could not recall when the fingernails of his left hand had last been trimmed. Resident #90 further indicated he was satisfied with the length of the fingernails on his right hand but he could not use his left arm or hand and could not see whether the fingernails of his left hand needed to be trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2021 at 2:57 PM an observation of the fingernails of Resident #90's left hand with NA #2 revealed they extended 1/4 to 1/2 inch beyond the tip of each finger. An interview with NA #2 at that time indicated she assisted Resident #90 with his bath that morning, had washed his left hand, and had noticed the fingernails of his left hand needed trimming. She stated she could not trim Resident #90's fingernails because he had diabetes. NA #2 stated she would normally notify the nurse if a resident's fingernails needed trimming but she didn't usually work with Resident #90 and had not notified his nurse that day. On 10/26/2021 at 3:09 PM an observation of the fingernails of Resident #90's left hand was conducted with Nurse #8. In an interview with Nurse #8 at that time she stated the fingernails of Resident #90's left hand extended 1/4 to 1/2 inch beyond the tip of each finger and needed to be trimmed. She further indicated she was assigned to care for Resident #90 that day. She stated she regularly cared for him. Nurse #8 went on to say Resident #90 had diabetes and nursing assistants were not allowed to trim his fingernails. She stated she usually checked the fingernails of diabetic residents weekly to see if they needed trimming. She stated she had not checked Resident #90's fingernails that week. Nurse #8 further indicated she could not recall when she had last checked or trimmed Resident #90's fingernails On 10/26/2021 at 3:25 PM an observation of the fingernails of Resident #90's left hand was conducted with the Director of Nursing (DON). In an interview at that time the DON stated the fingernails of Resident #90's left hand extended at least 1/4 inch beyond the tip of each finger and needed to be trimmed. She further indicated the nursing assistants were not allowed to trim Resident #90's fingernails as he had diabetes. She went on to say she expected NA's providing ADL care to report to the resident's nurse or to her if a resident needed their nails trimmed and the NA's were unable to do so. The DON stated she trimmed resident's fingernails weekly. She stated she last trimmed Resident #90's fingernails about a month ago. 41240 2. Resident #80 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease affecting the left non-dominant side. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. She required extensive assistance with personal hygiene, and total assistance with bathing. The MDS was coded no rejection of care for the 7 day look back assessment period. Per the MDS she had functional range of motion limitations on one side of the upper and lower extremity. A care plan last reviewed on 10/15/2021 revealed no plan of care that focused on Resident #80's activity of daily living or contracture. An observation on 10/26/2021 at 10:00 am revealed Resident #80's left hand was in a closed position with the pinky and middle finger nails approximately one-half inch in length. The finger nails were touching the palm of her hand while in the closed position. The rest of her fingers were closed tightly in her hand and could not be seen. During an interview with Resident #80 on 10/27/2021 at 11:00 am, she stated it have been a long time since she was able to open her hand. She then stated her fingernails on the left hand have not been cut in a while. She was unable to tell the last time her fingernails were cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/28/2021 at 3:00 pm revealed Resident #80's fingernails on her left hand were still long and touched the palm of her left hand. On 10/28/2021 at 3:45 pm during an interview with Nurse Aide (NA) #7 she stated fingernail care was usually done with the baths by the NAs. She stated she informed the nurses when a resident needed nail care. The NA stated she was not aware Resident #80's nails needed cutting. During an observation of Resident #80's fingernails on her left hand with Nurse #8 on 10/28/2021 at 4:00 pm, she stated the resident's nails were long and should have been cut to keep the nails from digging into her hand. She stated the NAs cuts the nondiabetic residents fingernails and the nurses cuts the diabetic residents fingernails. She also said the NAs usually informed the nurses when a resident fingernails needed to be cut by a nurse. She stated she was not informed by the NAs that Resident #80's fingernails needed cutting. The Director of Nursing stated on 10/29/2021 at 11:14 am during an interview she heard Resident #80's fingernails on her contracted hand were long . She then stated her fingernails should have been cut by the NAs or the nurses. The Administrator stated on 10/29/2021 at 1:45 pm the facility had two nurses that cut the resident's fingernails when needed. She stated the NAs should have been monitoring Resident #80's fingernails and informed the nurses when they needed to be cut.

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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** 37468 Based on staff, physician, nurse practitioner, police officer and emergency medical technicians (EMT) interviews, and record review the facility failed to obtain physician's orders prior to treating a wound and failed to identify, assess, and monitor a wound to determine the need for medical treatment for an open wound that progressively deteriorated from [DATE] through [DATE]. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on [DATE] to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on [DATE] when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse administered a discontinued treatment to the wound and failed to assess and document the status of the wound. During this time, staff failed to identify, report, and document this wound on weekly skin assessments. Immediate jeopardy was removed on [DATE] when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #200 was admitted to the facility on [DATE] with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands). Resident #200's quarterly minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments. Resident #200's care plan dated [DATE] revealed he was care planned to have a pressure ulcer to his sacral area, right axilla, and left and right buttock. There was no mention of a wound to his left armpit. He was also care planned to resist wound treatment care. The interventions included to reiterate the purpose and advantages of treatment for the resident as well as assess his resistance to care. Review of Resident #200's Treatment Orders and Treatment Administration Records from [DATE] through [DATE]th, 2021 revealed he was ordered on [DATE] to have his left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on [DATE]. The order was discontinued by Physician #1 and transcribed by the Wound Care Nurse. A review of the physician and Nurse Practitioner (NP) notes from [DATE] through [DATE] revealed no reference to Resident #200's left armpit wound. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of the medical record revealed no documentation of the wound to his left armpit from [DATE] through [DATE]. There were no assessments or measurements of the wound. A review of Resident #200's weekly skin assessments from [DATE] to his time of death ([DATE]) revealed no documentation of a wound to his left armpit. There was no documentation of skin check refusals during this time on the skin check assessments. On [DATE] a skin check completed by Nurse #1 indicated Resident #200 had alterations in skin. There was no further documentation. On [DATE] a skin check completed by Nurse #3 indicated Resident #200 had alterations to his skin. The comment note indicated the skin alteration was to the resident's sacrum. On [DATE] a skin check completed by Nurse #4 indicated Resident #200 had no alterations to his skin. A nursing note dated [DATE] revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 AM at the facility. The EMS record dated [DATE] indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified. During an interview on [DATE] at 1:03 PM Emergency Medical Technician (EMT) #1 stated he was at the facility on [DATE] for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was wide open. He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer. During an interview on [DATE] at 2:00 PM EMT #2 stated he was dispatched to the facility on [DATE] for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound ' s tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of [DATE]. EMT #3 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time. The police case narrative dated [DATE] revealed Police Officer #1 arrived at the facility in response to a death in the facility on [DATE]. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased 's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was several inches wide and extended up inside his body. The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced. During an interview on [DATE] at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on [DATE] and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. Review of the police report photographs taken on [DATE] at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.). (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 [DATE] at 9:43 AM the Wound Care Nurse stated she remembered Resident #200. She stated she was the wound care nurse at that time, and he was on her caseload. She indicated she was providing wound care to his cyst to his left underarm and on [DATE] the treatment was discontinued but she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner on [DATE] as the wound had not improved and had not healed at that time. She revealed that until his death ([DATE]) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the wound in the medical record from [DATE] through [DATE]. She indicated she had not completed any assessments or wound measurements from [DATE] through [DATE]. She visualized the wound and provided the non-ordered treatment to his left armpit up until his death and it was progressively deteriorating till his death on [DATE]. The Wound Care Nurse indicated she worked every Monday through Friday and every other weekend and the nurses for the unit complete the wound care when she was not working. She stated because there was no physician's order for the treatment the staff working when she was not in the facility would not have known to do the dressing change to the left armpit of Resident #200. She stated she had not verbally gone to the nurses and informed them of the dressing change she was doing for him that was not ordered by the physician. She stated a couple of days before his death his left armpit wound had developed an odor. She stated it was concerning to her that the wound had deteriorated in size and developed an odor and she notified Nurse Practitioner #1 verbally, but Nurse Practitioner #1 did not write a new order or do anything for the wound. She stated she did not share this concern with anyone or document the interactions or concerns. During an interview on [DATE] at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She stated in [DATE] Resident #200 completed antibiotic treatment and she had been told the wounds had gotten better. She indicated she had not known Resident #200's wound progressively deteriorated from [DATE] through [DATE] nor had she known the Wound Care Nurse was completing treatments without orders. She stated that orders were to be obtained prior to treatments being completed. The Wound Care Nurse's interview that indicated she informed NP #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with NP #1. She denied ever being notified after [DATE] by staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. NP #1 was informed that no assessments or measurements of the wound were completed from [DATE] through [DATE] despite the Wound Care Nurse being aware of the wound. She stated that identified wounds were to be assessed and monitored. She indicated without documented assessments there was no way to ascertain if there were changes in the wound that would require a change in the treatment plan. (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 [DATE] at 12:33 PM with Physician #1 the Wound Care Nurse's interview in which she reported that she completed treatments with no physician's order from [DATE] through [DATE] as well as her statement that she completed no assessments or measurement of the wounds throughout this same time period were reviewed with the physician. He stated that orders were to be obtained prior to treatments being completed and identified wounds were to be assessed, monitored, and documented. He stated wound measurements were part of the assessment. He indicated without assessments and measurements there was no way to determine if there were changes in the wound that would require a change in the treatment plan. He further stated he was unable to understand why the Wound Care Nurse would not have gotten an order for treatment of a wound and why she would not have completed wound assessments and measurements in order to monitor the wound's status. He indicated that neither he nor the nurse practitioner would ever deny an order for a wound to be treatment. The police report photographs of the wound to Resident #200's left armpit (taken [DATE]) were reviewed with Physician #1 during interview. He stated he was unsure if the wound could have developed after his death or how long it would have taken to develop such a wound. The Physician stated he felt the wound had a severe appearance in the photographs and had reiterated he had not known why the wound care nurse had no measurements, treatment records, or weekly wound assessments if she was following the wound. He stated due to the lack of documentation it was impossible to know if and when the wound was or was not present or the severity of the wound until the time of the photographs by the police department. During an interview on [DATE] at 1:35 PM the Director of Nursing stated wound treatment should not be done without and order and if the wound care nurse deemed a wound needed to have continued treatment, she should request the order be continued or changed depending on the situation. Identified wounds were to be assessed, monitored, and documented. She concluded wound measurements were part of the assessments in order to follow the wound progress. During an interview on [DATE] at 10:32 AM Nurse #1 stated she did skin check for Resident #200 but did not remember him very well. She stated from [DATE] through [DATE] Resident #200 was on her assignment for weekly skin checks. She stated she did not remember why she checked yes for skin alteration on [DATE]. She stated she did not identify any wounds under his arms during her skin assessments of the resident and if she had noted any wounds to his armpits, she would have documented it and notified the wound nurse. She stated if he had refused his weekly skin assessments, she would have documented the assessment as refused, therefore he did not refuse his weekly skin assessments as she had documented them as completed. She stated a full head to toe skin check included observing the skin of a resident from top to bottom and then turning the resident to check the skin on their back. She stated she usually observed under the arm for skin assessments but could not remember in Resident #200's case if she observed under his arm during his skin assessment. During an interview on [DATE] at 11:44 AM Nurse #3 stated she did remember Resident #200. She stated she did a skin check on [DATE] and noted he had a pressure ulcer wound to his sacrum. Resident #200 was able to raise his arms and she did not identify any wound under his left arm. She further stated had she identified any alterations to his skin under his left arm and armpit she would have documented it on her skin assessment and notified the wound care nurse. The nurse stated if Resident #200 had refused his skin check she would have documented the skin check as refused. She stated because she documented his skin check as complete, he did not refuse his skin assessment on [DATE]. (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 [DATE] at 12:30 PM Nurse #4 stated she did a skin check on Resident #200. She stated she could not remember the date but if the documented date was [DATE] then that was when she did the skin check. She stated if she documented no alterations in skin that meant that he did not have any wounds present. She further stated she did not identify any wound to his left underarm or she would have documented the wound and notified the wound care nurse. She stated she could not remember if there were dressings on his left armpit or not but if she saw issues with his skin, she would have documented them. She stated he did not refuse the skin assessment, or she would not have documented the skin check as complete. During an interview on [DATE] at 9:55 AM The Director of Nursing stated if a wound was present under Resident #200's arm at the time they did their skin assessments, it should have been documented and reported to the wound care nurse and nurse on the hall who would be responsible for notifying the Physician, responsible party, and Director of Nursing. If the wound was present at the time of these skin checks she did not know why they did not identify the wound. The Administrator was notified of the immediate jeopardy on [DATE] at 2:49 PM. On [DATE] at 12:51 PM the facility provided the following credible allegation of immediate jeopardy removal. The Removal Plan: F684 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance, and. On [DATE] the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired [DATE]) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from [DATE] through [DATE]. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from [DATE] through [DATE]. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from [DATE] through [DATE] for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from [DATE] through [DATE]. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. Upon arrival to facility on [DATE] the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete The Administrator completed a 24-hour report to the State Agency regarding neglect on [DATE] when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on [DATE] and terminated on [DATE]. The wound Nurse was reported to the North Carolina Board of Nursing on [DATE] for professional standards violations. The Director of Health Services initiated 100% body audits on all residents within the facility on [DATE]. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on [DATE] 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 wounds to ensure weekly documentation including ongoing assessments including wound measurements are currently in place and documented. Review of documentation identified no residents without documentation at this point in time. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed 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 that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after [DATE] until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after [DATE] 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. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Any Certified Nursing Assistant will not be allowed to work after [DATE] until they receive the education. The Clinical Competency Coordinator/RN is responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Alleged date of IJ Removal [DATE] The credible allegation for Immediate Jeopardy removal was validated on [DATE] which removed the Immediate Jeopardy on [DATE], as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on providing wound care treatments according to physician orders, wound assessments, wound measurements, and identification of new wounds and skin assessments. The facility's Immediate Jeopardy removal date of [DATE] was validated.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility nursing staff failed to demonstrate competency and skill sets to effectively manage a resident ' s wound and to report a change in wound condition to the physician for evaluation of a wound that progressively deteriorated for more than a 3-month period of time. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on [DATE] to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on [DATE] when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse administered a discontinued treatment to the wound and failed to assess and document the status of the wound according to her training. During this time, staff trained on skin assessments failed to identify, report, and document this wound on weekly skin assessments. Immediate jeopardy was removed on [DATE] when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: This tag is cross referenced to: Tag F580 - Based on staff, physician, nurse practitioner, and police officer interviews, and record review the facility failed to notify the physician of an open wound that progressively deteriorated from [DATE] through [DATE]. This failure resulted in the resident receiving no physician evaluation of the wound and no physician ordered treatments to the wound. Resident #200 was identified by Emergency Medical Services (EMS) and police on [DATE] to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Tag F600 - Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility neglected to provide necessary care and services to a resident by failing to effectively assess and monitor an open wound, failing to obtain physician ' s orders prior to treating the wound, and failing to notify the physician of an open wound that progressively deteriorated from [DATE] through [DATE]. Resident #200 was observed by Emergency Medical Services (EMS) on [DATE] with a large tunneling wound under his left arm at the time of death. This was for 1 of 3 residents reviewed for wound care (Resident #200). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Tag F684 - Based on staff, physician, nurse practitioner, police officer and emergency medical technicians (EMT) interviews, and record review the facility failed to obtain physician ' s orders prior to treating a wound and failed to identify, assess, and monitor a wound to determine the need for medical treatment for an open wound that progressively deteriorated from [DATE] through [DATE]. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on [DATE] to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). During an interview on [DATE] at 3:26 PM Nurse #3 stated when she was hired, she was trained on weekly skin checks. She further stated they were to do a head-to-toe assessment. She stated she would start with the resident ' s head and observe the integrity of the skin to the resident ' s head. She stated while checking their head she would palpate their neck to check their glands. She stated and then they would have the resident raise their arms and observe the skin under their arms. Then she would inspect their chest and then peri-area and groin. Then she would check legs and feet. Then the resident would be turned over and they would check the back and the gluteal fold and legs. She stated she performed the skin assessment on [DATE] and noted his skin issue to Resident #200 ' s sacrum. Upon being informed of the wound care nurse ' s description of the wound as well as the description by police and EMT at the time of his death she stated she did not recall identifying such a wound. She further stated she could not explain why the wound would not have been documented in her assessment if it had been present. She denied having any knowledge of the presence of or beginning of a wound to his left underarm in her skin assessment she completed on [DATE]. During an interview on [DATE] at 4:42 PM Nurse #4 stated she was trained how to complete head to toe skin assessments. She further stated she would start with observations of the head, and then move to the front of the resident, then shoulders, then back, then legs and feet, and finally arms and hands. She stated she would have documented if Resident #200 refused to raise his arms so if she did not document refusal, she would have observed under his arms for skin integrity. She further stated she had no idea how she could have missed a wound as it was described by the wound care nurse, EMTs, and responding police officer. She stated the only wound she identified Resident #200 with on [DATE] was the wound under his buttock which she would not note this wound in her skin assessment because it was a pressure ulcer already being treated and it was up to the wound care nurse to document those measurements and treatments. During an interview on [DATE] at 10:24 AM the Wound Care Nurse indicated she began working with wounds at the facility in [DATE]. She indicated she received training at the facility on how to identify, assess, evaluate, monitor, and document skin conditions. This training was completed for her in ,d+[DATE] when she took the position of wound care nurse. When asked why she had not implemented this training for Resident #200 ' s left arm pit wound she indicated she had no reason she chose not to. She acknowledged that she should have assessed and evaluated the open wound to his left armpit, monitored the wound ' s status, and documented this in the medical record in accordance with her training. The Wound Care Nurse reported she was trained to acquire orders for wound care prior to providing treatment. She stated she had no reason why she provided the treatment without an order. She revealed she had not asked the physician or nurse practitioner for orders and that she knew she should have. She stated she was aware she should have completed all these steps due to her training at the time it was happening and had no reason she did not follow her training. The skin assessments completed from the [DATE] through [DATE] that all failed to identify Resident #200 ' s left arm pit wound were reviewed with the Wound Care Nurse. The Wound Care Nurse stated she would have identified a wound of that size on a skin assessment but could not speak to how the other nurses missed the wound. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:28 PM Staff Development Coordinator #1 stated she was the Staff Development Coordinator (SDC) from 2019 through [DATE]. When staff were hired, they were provided education on wound treatments and documentation of treatments. She stated they had a skills observation checkoff for skin assessments that were done with staff upon orientation as well. Staff were educated on notification of changes of residents to the physician and responsible party to include incidents involving skin concerns on an as needed basis. They also educated staff on not providing treatments without orders, not obtaining orders for needed skin treatments, and education on wound care documentation on an as needed basis. She stated she believed the last time any of these issues were needed to be in-serviced was back in 2019 and did not have those records immediately available. She stated the new SDC had done some in-services since [DATE] on the topic of wound care. This in-service was due to a new policy that had been initiated by corporate and did not have anything to do with any concerns identified with the care provided in the facility. During an interview on [DATE] at 1:35 PM Staff Development Coordinator #2 stated she had provided in-services since [DATE] on the topic of wound care. This in-service was due to a new policy that had been initiated by corporate and did not have anything to do with any concerns identified with the care provided in the facility. During an interview on [DATE] at 9:32 AM the Administrator stated it was her expectation that staff would follow their training to perform full head to toe skin assessments and that they would identify, and report concerns of skin integrity. During an interview on [DATE] at 9:55 AM The Director of Nursing stated nursing staff were trained on skin checks and Nurse #1, Nurse #3, and Nurse #4 received skin assessment training. She further stated if a wound was present under Resident #200 ' s arm at the time they did their skin assessments, it should have been documented and reported to the Wound Care Nurse and nurse on the hall who would be responsible for notifying the Physician, responsible party, and Director of Nursing. If the wound was present at the time of these skin checks she did not know why they did not identify the wound. The Wound Care Nurse had been trained that identified wounds were to be assessed, monitored, documented, and treatment was to be provided according to physician ' s orders. She did not understand why the wound care nurse did not follow her training. The Administrator was notified of the immediate jeopardy on [DATE] at 9:36 AM. On [DATE] the facility provided the following credible allegation of immediate jeopardy removal. The Removal Plan: F726 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and (continued on next page)

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	345371	A. Building B. Wing	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired [DATE]) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from [DATE] through [DATE]. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200 ' s open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from [DATE] through [DATE]. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from [DATE] through [DATE] for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from [DATE] through [DATE]. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. Weekly skin assessments from [DATE] through [DATE] failed to identify Resident #200 ' s open wound to the axilla area. The facility was unaware of the Wound nurse ' s lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. The facility was unaware of the failure of nurses to identify the open wound during weekly skin assessments from [DATE] through [DATE]. Upon arrival to facility on [DATE] the EMS /police noted the resident ' s axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on [DATE]. All residents have the potential to have suffered a serious outcome as a result of this noncompliance. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Administrator completed a 24-hour report to the State Agency regarding neglect on [DATE] when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on [DATE] and terminated on [DATE]. The wound Nurse was reported to the North Carolina Board of Nursing on [DATE] for professional standards violations. The Director of Health Services initiated 100% body audits on all residents within the facility on [DATE]. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on [DATE] and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by [DATE] will be educated prior to their next scheduled shift. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed 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 that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after [DATE] until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds. The Director of Health Services and/or Nurse Managers began education on [DATE] regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after [DATE] until they receive the education. The Director of Health Nursing and/or RN Nurse Managers have validated, (by observation) the [DATE] skin observations completed by the License Nurses for comprehensive assessment and accuracy. No discrepancies where identified. The Clinical Competency Coordinator, Director of Health Services and RN Managers are observing all Licensed Nurse ' s on [DATE] complete skin observation to validate competency of the comprehensive assessment and for accuracy of the assessment. Licensed Nurses not deemed competent will be re-educated and reevaluated to validate competency prior to completing further skin assessments. Licensed Nurse will not be allowed to work after [DATE] until they have been observed and validated for competency of the comprehensive assessment and for accuracy of the assessment . The Clinical Competency Coordinator/RN is responsible for ensuring education and evaluation of competency is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after [DATE]. Alleged date of IJ Removal [DATE] (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The credible allegation for Immediate Jeopardy removal was validated on [DATE] which removed the Immediate Jeopardy on [DATE], as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on providing wound care treatments according to physician orders, wound assessments, wound measurements, and identification of new wounds and weekly skin assessments. The facility ' s Immediate Jeopardy removal date of [DATE] was validated.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32503 Based on observations and interviews with facility staff and the consulting dietitian the facility failed to provide the correct consistency of food to 1 (Resident #3) of 5 residents reviewed for nutrition. The findings included: Resident #3 was admitted to the facility on [DATE]. Her diagnoses included traumatic subdural hemorrhage, mixed receptive-expressive language disorder and diabetes. The quarterly Minimum Data Set, dated dated dated [DATE] indicated Resident #3 understood and was able to understand. She was coded as moderately cognitively impaired. She required extensive assistance with most activities of daily living except she was dependent on staff for toileting and independent with eating. She received a mechanically altered diet. The October 2021 Physician orders revealed the current diet for Resident #3 was regular puree. A dietary note written on 10/18/21 by the Dietary Manager revealed Resident #3 continued to receive a regular pureed diet. During a meal observation on 10/25/21 at 12:25 PM Resident #3 ' s lunch meal tray was on her over the bed table. Resident #3 was feeding herself. The meal tray ticket identified Resident #3 was on a regular puree diet. The meal tray included pureed okra. The pureed okra contained visible pieces of okra. On 10/25/21 at 12:35 PM Unit Manager stated she observed Resident #3 ' s lunch meal tray and she could see the pieces of okra. She removed the plate containing the okra. On 10/25/21 at 12:40 PM the Administrator stated it was a concern to have visible pieces of okra in the pureed item. She added Resident #3 was known to consume whole pieces of food by taking the food from other resident ' s trays or food items brought in by her family. On 10/25/21 at 12:47 PM the Dietary Manager said pureed foods should not have visible pieces of food if it was pureed correctly. The Speech Therapist was interviewed on 10/27/21 at 1:30 PM. She stated Resident # 3 required a pureed diet because she did not chew the foods even when instructed to do so. She swallowed foods whole. During an interview with the consulting dietitian on 10/28/21 at 9:00 AM she stated Resident #3 was on a pureed diet and the pureed foods should not have any pieces in them.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37468 Based on staff interviews and record review the facility failed to document wound care treatments and assessments for 1 of 3 residents reviewed for wound care (Resident #200). Findings included: Resident #200 was admitted to the facility on [DATE] with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands). Resident #200's quarterly minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. Review of Resident #200's Treatment Orders and Treatment Administration Records from [DATE] through [DATE]th, 2021 revealed he was ordered on [DATE] to have his left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on [DATE]. The order was discontinued by Physician #1 and transcribed by the Wound Care Nurse. There were no further treatments documented for his left armpit wound. A review of the physician and Nurse Practitioner (NP) notes from [DATE] through [DATE] revealed no reference to Resident #200's left armpit wound. Further review of the medical record revealed no documentation of the wound to his left armpit from [DATE] through [DATE]. There were no assessments or measurements of the wound. A nursing note dated [DATE] revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility. The EMS record dated [DATE] indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified. The police case narrative dated [DATE] revealed Police Officer #1 arrived at the facility in response to a death in the facility on [DATE]. Resident #200 had one large open wound under his left arm that was several inches wide and extended up inside his body. The officer documented the open wound that was not bandaged and showed no signs of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:43 AM the Wound Care Nurse stated she remembered Resident #200. She stated she was the wound care nurse at that time, and he was on her caseload. She indicated she was providing wound care to his cyst to his left underarm and on [DATE] the treatment was discontinued but she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner on [DATE] as the wound had not improved and had not healed at that time. She revealed that until his death ([DATE]) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the wound in the medical record from [DATE] through [DATE]. She indicated she had not completed any assessments or wound measurements from [DATE] through [DATE]. During an interview on [DATE] at 12:33 PM with Physician #1 the Wound Care Nurse's interview in which she reported that she completed treatments with no physician's order from [DATE] through [DATE] as well as her statement that she completed no assessments or measurement of the wounds throughout this same time period were reviewed with the physician. He stated that orders were to be obtained prior to treatments being completed and identified wounds were to be assessed, monitored, and documented. He stated wound measurements were part of the assessment. He indicated without assessments and measurements there was no way to determine if there were changes in the wound that would require a change in the treatment plan. He stated due to the lack of documentation it was impossible to know if and when the wound was or was not present or the severity of the wound until the time of the photographs by the police department. During an interview on [DATE] at 1:35 PM the Director of Nursing stated wounds were to be assessed, monitored, and documented. Wound care treatment was to be documented as well. She concluded wound measurements were part of the assessments in order to follow the wound progress.