STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365952	A. Building B. Wing	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32087 Based on medical record review, staff interviews, community member interviews, review of an infection control log, review of an autopsy report, review of a coroner ' s case summary document, and review of facility policies for neglect, pressure ulcer prevention and treatment, and medication administration, the facility failed to perform timely and adequate skin assessments, failed to initiate pressure wound treatments and interventions, and failed to administer an antibiotic medication as ordered for one resident (#97). This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death when Resident #97 was assessed at admission with no pressure ulcers and was assessed at risk for pressure ulcer development. Resident #97 ' s skin was not assessed timely and there was no documentation of interventions implemented to prevent pressure ulcer development until [DATE] when Wound Nurse Practitioner (WNP) #810 assessed Resident #97 and discovered an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (non-viable yellow, tan, gray, green or brown tissue) or eschar (dead or devitalized tissue) on the sacrum. WNP #810 implemented wound treatments, a low air loss mattress to Resident #97 ' s bed, and an antibiotic medication which were not administered and provided to Resident #97 as ordered. Resident #97 was transferred to the hospital and subsequently died from bacterial sepsis due to a sacral pressure ulcer as a result of medical neglect. Resident #97 ' s death occurred by failure of caregiver(s) to provide adequate and timely medical care for a sacral pressure wound and the manner of death was ruled a homicide by the coroner. This affected one (#97) of six (#21, #23, #47, #51, #60, and #97) residents reviewed for pressure ulcers and medications. The facility identified five (#21, #23, #47, #51, and #60) residents currently residing in the facility with pressure ulcers. The census was 52. On [DATE] at 3:57 P.M., Administrator #545, [NAME] President of Clinical Services (VPCS) #750, and Regional Director of Operations (RDO) #770 were notified Immediate Jeopardy began on [DATE] when Resident #97 was assessed with an unstageable pressure ulcer to the sacrum which did not exist upon admission. Resident #97 was assessed at risk for pressure ulcer development on admission and throughout the stay in the facility. The facility did not complete skin assessments as ordered, and there was no documentation of pressure-reducing interventions in place prior to the discovery of the pressure ulcer on [DATE]. WNP #810 ordered a wound treatment, a low air loss mattress, and an antibiotic medication on [DATE] which were not administered as ordered or implemented in a timely manner. Resident #97 was sent to the hospital on [DATE] due to the condition of the pressure ulcer on the sacrum and ultimately died on [DATE] at 8:15 P.M. Resident #97 died from bacterial sepsis of the sacral pressure ulcer due to medical neglect. Resident #97 ' s death was ruled a homicide by the coroner from the failure of caregiver(s) to provide timely and adequate care for the sacral wound. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on [DATE] at 1:50 P.M. when the facility implemented the following corrective actions: On [DATE], the facility held a Quality Assurance and Performance Improvement (QAPI) meeting with Medical Director #890 to discuss the incident about Resident #97 and develop a plan of correction. On [DATE], Director of Nursing (DON) #518, Assistant Director of Nursing (ADON) #515, and regional nurses (Regional Director of Clinical Services (RDCS) Registered Nurse (RN) #700, Regional Director of Minimum Data Set (MDS) RN #710, Regional Director of MDS RN #720, RDCS RN #730, and RN Travel Nurse #740) began full skin assessments and ensured assessments for pressure ulcer development risk were in place for all 52 residents residing in the facility. All assessments were completed by [DATE]. On [DATE], DON #518, ADON #515, and regional nurses began assessments to validate the presence of unaddressed skin impairment, ensure appropriate interventions were in place, and care plan interventions were updated of all 52 residents in the facility. A visual check was performed of all 52 residents to ensure appropriate pressure-reducing interventions were in place and was completed on [DATE]. On [DATE], regional nurses began education to all facility staff on neglect with all facility staff members educated by [DATE]. On [DATE], DON #518 began education to all facility nurses and nurse aides on pressure reducing interventions, identifying residents at risk for pressure ulcer development, following physician orders, and completing skin assessments. The education was completed on [DATE]. On [DATE], Administrator #545 initiated a self-reported incident (SRI) related to the allegation of neglect in Resident #97 ' s care. On [DATE], new admissions to the facility were voluntarily stopped until an unknown date to be determined by the QAPI committee. On [DATE], DON #518 began audits of residents assessed at high risk for pressure ulcer development to ensure treatments and interventions were ordered and were observed in place. DON #518 or designee will continue with these audits three times weekly for six weeks. On [DATE], DON #518 began review of all new admissions by completing a second skin assessment, evaluating the resident ' s risk for pressure ulcer development, and ensuring interventions were ordered and observed in place. DON #518 or designee will continue with these reviews three times weekly for six weeks. On [DATE], RN Travel Nurse #740 reviewed antibiotic medication orders for all three (#11, #17, and #21) residents currently prescribed antibiotic medications. The medical record was reviewed to ensure orders were current, the antibiotic was given as ordered, the medication administration record (MAR) reflected administration of the medication, and there were no missed doses. DON #518 or designee will monitor antibiotic medication orders and administration of the antibiotic five times weekly for six weeks to ensure compliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], review of the medical records for Resident #21, Resident #23, Resident #47, Resident #51, and Resident #60, who all were assessed with pressure ulcers currently in the facility, revealed no concerns related to treatments completed as ordered, interventions in place as ordered, skin assessments completed timely, medications administered as ordered, and care plan interventions in place. On [DATE], between 12:58 P.M. and 1:50 A.M., ADON #515, Licensed Practical Nurse (LPN) #555, LPN #522, State tested Nurse Aide (STNA) #502, STNA #503, and STNA #560 verified they were educated on resident neglect, pressure reducing interventions, identifying residents at risk for pressure ulcer development, following physician orders, and completing skin assessments. All staff members interviewed were knowledgeable of the content of each education provided by the facility. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #97 ' s medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, muscle weakness, morbid (severe) obesity, major depressive disorder, anxiety disorder, atrial fibrillation, acute kidney failure, altered mental status, essential hypertension, and lymphedema. Resident #97 was discharged from the facility on [DATE]. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was assessed with severely impaired cognition, required extensive two-plus persons physical assistance for bed mobility, was at risk for developing pressure ulcers and injuries, with no pressure ulcer present on admission, and interventions of a pressure reducing device for a chair and a pressure reducing device for a bed. Review of the Care Area Assessment (CAA) Summary revealed the care area of pressure ulcers was triggered and noted Resident #97 had a left inner ankle wound on admission and had potential for further skin deficits from cognitive loss, decreased mobility, weakness, and incontinence. Results of the pressure ulcer CAA indicated a care plan for pressure ulcers would be initiated. Review of an admission nursing assessment dated [DATE] at 4:22 P.M. revealed Resident #97 was admitted to the facility from another nursing home with an admitting diagnoses of acute kidney failure and need for long term care. Resident #97 required extensive assistance with bed mobility, was alert and oriented to person only, and was assessed with no pressure ulcers or wounds on admission. Review of an admission assessment used to predict pressure ulcer development risk dated [DATE] revealed Resident #97 was assessed at risk. Subsequent assessments completed on [DATE], [DATE], and [DATE] revealed Resident #97 was assessed at high risk for pressure ulcer development. Review of a late entry nurse practitioner progress note dated [DATE] revealed Resident #97 was a new admission to the facility from another nursing home, and was supposed to go home with her husband, but became too hard to care for on his own. Resident #97 was alert and oriented with an ongoing wound to the left ankle that was wrapped in a clean bandage. Resident #97 ' s skin was documented as pink, warm, and dry with a wound to the left ankle and no other skin impairments noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician order dated [DATE] revealed Resident #97 was ordered weekly skin assessments at bedtime every Saturday. Review of the [DATE] Treatment Administration Record (TAR) revealed Resident #97 ' s skin assessments were scheduled for [DATE] and [DATE] at 9:00 P.M. Further review of the [DATE] TAR revealed the skin assessment scheduled for [DATE] was not completed and the skin assessment on [DATE] was documented as completed with no impairments noted. Review of weekly skin assessments dated [DATE] and [DATE] revealed Resident #97 had a non-pressure ulcer to the left inner ankle with no other skin impairments identified. There were no further skin assessments completed in the medical record for Resident #97 between [DATE] and [DATE]. Review of a physician assistant progress note dated [DATE] at 7:09 P.M. revealed Resident #97 was seen for a readmission pain management evaluation and was noted to have been seen by the physician assistant at another skilled nursing facility over a year ago. Resident #97 was noted to have a bandage on the left foot and ankle but Resident #97 denied any wound, however, Resident #97 did indicate she had a wound on her buttocks. The physician assistant recommended proper repositioning and indicated the facility physician or nurse practitioner would need to address that. The physician assistant ' s physical examination of Resident #97 ' s skin included notation of lesions with no location specified and no other skin impairments noted. Review of a shower sheet dated [DATE] revealed Resident #97 was identified with no skin impairments. This was the only documented shower Resident #97 received between [DATE] and [DATE] in the medical record. Review of the [DATE] infection control log revealed Resident #97 tested positive for COVID-19 on [DATE] and was placed in isolation until [DATE]. Review of a late entry nurse practitioner progress note dated [DATE] at 2:09 P.M. revealed Resident #97 received wound care for the left ankle wound with no new issues or complaints and no indication of any other skin impairments. Resident #97 ' s skin was assessed as pink, warm, and dry with a notation to continue wound care management of the left ankle. Review of the [DATE] TAR revealed Resident #97 ' s skin assessments were scheduled for [DATE], [DATE], [DATE], and [DATE] at 9:00 P.M. Further review of the [DATE] TAR revealed the skin assessments scheduled for [DATE], [DATE], and [DATE] were not completed and the assessment dated [DATE] indicated Resident #97 was in the hospital. Review of a care plan dated [DATE] revealed Resident #97 had an activities of daily living (ADLs) self-care performance deficit related to generalized weakness and abnormality of gait and mobility. Care plan interventions included Resident #97 required extensive assistance by one to two staff members to turn and reposition in bed as necessary and Resident #97 required a skin inspection with staff instructed to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a care plan dated [DATE] revealed Resident #97 had potential or actual skin impairments to the skin related to lymphedema and subcutaneous tissues with a noted non-pressure chronic ulcer of the left ankle and fungal redness under the breasts. Care plan interventions included for Resident #97 to have weekly treatment documentation to include measurements of each area of skin breakdown and any other notable changes or observations, Resident #97 needed a pressure relieving/reducing cushion to protect the skin when up in a chair, Resident #97 needed a pressure relieving/reducing mattress to protect the skin when in bed, and the staff should follow facility protocols for treatment of injury. Review of physician orders dated between [DATE] and [DATE] revealed no orders were created for pressure relieving devices to be implemented to Resident #97 ' s bed or chair as care planned. Review of nursing progress notes dated between [DATE] and [DATE] revealed no documented evidence of any interventions utilized to relieve pressure for Resident #97 when in bed or in a chair. Review of a wound practitioner visit progress note dated [DATE] revealed Resident #97 was seen by WNP #810 for an initial evaluation and treatment of a wound. WNP #810 noted an unstageable, full thickness pressure ulcer to Resident #97 ' s sacrum with a surrounding area of eschar as well as a nearby deep tissue pressure ulcer. WNP #810 indicated the pressure ulcer had copious amounts of putrid, seropurulent (wound fluid drainage that appears as light green, brown, yellow, or tan) drainage with a large amount of wet, non-viable tissue partially obscuring the deep sacral wound. WNP #810 debrided the overlaying wet necrotic tissue to remove the seropurulent drainage and reveal the extent of the wound depth and removed loose tan necrotic tissue from the wound bed. Further assessment of Resident #97 ' s sacral pressure ulcer once WNP #810 removed the obstructing non-viable tissue revealed measurements of 13.5 centimeters (cm) long by 15. 2 cm wide with no measurable depth. The pressure ulcer had tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) noted at the 7:00 o ' clock position with a maximum distance of 8.4 cm with no sinus tract noted and undermining (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface) was noted at the 6:00 o ' clock position and ended at the 12:00 o'clock position with a maximum distance of 2.0 cm. The wound bed at between one (1) percent (%) and 25% eschar and between 76% and 100% slough with no healthy tissue noted. The pressure ulcer was cleaned with copious amounts of saline to obtain a wound culture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the wound practitioner visit progress note dated [DATE] revealed WNP #810 ordered for Resident #97 ' s wound to be cleansed with wound wash and Dakin ' s one-fourth (,d+[DATE]) strength (a solution used to cleanse wounds and prevent infection) moistened gauze applied, then Kerlix gauze packed into the wound tunneling and undermining, covered with a four-inch by four-inch gauze then an absorbent pad, and secured with tape. The dressing was to be changed twice daily and as needed for soiling, saturation, or accidental removal. WNP #810 noted Resident #97 had large amounts of drainage and may need dressing changes completed three to four times daily for the next few days and for staff to not allow excess drainage to lie on the surrounding skin. WNP #810 requested a low air loss mattress be obtained for Resident #97 and recommended bedrest only until Resident #97 ' s sacral wound was more stable. WNP #810 also recommended starting a broad-spectrum antibiotic such as doxycycline 100 milligrams (mg) by mouth for 10 days until wound culture results were available. WNP #810 documented an addendum that Resident #97 ' s power of attorney (POA) was contacted on [DATE] and discussed Resident #97 ' s wound status and treatment plan. Resident #97 ' s POA expressed the desire to treat the pressure ulcer as needed to prevent any further discomfort or preventable complications such as sepsis, and Resident #97 ' s POA agreed to serial debridement as needed and agreed that should Resident #97 ' s wound significantly deteriorate or cause increased or further discomfort she would want Resident #97 to be sent to the hospital. WNP #810 noted the information was conveyed to Former DON #850 on the morning of [DATE]. Review of a laboratory document revealed Resident #97 had a wound culture collected on [DATE] at 2:40 P. M. Results of the wound culture were received on [DATE] at 9:32 A.M. and revealed many neutrophils (a type of white blood cell that helps the body fight infection), many Gram-negative rods (bacteria), many Gram-positive cocci (bacteria) in clusters, with heavy growth of proteus mirabilis (a Gram-negative bacterium) and light growth of Escherichia coli (E. coli, a Gram-negative bacterium). Review of a physician order dated [DATE] revealed Resident #97 was ordered to have the sacral wound cleansed with normal saline, patted dry, have collagen applied, then a calcium alginate dressing, and covered with an island dressing every shift. The order was scheduled to start on [DATE]. Review of a physician order dated [DATE] revealed Resident #97 was ordered the antibiotic doxycycline hyclate 100 mg by mouth twice daily for infection for 10 days per wound care nurse practitioner. Further review of the physician orders between [DATE] and [DATE] revealed there was no order for a low air loss mattress for Resident #97 ' s wound healing as recommended by WNP #810 on [DATE]. Review of the [DATE] TAR revealed Resident #97 ' s wound treatment was not completed on the evening shift on [DATE] nor the morning or evening shift on [DATE]. Review of the [DATE] Medication Administration Record (MAR) revealed Resident #97 did not receive ordered doses of doxycycline hyclate 100 mg on [DATE] and [DATE] in the evening and on [DATE] in the morning. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nurse practitioner progress note dated [DATE] at 6:48 P.M. revealed Resident #97 was visited to follow up monthly on chronic issues. The nurse practitioner documented Resident #97 was doing well at this time and was currently in her bed resting. There was no indication of the type of mattress applied to Resident #97 ' s bed during the nurse practitioner ' s visit. The nurse practitioner noted ongoing treatment of Resident #97 ' s left ankle wound with no plan or treatment documented for Resident #97 ' s sacral pressure ulcer. The nurse practitioner ' s documentation of Resident #97 ' s skin during the visit was the skin was pink, warm, and dry with a wound to the left ankle. Review of a nursing progress note dated [DATE] at 11:57 A.M. revealed Resident #97 ' s low air loss mattress came to the facility on [DATE] and was placed on the bed. Review of a nursing progress note dated [DATE] at 11:00 A.M. revealed Resident #97 was transported to the hospital as Resident #97 ' s POA insisted she be sent out due to deteriorating wound and mental status. Review of a transfer form dated [DATE] at 11:00 A.M. revealed Resident #97 had an unplanned transfer due to a skin wound or ulcer and proper notifications were made. Review of a nursing progress note dated [DATE] at 5:23 P.M. revealed Resident #97 ' s POA was at the facility with family to gather Resident #97 ' s belongings and stated Resident #97 was actively dying. Review of a report from the county coroner ' s office revealed an autopsy was completed on [DATE] at 8:30 A.M. for Resident #97 by Deputy Coroner (DC) #950. Resident #97 ' s noted date of death was [DATE] at 8:15 P.M. DC #950 noted Resident #97 had evidence of wounds or trauma with a large stage four (full-thickness skin and tissue loss) pressure ulcer over the lower back measuring 4 , d+[DATE] inches long by 7 ,d+[DATE] inches wide which included the surrounding green-black eschar. DC #950 indicated the center of the wound had a 2 ,d+[DATE] inches long by 3.0 inches wide area defect down to the sacral spine. The soft tissue in the wound was dark tan and red to green-gray, macerated (a white appearance with very soft texture), and extended through the deep tissue surrounding the sacral bone. Resident #97 ' s sacral bone was tan-pink and friable (easily crumbled). There was purulent (fluid containing pus) tan-pink exudate (any fluid that has been forced out of the tissues or its capillaries because of inflammation or injury) in the soft tissue and no involvement of the pelvic organs. DC #950 performed a microscopic examination of Resident #97 ' s sacral ulcer deep tissue and it was significant for sheets of neutrophils dissecting through degenerating skeletal muscle and connective tissue. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a documented case summary of Resident #97 ' s death from DC #950 revealed the date of Resident #97 ' s examination was [DATE]. Resident #97 ' s autopsy findings included a large stage four pressure ulcer over the sacrum with necrosis extending through the deep tissue surrounding the sacral bone, necrotizing fasciitis (inflammation of the fasciae of muscles or other organs results in rapid destruction of overlying tissues) and myositis (a group of rare conditions with symptoms of weak, painful, or aching muscles) by microscopic examination, purulent tan-pink exudate, friable sacral bone, and gangrenous (dead tissue) skin surrounding deep tissues in the wound. Resident #97 had blood and sacral wound cultures obtained during the autopsy and were positive for proteus mirabilis and Escherichia coli. DC #950 documented, it was his opinion, Resident #97 ' s cause of death was bacterial sepsis (proteus mirabilis and E. coli) due to a sacral pressure ulcer due to medical neglect. Resident #97 ' s injury occurred by failure of caregiver(s) to provide adequate or timely medical care for a sacral pressure ulcer and the manner of death was documented as homicide. A telephone interview was completed on [DATE] at 8:28 A.M. with Long-Term Care Ombudsman Program Director (LTCOPD) #800 who stated he went to the facility on [DATE] to see Resident #97 and observed her in her room lying in bed. LTCOPD #800 stated there was a foul odor in the room and Resident #97 was completely curled up with her head against the wall and appeared uncared for. LTCOPD #800 stated he could see Resident #97 ' s foot sticking out from the blanket and could see it had a treatment on it, and the fitted sheet was partially off the mattress and noted a regular mattress on Resident #97 ' s bed. LTCOPD #800 stated he asked Resident #97 if she needed repositioned and Resident #97 indicated she did, so he went to tell the director of nursing. LTCOPD #800 stated he talked to the director of nursing about Resident #97 ' s condition and the director of nursing showed him a few documents from Resident #97 ' s medical record which included review of Resident #97 ' s admission nursing assessment which showed no skin impairments. LTCOPD #800 stated he knew something was not right, so he and the director of nursing walked down to Resident #97 ' s bedroom to address the issues and noted Resident #97 now had a low air loss mattress on her bed, she was changed, and repositioned. Interview on [DATE] at 11:22 A.M. with VPCS #750 verified there was no documentation of a pressure ulcer to Resident #97 ' s sacrum on admission, no documentation of interventions utilized to prevent pressure ulcer development, no consistent assessments of Resident #97 ' s skin completed, and once wound treatments and antibiotics were ordered for Resident #97, the facility did not complete the treatments or administer the medications as ordered. VPCS #750 stated there were no administrative staff still working in the facility who would have been employed during the time Resident #97 was in the facility. VPCS #750 stated ADON #515 was still employed by the facility but was on a leave of absence while Resident #97 resided in the facility. VPCS #750 stated the majority of direct care staff at that time were agency staff and she was not aware of any direct care staff currently employed by the facility who took care of Resident #97. A telephone interview was completed on [DATE] at 1:28 P.M. with DC #950 who verified he was the individual that completed Resident #97 ' s autopsy and case summary of Resident #97 ' s death. DC #950 stated all the information about Resident #97 ' s autopsy findings was in the two reports and confirmed, after reviewing Resident #97 ' s case again, he continued to rule Resident #97 ' s death a homicide as a result of medical neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was completed on [DATE] at 2:20 P.M. with WNP #810 who verified she saw Resident #97 once while she was a resident in the facility on [DATE]. WNP #810 stated Former Director of Nursing (FDON) #850 contacted her and stated she needed her to see Resident #97. WNP #810 stated FDON #850 told her they found a wound on Resident #97 the past couple days but thought the wound was there longer. WNP #810 stated when she saw Resident #97 on [DATE] her wound had a dressing on it, but she did not know where the dressing came from or who ordered it. WNP #810 stated Resident #97 ' s sacral pressure ulcer had dead tissue hanging in flaps over it and when WNP #810 touched it with her hands, it would just fall off. WNP #810 stated the severity and odor from Resident #97 ' s wound was very bad. WNP #810 stated she spoke to Resident #97 ' s family and they did not know how long the wound had been there either. WNP #810 stated she took some of the dead tissue off the wound, cleaned it, and applied a dressing before ordering scheduled treatments, an antibiotic, and a low air loss mattress for Resident #97 ' s bed. WNP #810 stated she looked at Resident #97 ' s medical record and saw the antibiotic she ordered was not initiated, and when WNP #810 informed FDON #850, she indicated she thought the antibiotic was initiated but it was for another resident, so it was started that day. WNP #810 stated she told FDON #850 many times to monitor Resident #97 ' s wound condition and if it got any worse to send her to the hospital. WNP #810 stated a few days later Resident #97 ' s POA contacted her and told her the wound was getting worse. WNP #810 stated the facility never contacted her about the wound getting worse and they never sent Resident #97 to the hospital until Resident #97 ' s POA had concerns. WNP #810 stated she talked to FDON #850 after Resident #97 was sent to the hospital and FDON #850 told her she never looked at Resident #97 ' s wound after WNP #810 saw her on [DATE] and FDON #850 told her Resident #97 was now in hospice care, so the facility no longer had to worry about the wound. WNP #810 stated she no longer provided services for residents in the facility. Interview on [DATE] at 12:58 P.M. with ADON #515 verified she was on a leave of absence from the facility while Resident #97 was in the facility. ADON #515 stated she had no knowledge about Resident #97 but confirmed she found the one and only shower sheet documented in Resident #97 ' s medical record dated [DATE]. A telephone interview was completed on [DATE] at 2:51 P.M. with Medical Director (MD) #890 who stated he began his role as medical director for the facility at the start of [DATE]. MD #890 stated he had no knowledge of Resident #97, until the facility asked him to review her medical record. MD #890 verified he never saw Resident #890 while she was in the facility and stated he had no record of the facility ever contacting him about Resident #97. MD #890 stated he had problems with the facility getting him information and, when he first started, there was no leadership as all the administrative staff were transitioning out of the facility. MD #890 stated the facility had a lot of systems collapse on them at the same time which contributed to Resident #97 ' s condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was completed on [DATE] at 3:51 P.M. with FDON #850 who stated she was director of nursing at the facility for around eight weeks and stated she was new to the facility when Resident #97 was admitted . FDON #850 stated she remembered Resident #97 was admitted to the facility with no wounds and one day the direct care staff came to her and told her Resident #97 had a bad wound on her buttocks. FDON #850 stated she contacted WNP #810 to look at the wound, but FDON #850 stated she did not personally see Resident #97 ' s pressure ulcer. FDON #850 verified she never observed Resident #97 ' s pressure ulcer while she was in the facility before she was sent out to the hospital. FDON #850 stated she was not aware if Resident #97 received wound treatments or received her ordered antibiotic and could not give specific dates or details about Resident #97 ' s care. FDON #850 stated she thought Resident #97 ' s wound happened very fast but could not give a timeline. FDON #850 stated most of the nurses during that time were through agency and could not recall any nurses or nurse aides who worked with Resident #97 that were still employed by the facility. Review of a facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised [DATE], revealed the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report a full assessment of pressure sore, pain assessment, mobility status, current treatments, including support surfaces, and all active diagnoses. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will assist the staff to identify the type of ulcer and will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. Review of a facility policy titled, Prevention of Pressure Injuries, revised [DATE], revealed residents will be assessed on admission (within eight hours) for existing pressure injury risk factors. The risk assessment will be completed weekly and upon any changes in condition. Staff will conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. The skin should be inspected on a daily basis when performing or assisting with personal care or ADLs. Appropriate surfaces should be selected based on the resident's risk factors and in accordance with current clinical practice. Review of a facility policy titled, Administering Medications, revised [DATE], revealed medications are administered in a safe and timely manner, and as prescribed. Review of a facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised [DATE], re[TRUNCATED]

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45445 Based on medical record review and staff interview, the facility failed to ensure a resident attended scheduled appointments and failed to set up a recommended appointment. This affected one (Resident #94) of one resident reviewed for appointment scheduling. Additionally, the facility failed to collect an ordered urine sample timely, delaying treatment for a Urinary Tract Infection (UTI). This affected one (Resident #94) of one resident reviewed for urine samples. The facility census was 52. Findings include: 1. Review of the medical record for the Resident #94 revealed an admitted [DATE]. Resident #94 was admitted to the facility for supportive care following a hospital admission from 01/23/22 through 02/09/22 for the treatment of an ischemic stroke with complicated management due to other health issues including a diagnosis of COVID-19 and a bleeding duodenal ulcer which required cautery. Admission diagnoses included cerebral infarct, dysphagia, cognitive communication deficit, mild protein calorie malnutrition, atrial fibrillations, obstructive and reflux uropathy, hemiplegia, pyelonephritis, and a peptic ulcer disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had impaired cognition, was dependent for bed mobility, dressing, eating, toilet use and personal hygiene, and required the physical assistance of one-person for bathing. Resident #94 had an indwelling urinary catheter. Review of the hospital discharge record dated 02/09/22 revealed a urology appointment scheduled for 02/10/22 at 3:00 P.M., a cardiology appointment on 02/15/22 at 3:00 P.M., and directions to call for a gastroenterology appointment and for a Computed Tomography Angiography (CTA) to be scheduled in one month to re-evaluate the retroperitoneal hematoma. Interview with the Assisted Director of Nursing (ADON) #515 on 12/27/22 at 1:00 P.M. verified the urology appointment was scheduled for 02/10/22, however the resident missed the appointment and went to the urologist on 03/24/22. Additionally, ADON #515 verified the cardiology appointment was scheduled on 02/15/22, but the resident did not attend until 03/11/22. Review of the progress note dated 03/28/22 revealed the CTA was scheduled after Resident #94's family member inquired about the appointment. The family member was informed the facility would have to get an order from the facility physician and arrange the appointment. Review of Resident #94's orders revealed an order for the CTA was obtained on 03/29/22. Further review of the medical record revealed the CTA was completed on 04/01/22. Interview with the ADON on 12/27/22 at 1:00 P.M. verified the order for Resident #94's CTA was not obtained until 03/29/22 and the ADON verified Resident #94 received the CTA on 04/01/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for the Resident #94 revealed an admitted [DATE]. Resident #94 was admitted to the facility for supportive care following a hospital admission from 01/23/22 through 02/09/22 for the treatment of an ischemic stroke with complicated management due to other health issues including a diagnosis of COVID-19 and a bleeding duodenal ulcer which required cautery. Admission diagnoses included cerebral infarct, dysphagia, cognitive communication deficit, mild protein calorie malnutrition, atrial fibrillations, obstructive and reflux uropathy, hemiplegia, pyelonephritis, and a peptic ulcer disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 had impaired cognition, was dependent for bed mobility, dressing, eating, toilet use and personal hygiene, and required the physical assistance of one-person for bathing. Resident #94 had an indwelling urinary catheter. Review of progress notes for 03/22/22 revealed Resident #94 had complaints of urinary symptoms. Review of the orders for Resident #94 revealed an order written on 03/22/22 for a urine sample to be obtained. The urine sample was not obtained until 03/25/22 (three days later). Review of the urinalysis results dated 03/28/22 revealed cloudy urine, ketones one plus, trace of blood and large number of leukocytes and many bacteria. Review of orders revealed an order dated 03/28/22 for Cipro (antibiotic) 500 milligrams to be administered orally twice a day for seven days for a urinary tract infection. Interview with the ADON on 12/27/22 at 1:00 P.M. verified the Resident #94 was ordered for a urine sample to be completed on 03/22/22, but the urine sample was not obtained until 03/25/22. This represents non-compliance investigated under Complaint Number OH00137792 and is an example of continued noncompliance from the survey dated 09/23/22.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32087 Based on medical record review, staff interviews, community member interviews, review of an infection control log, review of an autopsy report, review of a coroner's case summary document, and review of facility policies for neglect, pressure ulcer prevention and treatment, and medication administration, the facility failed to ensure proper administration was in place within the facility to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This directly affected one resident (#97) when the facility failed to perform timely and adequate skin assessments, failed to initiate pressure wound treatments and interventions, and failed to administer an antibiotic medication as ordered for Resident #97, but had the potential to affect all 52 residents residing in the facility. This affected one (#97) of six (#21, #23, #47, #51, #60, and #97) residents reviewed for pressure ulcers and medications. The census was 52. Findings include: Review of Resident #97's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, muscle weakness, morbid (severe) obesity, major depressive disorder, anxiety disorder, atrial fibrillation, acute kidney failure, altered mental status, essential hypertension, and lymphedema. Resident #97 was discharged from the facility on 09/24/22. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #97 was assessed with severely impaired cognition, required extensive two-plus persons physical assistance for bed mobility, was at risk for developing pressure ulcers and injuries, with no pressure ulcer present on admission, and interventions of a pressure reducing device for a chair and a pressure reducing device for a bed. Review of the Care Area Assessment (CAA) Summary revealed the care area of pressure ulcers was triggered and noted Resident #97 had a left inner ankle wound on admission and had potential for further skin deficits from cognitive loss, decreased mobility, weakness, and incontinence. Results of the pressure ulcer CAA indicated a care plan for pressure ulcers would be initiated. Review of an admission nursing assessment dated [DATE] at 4:22 P.M. revealed Resident #97 was admitted to the facility from another nursing home with an admitting diagnoses of acute kidney failure and need for long term care. Resident #97 required extensive assistance with bed mobility, was alert and oriented to person only, and was assessed with no pressure ulcers or wounds on admission. Review of an admission assessment used to predict pressure ulcer development risk dated 08/18/22 revealed Resident #97 was assessed at risk. Subsequent assessments completed on 08/25/22, 09/01/22, and 09/08/22 revealed Resident #97 was assessed at high risk for pressure ulcer development. Review of a late entry nurse practitioner progress note dated 08/18/22 revealed Resident #97 was a new admission to the facility from another nursing home, and was supposed to go home with her husband, but became too hard to care for on his own. Resident #97 was alert and oriented with an ongoing wound to the left ankle that was wrapped in a clean bandage. Resident #97's skin was documented as pink, warm, and dry with a wound to the left ankle and no other skin impairments noted. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a physician order dated 08/18/22 revealed Resident #97 was ordered weekly skin assessments at bedtime every Saturday. Review of the August 2022 Treatment Administration Record (TAR) revealed Resident #97's skin assessments were scheduled for 08/20/22 and 08/27/22 at 9:00 P.M. Further review of the August 2022 TAR revealed the skin assessment scheduled for 08/20/22 was not completed and the skin assessment on 08/27/22 was documented as completed with no impairments noted. Review of weekly skin assessments dated 08/24/22 and 09/02/22 revealed Resident #97 had a non-pressure ulcer to the left inner ankle with no other skin impairments identified. There were no further skin assessments completed in the medical record for Resident #97 between 09/03/22 and 09/19/22. Review of a physician assistant progress note dated 08/22/22 at 7:09 P.M. revealed Resident #97 was seen for a readmission pain management evaluation and was noted to have been seen by the physician assistant at another skilled nursing facility over a year ago. Resident #97 was noted to have a bandage on the left foot and ankle but Resident #97 denied any wound, however, Resident #97 did indicate she had a wound on her buttocks. The physician assistant recommended proper repositioning and indicated the facility physician or nurse practitioner would need to address that. The physician assistant's physical examination of Resident #97's skin included notation of lesions with no location specified and no other skin impairments noted. Review of a shower sheet dated 08/29/22 revealed Resident #97 was identified with no skin impairments. This was the only documented shower Resident #97 received between 08/17/22 and 09/24/22 in the medical record. Review of the September 2022 infection control log revealed Resident #97 tested positive for COVID-19 on 08/31/22 and was placed in isolation until 09/09/22. Review of a late entry nurse practitioner progress note dated 09/01/22 at 2:09 P.M. revealed Resident #97 received wound care for the left ankle wound with no new issues or complaints and no indication of any other skin impairments. Resident #97's skin was assessed as pink, warm, and dry with a notation to continue wound care management of the left ankle. Review of the September 2022 TAR revealed Resident #97's skin assessments were scheduled for 09/03/22, 09/10/22, 09/17/22, and 09/24/22 at 9:00 P.M. Further review of the September 2022 TAR revealed the skin assessments scheduled for 09/03/22, 09/10/22, and 09/17/22 were not completed and the assessment dated [DATE] indicated Resident #97 was in the hospital. Review of a care plan dated 09/10/22 revealed Resident #97 had an activities of daily living (ADLs) self-care performance deficit related to generalized weakness and abnormality of gait and mobility. Care plan interventions included Resident #97 required extensive assistance by one to two staff members to turn and reposition in bed as necessary and Resident #97 required a skin inspection with staff instructed to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a care plan dated 09/10/22 revealed Resident #97 had potential or actual skin impairments to the skin related to lymphedema and subcutaneous tissues with a noted non-pressure chronic ulcer of the left ankle and fungal redness under the breasts. Care plan interventions included for Resident #97 to have weekly treatment documentation to include measurements of each area of skin breakdown and any other notable changes or observations, Resident #97 needed a pressure relieving/reducing cushion to protect the skin when up in a chair, Resident #97 needed a pressure relieving/reducing mattress to protect the skin when in bed, and the staff should follow facility protocols for treatment of injury. Review of physician orders dated between 08/18/22 and 09/19/22 revealed no orders were created for pressure relieving devices to be implemented to Resident #97's bed or chair as care planned. Review of nursing progress notes dated between 08/18/22 and 09/19/22 revealed no documented evidence of any interventions utilized to relieve pressure for Resident #97 when in bed or in a chair. Review of a wound practitioner visit progress note dated 09/20/22 revealed Resident #97 was seen by WNP #810 for an initial evaluation and treatment of a wound. WNP #810 noted an unstageable, full thickness pressure ulcer to Resident #97's sacrum with a surrounding area of eschar as well as a nearby deep tissue pressure ulcer. WNP #810 indicated the pressure ulcer had copious amounts of putrid, seropurulent (wound fluid drainage that appears as light green, brown, yellow, or tan) drainage with a large amount of wet, non-viable tissue partially obscuring the deep sacral wound. WNP #810 debrided the overlaying wet necrotic tissue to remove the seropurulent drainage and reveal the extent of the wound depth and removed loose tan necrotic tissue from the wound bed. Further assessment of Resident #97's sacral pressure ulcer once WNP #810 removed the obstructing non-viable tissue revealed measurements of 13.5 centimeters (cm) long by 15.2 cm wide with no measurable depth. The pressure ulcer had tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) noted at the 7:00 o'clock position with a maximum distance of 8.4 cm with no sinus tract noted and undermining (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface) was noted at the 6:00 o'clock position and ended at the 12:00 o'clock position with a maximum distance of 2.0 cm. The wound bed at between one (1) percent (%) and 25% eschar and between 76% and 100% slough with no healthy tissue noted. The pressure ulcer was cleaned with copious amounts of saline to obtain a wound culture. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the wound practitioner visit progress note dated 09/20/22 revealed WNP #810 ordered for Resident #97's wound to be cleansed with wound wash and Dakin's 1/4 strength (a solution used to cleanse wounds and prevent infection) moistened gauze applied, then Kerlix gauze packed into the wound tunneling and undermining, covered with a four-inch by four-inch gauze then an absorbent pad, and secured with tape. The dressing was to be changed twice daily and as needed for soiling, saturation, or accidental removal. WNP #810 noted Resident #97 had large amounts of drainage and may needs dressing changes completed three to four times daily for the next few days and for staff to not allow excess drainage to lie on the surrounding skin. WNP #81) requested a low air loss mattress be obtained for Resident #97 and recommended bed rest only until Resident #97's sacral wound was more stable. WNP #810 also recommended staring a broad-spectrum antibiotic such as doxycycline 100 milligrams (mg) by mouth for 10 days until a wound culture results were available. WNP #810 documented an addendum that Resident #97's power of attorney (POA) was contacted on 09/20/22 and discussed Resident #97's wound status and treatment plan. Resident #97's POA expressed the desire to treat the pressure ulcer as needed to prevent any further discomfort or preventable complications such as sepsis, and Resident #97's POA agreed to serial debridement as needed and agreed that should Resident #97's wound significantly deteriorate or cause increased or further discomfort she would want Resident #97 to be sent to the hospital. WNP #810 noted the information was conveyed to Former DON #850 on the morning of 09/21/22. Review of a laboratory document revealed Resident #97 had a wound culture collected on 09/20/22 at 2:40 P.M. Results of the wound culture were received on 09/21/22 at 9:32 A.M. and revealed many neutrophils (a type of white blood cell that helps the body fight infection), many Gram-negative rods (bacteria), many Gram-positive cocci (bacteria) in clusters, with heavy growth of proteus mirabilis (a Gram-negative bacterium) and light growth of Escherichia coli (E. coli, a Gram-negative bacterium). Review of a physician order dated 09/19/22 revealed Resident #97 was ordered to have the sacral wound cleansed with normal saline, patted dry, have collagen applied, then a calcium alginate dressing, and covered with an island dressing every shift. The order was scheduled to start on 09/20/22. Review of a physician order dated 09/21/22 revealed Resident #97 was ordered the antibiotic doxycycline hyclate 100 mg by mouth twice daily for infection for 10 days per wound care nurse practitioner. Further review of the physician orders between 09/20/22 and 09/24/22 revealed no order for a low air loss mattress was ordered for Resident #97's wound healing as recommended by WNP #810 on 09/20/22. Review of the September 2022 TAR revealed Resident #97's wound treatment was not completed on the evening shift on 09/21/22 nor the morning or evening shift on 09/23/22. Review of the September 2022 medication administration record (MAR) revealed Resident #97 did not received ordered doses of doxycycline hyclate 100 mg on 09/21/22 and 09/22/22 in the evening and on 09/23/22 in the morning. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a nurse practitioner progress note dated 09/20/22 at 6:48 P.M. revealed Resident #97 was visited to follow up monthly on chronic issues. The nurse practitioner documented Resident #97 was doing well at this time and was currently in her bed resting. There was no indication of the type of mattress applied to Resident #97's bed during the nurse practitioner's visit. The nurse practitioner noted ongoing treatment of Resident #97's left ankle wound with no plan or treatment documented for Resident #97's sacral pressure ulcer. The nurse practitioner's documentation of Resident #97's skin during the visit was the skin was pink, warm, and dry with a wound to the left ankle. Review of a nursing progress note date 09/23/22 at 11:57 A.M. revealed Resident #97's low air loss mattress came to the facility on [DATE] and was placed on the bed. Review of a nursing progress note dated 09/24/22 at 11:00 A.M. revealed Resident #97's was transported to the hospital as Resident #97's POA insisted she be sent out due to deteriorating wound and mental status. Review of a transfer form dated 09/24/22 at 11:00 A.M. revealed Resident #97 had an unplanned transfer due to a skin wound or ulcer and proper notifications were made. Review of a nursing progress note dated 09/24/22 at 5:23 P.M. revealed Resident #97's POA was at the facility with family to gather Resident #97's belongings and stated Resident #97 was actively dying. Review of report from the county coroner's office revealed an autopsy was completed on 10/03/22 at 8:30 A.M. for Resident #97 by Deputy Coroner (DC) #950. Resident #97's noted date of death was 09/30/22 at 8:15 P.M. DC #950 noted Resident #97 had evidence of wounds or trauma with a large stage four (full-thickness skin and tissue loss) pressure ulcer over the lower back measuring 4 1/4 inches long by 7 1/2 inches wide which included the surrounding green-black eschar. DC #950 indicated the center of the wound had a 2 1/2 inches long by 3.0 inches wide area defect down to the sacral spine. The soft tissue in the wound was dark tan and red to green-gray, macerated (a white appearance with very soft texture), and extended through the deep tissue surrounding the sacral bone. Resident #97's sacral bone was tan-pink and friable (easily crumbled). There was purulent (fluid containing pus) tan-pink exudate (any fluid that has been forced out of the tissues or its capillaries because of inflammation or injury) in the soft tissue and no involvement of the pelvic organs. DC #950 performed a microscopic examination of Resident #97's sacral ulcer deep tissue and it was significant for sheets of neutrophils dissecting through degenerating skeletal muscle and connective tissue. Review of a documented case summary of Resident #97's death from DC #950 revealed the date of Resident #97's examination was 10/03/22. Resident #97's autopsy findings included a large stage four pressure ulcer over the sacrum with necrosis extending through the deep tissue surrounding the sacral bone, necrotizing fasciitis (inflammation of the fasciae of muscles or other organs results in rapid destruction of overlying tissues) and myositis (a group of rare conditions with symptoms of weak, painful, or aching muscles) by microscopic examination, purulent tan-pink exudate, friable sacral bone, and gangrenous (dead tissue) skin surrounding deep tissues in the wound. Resident #97 had blood and sacral wound cultures obtained during the autopsy and were positive for proteus mirabilis and Escherichia coli. DC #950 documented, it was his opinion, Resident #97's cause of death was bacterial sepsis (proteus mirabilis and E. coli) due to a sacral pressure ulcer due to medical neglect. Resident #97's injury occurred by failure of caregiver(s) to provide adequate or timely medical care for a sacral pressure ulcer and the manner of death was documented as homicide. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Manor	3231 Manley Road Maumee, OH 43537

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/20/22 at 11:22 A.M. with VPCS #750 verified there was no documentation of a pressure ulcer to Resident #97's sacrum on admission, no documentation of interventions utilized to prevent pressure ulcer development, no consistent assessments of Resident #97's skin completed, and once wound treatments and antibiotics were ordered for Resident #97, the facility did not complete the treatments or administer the medications as ordered. VPCS #750 stated there were no administrative staff still working in the facility who would have been employed during the time Resident #97 was in the facility. VPCS #750 stated ADON #515 was still employed by the facility but was on a leave of absence while Resident #97 resided in the facility. VPCS #750 stated the majority of direct care staff at that time were agency staff and she was not aware of any direct care staff currently employed by the facility who took care of Resident #97. A telephone interview was completed on 12/20/22 at 2:20 P.M. with WNP #810 who verified she saw Resident #97 once while she was a resident in the facility on 09/20/22. WNP #810 stated Former Director of Nursing (FDON) #850 contacted her and stated she needed her to see Resident #97. WNP #810 stated FDON #850 told her they found a wound on Resident #97 the past couple days but thought the wound was there longer. WNP #810 stated when she saw Resident #97 on 09/20/22 her wound had a dressing on it, but she did not know where the dressing came from or who ordered it. WNP #810 stated Resident #97's sacral pressure ulcer had dead tissue hanging in flaps over it and when WNP #810 touched it with her hands, it would just fall off. WNP #810 stated the severity and odor from Resident #97's wound was very bad. WNP #810 stated she spoke to Resident #97's family and they did not know how long the wound had been there either. WNP #810 stated she took some of the dead tissue off the wound, cleaned it, and applied a dressing before ordering scheduled treatments, an antibiotic, and a low air loss mattress for Resident #97's bed. WNP #810 stated she looked at Resident #97's medical record and saw the antibiotic she ordered was not initiated, and when WNP #810 informed FDON #850, she indicated she though the antibiotic was initiated but it was for another resident, so it was started that day. WNP #810 stated she told FDON #850 many times to monitor Resident #97's wound condition and if it got any worse to send her to the hospital. WNP #810 stated a few days later Resident #97's POA contacted her and told her the wound was getting worse. WNP #810 stated the facility never contacted her about the wound getting worse and they never sent Resident #97 to the hospital until Resident #97's POA had concerns. WNP #810 stated she talked to FDON #850 after Resident #97 was sent to the hospital and FDON #850 told her she never looked at Resident #97's wound after WNP #810 saw her on 09/20/22 and FDON #850 told her Resident #97 was now in hospice care, so the facility no longer had to worry about the wound. WNP #810 stated she longer provided services for residents in the facility. Interview on 12/21/22 at 12:58 P.M. with ADON #515 verified she was on a leave of absence from the facility while Resident #97 was in the facility. ADON #515 stated she had no knowledge about Resident #97 but confirmed she found the one and only shower sheet documented in Resident #97's medical record dated 08/29/22. ADON #515 stated a lot of the administrative staff had already left or were in the process of leaving so when she went out on leave she knew it would not be good for the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A telephone interview was completed on 12/21/22 at 2:51 P.M. with Medical Director (MD) #890 who stated he began his role of medical director of the facility at the start of September 2022. MD #890 stated he had no knowledge of Resident #97, and until the facility asked him to review her medical record, had never heard Resident #97's name. MD #890 verified he never saw Resident #890 while she was in the facility and stated he had no record of the facility ever contacting him about Resident #97. MD #890 stated he had problems with the facility getting him information and, when he first started, there was no leadership as all the administrative staff were transitioning out of the facility. MD #890 stated the facility had a lot of systems collapse on them at the same time which contributed to Resident #97's condition. A telephone interview was completed on 12/21/22 at 3:51 P.M. with FDON #850 who stated she was director of nursing at the facility for around eight week and stated she was new to the facility when Resident #97 was admitted . FDON #850 stated she remembered Resident #97 was admitted to the facility with no wounds and one day the direct care staff came to her and told her Resident #97 had a bad wound on her buttocks. FDON #850 stated she contacted WNP #810 to look at the wound, but FDON #850 stated she did not personally see Resident #97's pressure ulcer. FDON #850 verified she never observe Resident #97's pressure ulcer while she was in the facility before she was sent out to the hospital. FDON #850 stated she was not aware if Resident #97 received wound treatments or received her ordered antibiotic and could not give specific dates or details about Resident #97's care. FDON #850 stated she thought Resident #97's wound happened very fast but could not give a timeline. FDON #850 stated most of the nurses during that time were through agency and could not recall any nurses or nurse aides who worked with Resident #97 that were still employed by the facility. Review of a facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Review of a facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised 12/20/22, revealed the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report a full assessment of pressure sore, pain assessment, mobility status, current treatments, including support surfaces, and all active diagnoses. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will assist the staff to identify the type of ulcer and will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. Review of a facility policy titled, Prevention of Pressure Injuries, revised 12/20/22, revealed residents will be assessed on admission (within eight hours) for existing pressure injury risk factors. The risk assessment will be completed weekly and upon any changes in condition. Staff will conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. The skin should be inspected on a daily basis when performing or assisting with personal care or ADLs. Appropriate surfaces should be selected based on the resident's risk factors and in accordance with current clinical practice. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a facility policy titled, Administering Medications, revised 12/20/22, revealed medications are administered in a safe and timely manner, and as prescribed.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 32087 Based on review of Quality Assessment and Assurance (QAA) Committee/Quality Assurance Improvement Program (QAPI) meeting sign in sheets and staff interview, the facility failed to ensure QAA Committee/QAPI meetings occurred at least quarterly. This had the potential to affect all 52 residents residing in the facility. The census was 52. Findings include: Review of QAA Committee/QAPI meeting sign in sheets between January and December 2022 revealed the facility held no QAA Committee/QAPI meetings between May 2022 and September 2022, thus held no QAA Committee/QAPI meeting in the third quarter of 2022. Interview on 12/21/22 at 3:39 P.M. with Administrator #545 stated he was not the facility administrator during the span of May to September 2022, and verified there was no documentation of a QAA Committee/QAPI meeting in the third quarter of 2022.