STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425362	A. Building B. Wing	11/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley River Healthcare	1137 Sam Rittenberg Blvd Charleston, SC 29407

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34575 Based on facility policy review, record review, interviews, and facility document review, the facility failed to notify the responsible party of the need to alter treatment for 1 (Resident (R)3) of 13 residents reviewed for a change in condition. On 05/30/22, the facility received new orders to provide care to four open areas on R3's left foot and ankle, and the facility failed to notify the responsible party of the need to initiate treatment to the new open wounds that were identified. Findings include: Review of a facility policy titled, Notification of Changes, dated 01/07/22, specified The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include new treatment. A review of an Admission Record revealed the facility originally admitted R3 on 04/15/22 and readmitted the resident on 05/19/22 with diagnoses that included ankle fracture, chronic obstructive pulmonary disease (COPD), reduced mobility, and dementia. The record indicated the resident was discharged from the facility on 06/13/22. A review of Progress Notes revealed an admission summary dated 04/15/22 which indicated R3 arrived at the facility via ambulance and had no skin issues present. The note further indicated the resident's left ankle was in a cast due to a fracture. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/22, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance for bed mobility and transfer and was dependent for locomotion. The MDS indicated the resident was at risk for developing pressure ulcers/injuries, but did not indicate the presence of a surgical wound. Review of a care plan, dated as initiated 04/15/22, revealed the resident was at risk for developing pressure ulcers related to limited mobility. The care plan further indicated the resident had a self-care deficit related to a left ankle fracture and dementia with an intervention initiated on 04/19/22 to complete a left leg cast check and monitor for circulation and edema every shift. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an orthopedic follow-up visit note revealed on 04/27/22 that the left lower extremity splint was removed, and that the resident had, Well healed incisions medial and laterally. The note also indicated, No boot or brace for now as [the resident] has area of denuded skin [area of abrasion or removed skin] medially from fracture blister. A review of physician's Progress Notes, dated 05/20/22, revealed the facility readmitted R3 on 05/19/22 after the resident was admitted to the hospital on 05/06/22 due to worsening shortness of breath and was treated for an acute exacerbation of COPD and was also treated for a urinary tract infection (UTI). The note indicated the resident had surgery to the left ankle on 04/12/22 and that staff were to monitor incision. A review of physician's orders in R3's medical record revealed an order dated 05/30/22 directing the staff to clean areas to the left outer ankle, left posterior ankle, left inner ankle, and the top of the left foot with wound cleanser, apply bacitracin (an anti-infective ointment used to treat minor cuts and scrapes), cover the open areas with non-stick gauze, and wrap the foot with kerlix (roll gauze). A review of R3's Treatment Administration Record for June '22 revealed the physician-ordered treatments for the left outer ankle, left inner ankle, left posterior ankle, and the top of the left foot were scheduled for 9:00 AM daily. Nurses' initials were documented to indicate the treatments were provided as ordered daily, except on 06/05/22, 06/06/22, and 06/13/22. Further review of R3's clinical record revealed no documented evidence the resident's responsible party was made aware of the need for wound treatments related to open areas on the resident's left foot and ankle. During an interview on 11/03/22 at 3:00 PM, Licensed Practical Nurse (LPN)2 stated if there were new findings on the skin, a skin tear, or skin breakdown, he would contact the wound care nurse and let the family know. During an interview on 11/03/22 at 5:44 PM, R3's family member stated the resident was picked up by family and taken to the orthopedic doctor on the date of discharge, 06/13/22, for a scheduled follow-up. The complainant indicated they were unaware the resident had open wounds on the foot/ankle and that treatment had been initiated for the wounds. The family member stated that the orthopedic doctor expressed that he was shocked to find hardware protruding out of the resident's ankle and a large blackened area on the side of the foot. Review of R3's orthopedic follow-up note, dated 06/13/22, revealed the resident's ankle had exposed hardware laterally, which would require removal to prevent infection. During an interview on 11/05/22 at 12:30 PM, the Director of Nursing (DON) stated she was a new employee and was not familiar with R3. The DON indicated a resident's family and physician were to be notified of any new actions or interventions. If the resident functioned as their own responsible party, she expected the staff to ask the resident if they wanted their family members to be notified. The Administrator was in attendance during the interview and concurred with the DON's statement and stated she was unaware of R3's wounds.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	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** 34575 Based on facility policy review, record review, and interviews, the facility failed to develop a care plan to address pressure ulcer risk for 1 Resident (R)9 of 5 sampled residents reviewed for wounds. The facility admitted R9 with no pressure ulcers. According to the Minimum Data Set (MDS), R9 was identified as at risk for pressure ulcers; however, the facility failed to develop a care plan to address the resident's pressure ulcer risk, and R9 developed four pressure ulcers/injuries. Findings include: Review of a facility policy titled, Comprehensive Care Plans, implemented 10/01/22 and reviewed/revised on 10/25/22, indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Further review of the policy revealed 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. According to the care plan policy, 6 The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. A review of the facility's undated policy titled, Pressure Injury Prevention and Management, revealed Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status, where feasible. 1. A review of R9's Admission Record indicated the facility admitted the resident on 08/04/22 with diagnoses that included syncope and collapse, disease of the spinal cord, difficulty walking, muscle wasting and atrophy, xerosis cutis (abnormally dry skin), tinea pedis (athlete's foot), vitamin D deficiency, and orthostatic hypotension (blood pressure drops with changes in posture/position). A review of an All-Inclusive Admission with Baseline Care Plans assessment dated [DATE] at 11:15 AM revealed the facility admitted R9 from a hospital. The resident was alert and oriented. According to the assessment, R9 had a non-pressure skin condition and was at moderate risk for pressure ulcers. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of an admission MDS with an Assessment Reference Date (ARD) of 08/10/22, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident did not reject care that was necessary to achieve the resident's goals for health and well-being. Further review of the MDS revealed R9 required extensive assistance of staff with bed mobility and transfers and was dependent on staff for walking and locomotion. The MDS also indicated R9 was always incontinent of bowel and bladder. The resident had complaints of difficulty or pain with swallowing, was on a mechanically altered diet, and weighed 96 pounds. According to the MDS, R9 had one stage II pressure ulcer that was present upon admission and was at risk of developing pressure ulcers/injuries. Review of R9's care plan, dated as initiated on 08/05/22 and revised on 08/22/22, revealed the facility identified the resident had skin impairment related to diagnoses of tinea pedis and xerosis cutis. The goal was for the resident to have no complications related to the alteration of skin integrity. The facility developed interventions for skin impairment including to encourage good nutrition and hydration to promote healthier skin; keep the skin clean and dry; monitor/document the location, size, and treatment of skin injury; and to report abnormalities including, failure to heal, signs and symptoms of infection, and maceration. There was no evidence that the facility developed a care plan related to the resident's risk for pressure ulcer development or the development of a pressure ulcer to the sacrum, with interventions to prevent new pressure sores/injuries from developing. Review of a nurse's Progress Note dated 08/18/22, revealed R9 had a wound to the sacrum (lower part of the back above the tail bone) that was healing well with minimal serous drainage. The note indicated the wound had 10% slough (dead skin tissue that may have a yellow or white appearance) and 80% granulation tissue (new skin tissue) present. According to the note, the wound care physician was going to see the resident in one week. A review of a wound physician's Initial Wound Evaluation & Management Summary, dated 08/24/22, revealed the wound to R9's sacrum was an unstageable pressure area due to necrotic tissue (dead tissue). According to the wound care physician's note, R9's pressure ulcer covered a surface area of 10.50 centimeters (cm), measuring 3.0 cm long by (x) 3.5 cm wide x 0 cm deep, and had a moderate amount of serous exudate (clear, thin drainage). The physician surgically debrided the pressure sore, removing the dead tissue. The physician's treatment plan was to apply calcium alginate and Santyl to the area and cover the area with a gauze island dressing with a border daily for 30 days. The wound care physician also recommended keeping pressure off the wound, repositioning the resident per facility protocol, and providing a Group-2 mattress (a low air loss mattress used to relieve pressure). In addition, the wound care physician recommended a barrier cream to treat dermatitis caused by incontinence/incontinence briefs. Further, the wound care physician indicated the resident should follow up with a wound care specialist within seven days. Review of a nurse's Progress Note dated 09/15/22 at 3:54 PM, revealed R9 had a new pressure injury to the left heel, a deep tissue injury (DTI - an unopened wound that looks purple or dark red and is an injury to the tissue below the skin from prolonged pressure). The note indicated staff were educated on the importance of repositioning the resident per protocol and elevating the resident's heels off the mattress. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	A review of a Head to Toe Skin Assessment for R9, dated 09/29/22, revealed the resident had developed a deep tissue injury (DTI) to the right heel. The assessment indicated the resident would wear heel booties while in bed and that the resident's care plan was reviewed/revised. However, a review of the resident's care plan revealed no documented evidence the facility developed a care plan to address the resident's risk for pressure ulcers, the pressure ulcer to the sacrum, nor the deep tissue injuries to both heels. A review of a nurse's Progress Note, dated 10/15/22 at 9:01 PM, revealed the wound care nurse noted the pressure ulcer to R9's sacrum was deteriorating. The note indicated an air mattress and heel boots that were requested previously were not available. The facility continued to have no evidence of a care plan for R9 to address the treatment/healing of the resident's pressure ulcers, nor interventions to prevent new pressure ulcers/injuries from developing. A review of a nurse's Progress Note, dated 10/27/22 at 4:40 AM, revealed R9 complained of pain and discomfort to her bottom (sacrum). The nurse documented the dressing was changed and there was an odor from the pressure ulcer. Review of Skin & Wound Evaluations, dated 11/04/22, revealed the following: - R9 had a deep tissue injury to the right trochanter that was acquired at the facility on 11/02/22. The evaluation indicated the surface area of the injury was 19.4 cm, and the wound measured 4.9 cm long x 4.7 cm wide x 0 cm deep. - R9's left heel had an unstageable pressure area due to slough and/or eschar. The area measured 1.1 cm long x 1.3 cm wide, which was an increase in size according to the last measurements completed on 10/19/22. The wound bed was described as 100% eschar. - R9's right heel had an unstageable pressure area due to slough and/or eschar. The area measured 3.0 cm long x 4.4. cm wide. The wound bed was described as 100% eschar. - R9's sacral wound was identified as a Kennedy terminal ulcer (a type of ulcer that develops during the final weeks of life and results from underlying skin failure associated with the dying process). According to the evaluation, the area was unstageable due to the presence of slough and eschar in the wound bed. The wound covered a surface area of 47.7 cm and measured 7.6 cm long by 7.9 cm wide x 0.4 cm deep, with 3.0 cm undermining, which was an increase in size since the last measurements were obtained on 10/19/22 (4.7 cm long x 2.8 cm wide x 0.2 cm deep, with 1.0 cm undermining). The wound bed was described as containing 40% slough and 10% eschar. The wound was further described as bleeding, with moderate sanguineous/bloody exudate and had a faint odor. Review of Progress Notes dated 11/05/22 at 2:20 AM revealed staff found R9 at 1:50 AM, unresponsive and without respirations, breath sounds, and pulse. The resident's physician and hospice were notified of the resident's death. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/04/22 at 12:21 PM, the MDS Coordinator stated she had worked at the facility since 08/29/22 in this role. She stated she initiated a 48-hour care conference and was also responsible for developing residents' care plans in the facility. The MDS Coordinator acknowledged there was no care plan for R9's pressure ulcers/injuries. The MDS Coordinator stated the previous wound care nurse was supposed to update care plans based on her findings, the interventions she implemented, and the treatment provided; however, the wound care nurse had not been completing residents' care plans. According to the MDS Coordinator, she was in the process of auditing all care plans, and stated care plans should reflect pressure injury and be updated. During an interview on 11/05/22 at 12:30 PM, the Director of Nursing (DON) and Administrator stated wounds should be addressed in the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34575 Based on facility policy review, record review, and interviews, the facility failed to revise residents' care plans to address actual skin breakdown for 2 Residents (R)3 and R1 of 5 sampled residents reviewed for wounds. Findings include: A review of a facility policy titled, Care Plan Revisions Upon Status Change reviewed/revised 10/25/22, revealed, The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. The policy also indicated the following: - b. The MDS [Minimum Data Set] Coordinator and the Interdisciplinary Team will discuss the resident condition and elaborate on interventions options. - d. The care plan will be updated with the new or modified interventions. - f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. 1. A review of an Admission Record revealed the facility originally admitted R3 on 04/15/22 and readmitted the resident on 05/19/22 with diagnoses that included ankle fracture, chronic obstructive pulmonary disease (COPD), reduced mobility, and dementia. The resident was discharged from the facility on 06/13/22. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/22, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance for bed mobility and transfer and was dependent for locomotion. The MDS indicated the resident was at risk for developing pressure ulcers/injuries. A review of R3's Care Plan, dated as initiated 04/15/22, revealed the resident was at risk for developing pressure ulcers related to limited mobility and had an activities of daily living (ADL) self-care deficit related to a left ankle fracture and dementia. Interventions included checking the left leg cast and monitoring for circulation and edema every shift (initiated on 04/19/22) and turning/repositioning as indicated, shifting weight to enhance circulation (initiated on 04/17/22). Review of R3's orthopedic follow-up visit notes revealed on 04/27/22, the splint to the resident's left lower extremity was removed to reveal, Well healed incisions medial and laterally. The notes indicated, No boot or brace for now as [the resident] has area of denuded skin (area of abrasion or removed skin) medially from fracture blister. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Physician Orders revealed an order dated 05/30/22 directing the staff to clean areas to the left outer ankle, left posterior ankle, left inner ankle, and top of left foot with wound cleanser, to apply bacitracin (an anti-infective ointment used to treat minor cuts and scrapes) and to cover the open areas with non-stick gauze, and wrap the foot with kerlix (a type of dressing). A review of physician's orders in R3's medical record revealed an order dated 05/30/22 which directed the nursing staff to clean areas to the left outer ankle, left posterior ankle, left inner ankle, and the top of the left foot with wound cleanser, apply bacitracin (an anti-infective ointment used to treat minor cuts and scrapes), cover the open areas with non-stick gauze, and wrap the foot with kerlix (roll gauze). There was no evidence the resident's care plan was revised to include the care, assessments and treatment necessary for the actual skin breakdown referenced in the physician's orders dated 05/30/22. During an interview on 11/04/22 at 12:21 PM, the MDS Coordinator stated she had worked at the facility since 08/29/22 in this role. She stated she initiated the 48-hour care conference, setting the schedules for the MDS submissions, and completing the MDS assessments. The MDS Coordinator stated she was also responsible for developing, reviewing, and revising the care plans in the facility, and she obtained the information for updates through clinical meetings and as situations occurred. For long-term care residents, the MDS Coordinator stated she would look at the computer to review any changes in therapy or treatments and communicate with staff, then update the care plans accordingly. The MDS Coordinator further stated that for wounds, the previous wound care nurse would update the care plans based on her findings, what interventions she put in place, and the treatments provided, but it was not getting done. The MDS Coordinator stated she was in the process of auditing all the care plans, and the care plans were to be updated to reflect wounds. The new wound care nurse would take over the revisions once they were up to date. The MDS Coordinator acknowledged there was no care plan for R3's wounds. During an interview on 11/05/22 at 12:30 PM, the Director of Nursing (DON) and Administrator stated wounds should be addressed in the care plan and any changes in condition should also be documented. 2. A review of R1's Admission Record revealed the resident had diagnoses that included rheumatoid arthritis, osteoarthritis, end stage renal disease, systemic lupus (a chronic disease that causes inflammation), dependence on dialysis, and anemia. A review of R1's admission MDS with an ARD of 11/12/21 revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. According to the MDS, the resident required extensive assistance of two or more people for bed mobility and transfer. Further review of the MDS revealed the resident was always incontinent of urine and frequently incontinent of bowel. The MDS also indicated R1 was at risk for developing pressure ulcers/injuries and had a pressure reducing device for the chair and bed. At the time of the assessment, the resident had no foot problems or other wounds/skin problems identified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's care plan, dated as initiated 02/02/22, revealed the resident was at risk for pressure ulcers related to a decline in mobility. Interventions included that staff were to observe the resident's skin daily during care for any redness, breakdown, blisters, bruises, discolorations, open areas, scratches and/or rashes; minimize pressure over bony prominences; and report changes in skin status to the physician. A review of a provider's Progress Note, dated 04/12/22 revealed nursing alerted the provider that R1 had a callused area on top of the second toe on the right foot. The note revealed the area appeared to be a callus with some sloughing off. The provider's assessment and plan indicated a diagnosis of an acute, new foot callus of the second toe, a hammer toe with a referral to wound care, and an order to apply a barrier cream. There was no documented evidence the facility revised R1's care plan to address care/treatment of the resident's toe. Review of a hospital Discharge Summary, dated 04/21/22 for R1, revealed an order to apply Betadine twice per day to the second toe on the right foot for an open, dry bunion. There was no documented evidence the facility revised R1's care plan to address treatment of the resident's toe. A review of a dialysis provider note dated 05/10/22 revealed Medical Doctor (MD)1 identified that R1's right great toe had an ulcer with purulent drainage (drainage containing pus, a sign of infection). During an interview on 11/04/22 at 12:21 PM, the MDS Coordinator stated she had worked at the facility since 08/29/22 in this role. The MDS Coordinator stated was also responsible for developing, reviewing, and revising residents' care plans in the facility. She stated she obtained the information for care plan revisions/updates during clinical meetings and as situations occurred. She stated she also reviewed the computer for any changes in therapy or treatments and communicated the changes with staff and updated residents' care plans accordingly. The MDS Coordinator further stated the previous wound care nurse was supposed to update care plans based on her findings, the interventions she implemented, and the treatments provided; however, the wound care nurse had not been doing updates/revisions. During an interview on 11/05/22 at 12:30 PM, the Director of Nursing (DON) and Administrator stated wounds and any change in condition should be reflected in a resident's care plan.

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F 0684 Level of Harm - 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** 34575 Based on facility policy review, record review, interviews, and facility document review, the facility failed to provide treatment and care in accordance with professional standards of practice for 2 Residents (R3 and R5) of 13 sampled residents reviewed for appropriate treatment/care. Specifically, R3 underwent a surgical procedure to repair an ankle fracture, after which the facility admitted the resident. Approximately six weeks after admission, the facility obtained orders to provide daily treatments to wounds on the resident's ankle and foot. The facility failed to ensure assessments of the wounds were completed and documented. During a follow-up appointment with the orthopedic physician on 06/14/22, it was discovered that screws from the surgically installed hardware were protruding through the skin, which had not been reported to the orthopedic physician. R3 required a second surgical procedure to remove the hardware. Additionally, the facility admitted R5 with orders to administer intravenous antibiotics following a surgical procedure to the knee. The ordered antibiotics were not administered for three days, resulting in the resident requiring hospitalization to receive the antibiotic treatment after the resident was noted to have swelling and pain to the knee. Findings include: A review of a facility policy titled, Provision of Physician Ordered Services, reviewed/revised 10/25/22, revealed the purpose of the policy was to provide a process for provision of physician ordered services according to professional standards of quality. The policy defined Professional Standards of Quality as care and services are provided according to accepted standards of clinical practice. 1. A review of an Admission Record revealed the facility originally admitted R3 on 04/15/22 and readmitted the resident on 05/19/22 with diagnoses that included ankle fracture, chronic obstructive pulmonary disease (COPD), reduced mobility, and dementia. The resident was discharged from the facility on 06/13/22. A review of Progress Notes revealed an admission summary dated 04/15/22 that indicated R3 arrived at the facility via ambulance and had no skin issues present. The note further indicated the resident's left ankle was in a cast due to a fracture. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/22, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene and was dependent for locomotion. The MDS did not indicate that the resident had a surgical wound or received surgical wound care. Review of a care plan, dated as initiated 04/15/22, revealed the resident was at risk for developing pressure ulcers related to limited mobility. The care plan also indicated the resident had a self-care deficit related to a left ankle fracture and dementia with an intervention initiated on 04/19/22 to complete a left leg cast check and monitor for circulation and edema every shift. Review of physician's orders in R3's electronic medical record revealed admission orders dated 04/18/22 directing staff to check the resident's left leg cast for circulation each shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of orthopedic follow-up visit notes dated 04/27/22 revealed R3's left lower extremity splint was removed to expose, Well healed incisions medial and laterally. The note also indicated, No boot or brace for now as [resident] has area of denuded skin [area of abrasion or removed skin] medially from fracture blister. Review of physician's orders in R3's medical record revealed an order dated 05/30/22 dated 05/30/22 directing the staff to clean areas to the left outer ankle, left posterior ankle, left inner ankle, and the top of the left foot with wound cleanser, apply bacitracin (an anti-infective ointment used to treat minor cuts and scrapes), cover the open areas with non-stick gauze, and wrap the foot with kerlix (roll gauze). A review of R3's Treatment Administration Record (TAR) for June 22 revealed the 05/30/22 physician-ordered treatments to the left outer ankle, left inner ankle, left posterior ankle, and the top of the left foot were scheduled for 9:00 AM daily. Nurses' initials were documented to indicate the treatments were provided as ordered daily, except on 06/05/22, 06/06/22, and 06/13/22. The designated space for the nurse to initial that the treatment was completed was left blank on 06/05/22 and 06/06/22. The space for 06/13/22 had a code of 9 documented, which indicated, Other / See Progress Notes. Review of a Progress Note, dated 06/13/22 at 1:30 PM revealed the resident was discharged . Review of Head to Toe Skin Evaluation forms revealed the question Any new skin issues identified? was answered as, No on 04/19/22, 05/20/22, 05/25/22, 06/01/22, and 06/08/22. There was no documentation regarding any open areas/wounds on any of the skin evaluation forms and no reference to wounds in the Progress Notes dated between 05/30/22 (when the wound treatment orders were initiated) and the resident's discharge from the facility on 06/13/22. There was no documentation to indicate any wounds were observed or evaluated by a physician or nurse practitioner (NP) during that timeframe. Review of a Progress Note, dated 06/07/22 and signed by the NP, revealed the resident had a dressing to the left ankle that, needs to be changed today, discussed with nursing and says will change today. There was no indication the dressing was removed to allow visualization of the ankle/foot wounds during this visit. A review of a Discharge Note dated 06/10/22 and signed by the NP, indicated the resident was to discharge to an assisted living facility. The note indicated the resident, has been receiving wound care for [gender] wounds at left ankle. The note indicated the left ankle was wrapped and that the dressing was clean, dry, and intact. There was no documentation to indicate the dressing was removed to allow visualization of the ankle/foot wounds during this visit. Review of R3's orthopedic follow-up note, dated 06/13/22, revealed the resident's ankle had exposed hardware laterally, which would require removal to prevent infection. Review of an operative note dated 06/14/22 revealed the two exposed screws, plus two distal screws and lateral plate, were surgically removed. The resident did not return to the facility. During an interview on 11/03/22 at 1:33 PM, Certified Nursing Assistant (CNA)2 stated she remembered R3 and had accompanied the resident to a follow-up orthopedic visit on 04/27/22, at which time the physician removed the cast from the resident's left leg. CNA2 recalled there was some bruising around the ankle at the time of the follow-up visit, but there was no open skin, skin tears, or any concerns. She stated she did not take care of the resident after that, so could not speak to any concerns that occurred after that date. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/03/22 at 2:30 PM, Licensed Practical Nurse (LPN)1 stated she did not recall much about R3 and did not normally provide care to the resident. LPN1 did recall that she did not change the wound dressing on 06/13/22 because the resident was being discharged , and the family member was there early to take the resident to the orthopedic doctor and then home. LPN1 indicated that when wounds were identified, a wound sheet was completed and given to the wound nurse, the Director of Nursing (DON), or the NP. She stated body audits and weekly evaluations were completed. LPN1 stated if a pressure ulcer was found, an incident report was completed, either by the nurse or the wound nurse. LPN1 asserted that if she had seen open wounds, she would have called the NP and/or the physician and completed an assessment. During an interview on 11/03/22 at 5:44 PM, R3's family member stated the resident was picked up by family and taken to the orthopedic doctor on the date of discharge, 06/13/22, for a scheduled follow-up visit. The family member indicated they were unaware, prior to the visit, that there were orders in place at the facility for treatment of four open wounds. The family member indicated the orthopedic doctor said he was shocked to find hardware protruding out of the ankle and a large blackened area on the side of the foot. During an interview on 11/04/22 at 9:00 AM, after being asked to facilitate interviews with nursing staff who had provided care to R3, the Administrator revealed those staff were no longer employed by the facility. During an interview on 11/04/22 at 11:07 AM, the NP stated she did not remember R3. The NP reviewed her progress notes and stated she would not have unwrapped the ankle dressing if it looked clean, dry, and was dated. The NP further stated no one had asked her to look at the resident's ankle or expressed any concerns about the condition of the ankle. The NP stated she thought the wound doctor was still coming to the facility at that time. During an interview on 11/04/22 at 4:00 PM, the Administrator stated she was aware there had been a concern with wound management and stated this was why the former wound nurse was no longer employed with the facility. The Administrator stated her leadership team was all new to the facility. During an interview on 11/05/22 at 11:25 AM, the Medical Director (MD) stated she was not working at the facility when R3 was admitted or discharged and could not contribute any information regarding the resident's wounds. The physician and nurse practitioner who attended the facility between April '22 and June '22 were no longer affiliated with the facility and refused to speak with the surveyor. During an interview on 11/05/22 at 12:30 PM, with both the Administrator and Director of Nursing (DON) in attendance, revealed the DON was a new employee and was not familiar with the resident but stated if new wounds were identified, an assessment along with staging and management of the wounds should be completed. The DON stated the attending physician and nurse should both assess the wounds, and that the physician had a responsibility to look at the wounds and ensure the treatments were working. The Administrator stated her expectation was for the nursing staff to perform skin assessments weekly and, when wounds were discovered, to report them. She indicated she was unaware R3 had wounds to the ankle and stated, Nobody brought it to our attention. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. A review of an Admission Record indicated the facility admitted R5 on 09/28/22 with diagnoses that included orthopedic aftercare, infection, osteoarthritis of the knee, pain in the left knee, and presence of a left artificial knee joint. The record further indicated that R5 was discharged from the facility on 10/01/22. Review of an admission MDS with an ARD of 10/01/22 revealed R5 had a BIMS score of 13, which indicated the resident was cognitively intact. The MDS indicated the resident required supervision with bed mobility and limited assistance with dressing, toilet use and personal hygiene. The MDS revealed the resident had a surgical wound and indicated the resident did not receive antibiotics during the previous 7 days. Review of R5's care plan, dated as initiated 09/28/22, revealed interventions related to the resident receiving antibiotic therapy. The interventions directed staff to administer antibiotic medications as ordered by the physician and monitor/document the side effects and effectiveness every shift. Review of R5's hospital discharge summary dated 09/28/22 revealed an order for the resident to receive cefazolin (an antibiotic) 2 grams to be administered every eight hours for six weeks. Review of R5's physician orders revealed an order dated 09/28/22 at 5:03 PM for cefazolin sodium solution reconstituted 2 grams to be administered to the resident intravenously (IV) every eight hours for six weeks. The order was signed as confirmed by Licensed Practical Nurse (LPN1). Review of R5's physician orders revealed an order dated 09/30/22 at 12:47 PM for cefazolin sodium solution reconstituted 2 grams to be given IV every eight hours for six weeks. The order was signed by the physician and LPN2. Review of R5's Medication Administration Record (MAR) dated September '22 revealed the resident did not receive the IV Cefazolin. Review of R5's Progress Notes dated 09/29/22 at 2:24 PM and written by LPN1, revealed that per the pharmacy, the ordered Cefazolin was out for delivery. The note indicated the nurse practitioner (NP) was informed. Review of R5's Provider Notes revealed the resident was seen by the NP on 09/29/22. The note revealed the resident was, still on antibiotics for the infection in the left knee and that upon assessment, the left knee was normal temperature and color, and the wound was bandaged with a dressing that was dry and intact with no signs or symptoms of infection. The nurse practitioner who signed the note no longer worked at the facility and was not willing to speak with the surveyor. Review of R5's Progress Notes revealed a tele-medicine encounter on 10/01/22 at 4:25 PM with Medical Doctor (MD)3 related to the resident's complaint of knee pain. MD3 documented the resident had not received intravenous antibiotics since admission to the facility and had complaints of increased swelling to the affected knee and increased pain. The note indicated the resident's knee was swollen and warm to the touch. The resident was sent to the hospital on 10/01/22 at 5:00 PM. The surveyor team attempted to contact R5 via telephone on 11/03/22 at 8:10 AM. There was no response. The surveyor attempted to acquire contact information for MD3, but was unable to obtain a current telephone number. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/03/22 at 2:30 PM, LPN1 stated the nurses entered orders for new admissions electronically and the orders were automatically transmitted to the pharmacy to be filled. LPN1 indicated staff could also fax an order sheet to the pharmacy and that orders for IV antibiotics had to be faxed. LPN1 stated she had processed R5's orders for antibiotics and was not aware the pharmacy had not received the order. LPN1 stated she did not work after the order was submitted and does not know what happened. She indicated she had spoken with someone at the pharmacy who told her the medication was on the delivery truck. During an interview on 11/03/22 at 3:00 PM, LPN2 stated he took care of R5 for the first time on 09/29/22, the day of Hurricane [NAME]. LPN2 stated the facility lost power that day and the pharmacy stated a delivery would not be made that day because of the storm. The pharmacy promised delivery on 10/01/22 in the afternoon. LPN2 stated he re-faxed the Cefazolin order, and the order was received and scheduled for delivery the next day. LPN2 stated he informed the physician and was directed to hold the order until the medication was available. LPN2 indicated he was unaware of the cruciality of the medication. During an interview on 11/04/22 at 1:00 PM, the Pharmacy Director (PD) stated orders were mostly received by fax from facilities, and the pharmacy was able to receive orders electronically, but that all orders for intravenous medications had to be faxed. The pharmacy had specific cut off times for delivery, which were noon and 5:00 PM Monday through Friday, and the facilities would receive the deliveries approximately four hours later. The PD indicated there was only one delivery on Saturdays and Sundays, and the cut-off time was noon on those days. The PD stated although they were a 24/7 (available 24 hours a day, 7 days a week) network, intravenous medications could not be sent through a retail pharmacy and had to be processed according to the cut-off times. The PD stated R5's order for intravenous antibiotics never reached the pharmacy, that it was not faxed, and the pharmacy was unaware the order was out there to be filled. When the nurse called the pharmacy asking where the medication was, the PD indicated, we asked for a faxed copy of the order. The PD stated that 09/30/22 at 12:37 PM was the first time they received a fax, and it was signed by LPN2. The request missed the cut-off, and the pharmacy could not get another delivery out that evening because of Hurricane [NAME], so transportation was not working until the next afternoon, 10/01/22. Review of the order received by the pharmacy, time stamped 09/30/22 at 12:52 PM, evidenced the order was not received prior to the cut-off time of noon. Handwritten at the bottom of the order was, new start date 10/01/22. During an interview on 11/05/22 at 11:25 AM, MD2 stated she had not seen R5 and that the resident was seen by another provider upon admission and was discharged before she saw the resident. The other provider, a nurse practitioner, had resigned from the facility and was unwilling to answer questions. During an interview on 11/05/22 at 12:30 PM with both the Administrator and the Director of Nursing (DON) in attendance, the Administrator stated they were aware of the situation with R5. The DON indicated she was not employed with the facility at the time of R5's stay. The DON stated the staff were aware that all orders, especially antibiotics, had to be faxed to the pharmacy. The expectation of the administrative staff was for the nursing staff to follow physician orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34575 Based on observations, interviews, record reviews, facility policy review, and facility document review, the facility failed to monitor and assess residents' skin and pressure ulcers/injuries, failed to provide pressure ulcer treatment and prevention measures as ordered by the physician, and failed to implement measures to prevent pressure ulcers for 3 (Resident (R)9, R1, and R8) of 5 sampled residents reviewed for wounds. The failure resulted in non-healing and/or deterioration of pressure ulcers and had the potential to affect any resident who had or was at risk for pressure ulcers. It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on [DATE], when a physician ordered a treatment for a healing sacral wound for R9 and the facility subsequently failed to conduct and document weekly assessments of the wound and the resident's overall skin condition; failed to consistently provide treatment to the resident's pressure ulcers/injuries as ordered by the physician; and failed to obtain devices/equipment to treat and prevent pressure ulcers/injuries. On [DATE], R9, a hospice resident, expired in the facility with a Kennedy ulcer on the sacrum and deep tissue injuries (DTI) to both heels and the right hip. The Administrator and Director of Nursing (DON) were notified of the IJ and provided with the IJ template on [DATE] at 3:24 PM. A Removal Plan was requested. The State Survey Agency accepted the facility Removal Plan on [DATE] at 6:28 PM. The IJ was removed on [DATE] after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at a lower scope and severity of isolated harm that was not immediate jeopardy at F686. Findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of an undated facility policy titled, Pressure Injury Prevention and Management, revealed, This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. 'Pressure Ulcer/Injury' refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. 'Avoidable' means that the resident developed a pressure ulcer/injury, and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice, monitor and evaluate the impact of the interventions, or revise the interventions as appropriate. The policy also indicated The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. The policy indicated c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after newly identified pressure injury. Findings will be documented in the medical record. Continued review of the policy revealed, Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status, where feasible. A review of an undated facility policy titled, Documentation of Wound Treatments revealed, Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the presence of skin loss if non-pressure (partial or full thickness) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) iv. Presence, amount, and characteristics of wound drainage/exudate v. Presence or absence of odor vi. Presence or absence of pain 3. Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry intact). 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and effectiveness of current intervention c. Any treatments for pain, if present d. Modification of treatments or interventions e. Notifications to physician or responsible party regarding wound or treatment changes. Review of a facility policy titled Pressure Injury Prevention Guidelines, revised [DATE], revealed 1. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency of performing them. 4. In the absence of prevention orders, the licensed nurse will utilizing [sic] nursing judgment in accordance with pressure injury prevention guidelines to provide care, and will notify [the] physician to obtain orders. The policy further indicated, When physician orders are present, the facility will follow the specific physician orders. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A review of R9's Admission Record revealed the facility admitted the resident on [DATE] with diagnoses that included syncope and collapse, disease of the spinal cord, difficulty walking, muscle wasting and atrophy, xerosis cutis (abnormally dry skin), tinea pedis (athlete's foot), vitamin D deficiency, and orthostatic hypotension. A review of an All-Inclusive Admission with Baseline Care Plans assessment, dated [DATE] at 11:15 AM, revealed the facility admitted R9 from a hospital. The resident was alert and oriented upon admission and, according to the assessment, had a non-pressure skin condition and was at moderate risk for pressure ulcer development. A review of R9's care plan, dated as initiated [DATE] and revised [DATE], revealed the facility identified the resident had skin impairment related to the diagnosis of xerosis cutis. R9's care plan directed staff to encourage good nutrition and hydration to promote healthier skin; keep the skin clean and dry; monitor/document the location, size, and treatment of skin injury; and report abnormalities including failure to heal, signs and symptoms of infection, and maceration (softening and breaking down of skin resulting from prolonged exposure to moisture). A review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R9 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident did not reject care necessary to achieve the resident's goals for health and well-being. Further review of the MDS revealed R9 required extensive assistance of staff with bed mobility, transfers, dressing, toilet use, and personal hygiene and was dependent on staff for walking and locomotion. The MDS indicated R9 was always incontinent of bowel and bladder. The resident had complaints of difficulty or pain with swallowing, was on a mechanically altered diet, and weighed 96 pounds. Although the admission assessment indicated R9 had a non-pressure skin condition and there was no documented evidence a pressure ulcer was being treated, according to the MDS, R9 had one stage 2 pressure ulcer that was present upon admission and was at risk of developing pressure ulcers/injuries. A review of a Daily Skilled Evaluation dated [DATE], 12 days after admission, revealed the resident had moisture-associated skin damage (MASD). There was no description of the location or extent of the skin damage. A review of R9's physician orders and the resident's Treatment Administration Record (TAR) revealed no evidence the MASD was being treated. Further, a review of the resident's care plan revealed there was no indication the resident had MASD and no interventions to treat or heal the MASD. A review of R9's physician orders revealed an order dated [DATE] to cleanse a sacral (lower part of the back above the tail bone) wound with wound cleanser, pat the area dry, cover the wound bed with calcium alginate (an absorbent dressing), then apply a Derma [NAME] dressing (an absorbent, waterproof foam dressing) one time per day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of nurse's Progress Notes dated [DATE], revealed the wound care nurse documented that the dressing to R9's sacrum was changed, and the physician's order was clarified as a daily dressing change. According to the note, the sacral wound was healing well with minimal serous drainage. The note indicated the wound had 10% slough (dead skin tissue that may have a yellow or white appearance) and 80% granulation tissue (new skin tissue). According to the note, the wound care physician was going to see the resident in one week. The facility had no documented evidence of when the sacral wound was initially identified, nor were there any measurements of the wound, as required by the facility's policy. The resident's care plan was not revised to address the development of a pressure ulcer to the sacrum, with interventions to treat the pressure ulcer and prevent new pressure ulcers from developing. Review of R8's TAR revealed facility staff documented a treatment was provided to the sacral wound daily from [DATE] through [DATE]; however, there was no documentation the ordered treatment was provided on [DATE], [DATE], [DATE], and [DATE]. A review of a wound physician's Initial Wound Evaluation & Management Summary, dated [DATE], revealed the resident was seen for diaper dermatitis [irritation of skin in contact with an incontinence brief] of unknown duration. According to the physician's examination, the resident had irritated dermatitis to the buttocks and groin/perineal area and a wound was present. A review of the wound examination revealed the resident had a pressure wound to the sacrum that was unstageable due to the presence of necrotic tissue. The pressure ulcer covered a surface area of 10.50 centimeters (cm), measuring 3.0 cm long by (x) 3.5 cm wide x 0 cm deep, and had a moderate amount of serous exudate. The physician surgically debrided (removed damaged tissue) the pressure sore. The physician's treatment plan was to apply calcium alginate and Santyl to the wound and cover the area with a gauze island dressing with a border daily for 30 days. The wound care physician also recommended keeping pressure off the wound, repositioning the resident per facility protocol, and providing a Group-2 mattress (a low air loss mattress used to relieve pressure). In addition, the wound care physician recommended a barrier cream to treat diaper dermatitis. Further, the wound care physician indicated the resident should follow up with a wound care specialist within seven days. There was no documented evidence in the resident's medical record that the facility ensured the resident saw a wound care specialist again. In addition, review of R9's physician orders and TAR revealed there was no documentation that a barrier cream was provided for the resident. The ordered treatment for the pressure ulcer to the sacrum was not updated until [DATE], approximately 10 days after the wound physician's recommendation. Further, there was no evidence in the medical record that a group 2 mattress was acquired and provided for the resident. The care plan was not updated to address the pressure ulcer and include the wound physician's recommended interventions. A review of the wound physician's Progress Note dated [DATE] revealed the physician was signing off on R9, who remained at the facility. Again, there was no documented evidence that the resident saw another wound care specialist as recommended. A review of a Total Body Skin assessment dated [DATE] revealed R9 had one new wound. The location of the wound was not documented and there was no assessment (stage, size, drainage, description, etc.) of the wound. A review of the resident's physician orders and TAR revealed no evidence treatment was provided to the new wound. The new wound was not addressed on the resident's care plan. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to a nurse's Progress Note nine days later, on [DATE] at 3:54 PM, the wound care nurse documented a new area had been reported to R9's left heel as a deep tissue injury (DTI - an injury to the tissue below the skin from prolonged pressure, which appears as an unopened wound that looks purple or dark red). The note indicated the left heel DTI was measured and recorded and skin prep was ordered to be applied by nursing every shift. Review of R9's physician orders and TAR revealed no evidence this treatment was ordered or provided to the left heel on [DATE]. In addition, the note revealed there was improvement noted to the sacrum, as evidenced by a decrease in size and the amount of exudate. However, there was no documented assessment of the wound's size, stage, or appearance as required by the facility's policy. The note also indicated staff were educated on the importance of repositioning per protocol and elevating the resident's heels off the mattress; however, the resident's care plan did not include this information and was not revised. A review of a Head to Toe Skin assessment dated [DATE] revealed the resident now had DTIs to both heels. There was no documentation of the size or appearance of the injuries. The assessment indicated staff (no signature documented) notified the nurse practitioner on [DATE] and a new treatment order was obtained for skin prep to both heels, and to cover the heels with ComfiTel (a silicone wound dressing that adheres to intact skin, not wounds) and Tegaderm (a transparent dressing). The assessment indicated the resident would wear heel booties while in bed and that the resident's care plan was reviewed/revised; however, review of the resident's care plan revealed it was not revised to address the DTIs to both heels, nor were the interventions to treat the DTIs and relieve pressure addressed. A review of nurse's Progress Notes dated [DATE] at 6:52 PM revealed the wound care nurse assessed the progress of R9's sacral wound and recent DTI to the left heel. The wound care nurse indicated in the note that the sacral wound continued to slowly improve as evidenced by a decrease in wound size and the amount of exudate. The note indicated the wound bed was clean with 100% granulation with some maceration to the wound edges. The left heel had some notable evidence of improvement with a decrease in size. Further review of the note revealed the area to the right heel was in the early stages of DTI. There was no documented assessment of the pressure ulcer/injuries to include the stage/measurements or other descriptive information. The note indicated the staff and the resident were reminded of the importance of keeping the resident's heels off the bed. The care plan still did not address pressure ulcer treatment nor prevention. Further review of the note revealed the wound care nurse documented that she sent an email to the supply coordinator to order heel protecting boots and possibly an air mattress, more than one month after the wound care physician recommended an air mattress for R9. Further review of R9's Head to Toe Skin Evaluations, Skin and Wound Evaluations, Total Body Skin Assessments, and Progress Notes for August and [DATE] revealed the facility had no documented evidence skin assessments were conducted weekly, and there was no evidence the pressure ulcer to the resident's sacrum and DTIs to both heels were assessed weekly to track healing progress or promptly identify any potential deterioration. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nurse's Progress Note dated [DATE] at 5:34 PM revealed the wound care nurse documented that the pressure ulcer to the resident's sacrum continued to slowly heal. The note indicated the pressure ulcer continued to have 100% granulation tissue and a moderate amount of serous drainage. According to the wound care nurse's note, the treatment for the sacral pressure ulcer was changed from Santyl (breaks down damaged tissue) to collagen paste (encourages new tissue growth) daily. The note indicated that the right heel continued to improve; however, the left heel wound edges were not attached and treatment to the left heel was changed. According to the note, Heel protectors are being shipped and air mattress order is in. There was no assessment of the pressure ulcers/injuries to include measurements, presence or absence of pain, or other descriptive information. Two days later, on [DATE], the wound care nurse completed another Progress Note for R9. A review of the note revealed the wound bed of the sacral pressure ulcer was beefy red in color, the edges were attached, and the peri-wound was improving. The right heel was also showing signs of improvement. The nurse documented that no drainage or odor was noted, and the area was less painful for resident during the dressing change. The left heel also continued to improve and a decrease in wound size was evident. No measurements or other assessment information were documented. The note indicated a new physician's order was placed to use collagen paste in place of Santyl for treatment of the sacral pressure ulcer; however, review of R9's physician orders revealed the treatment order was not changed to collagen paste until seven days later, on [DATE], and then was discontinued on [DATE]. A review of a nurse's Progress Note dated [DATE] at 9:01 PM revealed the wound care nurse noted the pressure ulcer to R9's sacrum was deteriorating. However, there was no documented assessment of the pressure ulcer that included the stage, size, pain, drainage, or appearance of the wound. The note indicated the air mattress and heel boots that were requested previously were not available. According to the note, the treatment to the sacrum was changed to a wet-to-dry dressing. A review of R9's physician orders revealed a new order was entered on [DATE] to pack the sacral wound with packing strips soaked in 0.5% Dakin's solution (an antiseptic used to cleanse wounds and prevent infection) twice daily. A review of a Skin & Wound Evaluation dated [DATE] at 9:13 PM revealed the resident had developed a hematoma to the right heel that had been present for one week (The exact date was not documented; however, the wound care nurse had documented on [DATE] that the right heel was showing signs of improvement). The area measured 4.7 cm long x 3.2 cm wide x 2.1 cm deep. The wound bed was described as 100% eschar (dead tissue) with no exudate and the edges attached. The evaluation indicated the resident had pain during dressing changes/treatment and that a calcium alginate dressing was in place. According to the evaluation, progress (healing) was stalled. Further review revealed the resident was refusing to eat, which was unusual. In addition, according to the note, the air mattress had not been installed and the resident was up sitting in the same position in a wheelchair by the nurse's station every day. A review of the resident's care plan revealed it was not revised with interventions to prevent worsening of the resident's pressure ulcers/injuries nor to prevent new ulcers/injuries from developing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a Skin & Wound Evaluation dated [DATE], revealed the sacral wound was a stage 2 pressure ulcer (partial thickness skin loss with exposed dermis) that covered 9 cm of surface area and was 4.7 cm long x 2.8 cm wide x 0.2 cm deep, with 1.0 cm undermining (erosion of the tissue beneath the visible wound margins). The assessment did not address where the pressure ulcer was acquired (in the facility or present on admission), how long the pressure ulcer had been present, the appearance of the wound bed, whether there were signs of infection, whether drainage was present and if so, a description of the drainage, the appearance of the peri-wound and surrounding tissue, nor whether there was swelling, pain, or the temperature of the skin around the wound. Further there was no documentation of the progress of the wound (improving, stable, deteriorating). The devices/interventions that were noted as being in place were an air flow pad, incontinence management, moisture barrier, moisture control, and a turning/repositioning program. According to the evaluation, neither a foot cradle nor a mattress with a pump was in use. Further review revealed a Skin &Wound Evaluation, was completed on [DATE] for the hematoma to the left heel. The evaluation revealed the wound was acquired at the facility but did not specify the date it was identified. The wound measured 0.8 cm long x 0.4 cm wide with eschar covering 100% of the wound bed. There was no drainage, and the edges of the wound were attached, with dry/flaky skin surrounding the wound. No swelling was present, and the resident's pain during wound treatment was indicated to be four on a scale of zero to 10, with zero indicating no pain and 10 indicating the most severe pain. A review of a nurse's Progress Notes dated [DATE] at 4:40 AM revealed R9 complained of pain and discomfort to their bottom (sacrum). The nurse documented the dressing was changed and there was an odor from the pressure ulcer. The note indicated the nurse would continue to monitor the resident. Further review of the progress notes and a review of the physician orders revealed there was no evidence the physician was consulted regarding the odor from the wound. There was no further documentation regarding the resident's wounds until [DATE]. A review of a nurse's Progress Note dated [DATE] at 5:07 PM revealed a nurse spoke with R9's family about hospice and palliative care. According to a Progress Note dated [DATE] at 3:57 PM, R9 was admitted to hospice. A review of Progress Notes dated [DATE] at 2:41 PM, revealed a nurse completed a skin assessment which noted wounds to both heels, the right hip (this was the first reference to a wound on the right hip), and the sacrum. The note indicated the wounds to the heels were previously categorized as hematomas; however, based on the nurse's assessment and discussion with the provider, the wounds were re-categorized as unstageable wounds. The treatment for both heels was discontinued and new orders were received to apply betadine to the wound beds and cover with a foam dressing daily. The sacral wound remained categorized as a pressure ulcer and treatment orders remained for a Dakin's damp to dry dressing twice daily. Further review revealed Resident had a pressure ulcer to the right hip that was categorized as a DTI, and orders were received to treat the wound with betadine and cover with a bordered foam dressing. Review of Skin & Wound Evaluation forms dated [DATE] revealed the following: - R9 had a deep tissue injury to the right trochanter (hip) that was acquired at the facility on [DATE]. The surface area was 19.4 cm and the wound measured 4.9 cm long x 4.7 cm wide x 0 cm deep. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- R9's left heel had a pressure area that was unstageable due to slough and/or eschar. The area measured 1. 1 cm long x 1.3 cm wide, which was an increase in size according to the last measurements completed on [DATE]. The wound bed was described as 100% eschar. - R9's right heel had a pressure area that was unstageable due to slough and/or eschar. The area measured 3.0 cm long x 4.4. cm wide. The wound bed was described as 100% eschar. - R9's sacral wound was identified as a Kennedy terminal ulcer (a wound results from underlying skin failure associated with the dying process). According to the evaluation, the area was unstageable due to the presence of slough and eschar in the wound bed. The wound covered a surface area of 47.7 cm and measured 7.6 cm long x 7.9 cm wide x 0.4 cm deep, with 3.0 cm undermining, which was an increase in size since the last measurements were obtained on [DATE] (4.7 cm long x 2.8 cm wide x 0.2 cm deep, with 1.0 cm undermining). The wound bed was described as containing 40% slough. The wound was further described as bleeding, with? moderate sanguineous/bloody exudate and had a faint odor. On [DATE] at 8:15 AM, the Administrator, Director of Nursing (DON), and current wound care nurse approached the surveyor and stated R9 was actively dying and in too much pain to conduct wound care. Consequently, R9's wounds/wound care were not observed during the survey process. Continued review of Progress Notes dated [DATE] at 2:20 AM revealed staff found R9 at 1:50 AM, unresponsive and without respirations, breath sounds, nor a pulse. The resident's physician and hospice were notified of the resident's death. The wound care nurse who managed R9's wounds was no longer employed by the facility and was not available for interview. The Director of Nursing (DON) who was active in the care of R9's wounds was no longer employed by the facility and was not available for interview. The nursing staff who had documented the skin assessments for R9 were no longer employed by the facility and were not available for interview. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:35 AM, Licensed Practical Nurse (LPN) #2 stated the wound care nurse assessed residents' skin on admission. In the wound care nurse's absence, the staff nurse accepting the admission would conduct the skin assessment. If there were skin concerns, a treatment was entered into the computer system and the wound care nurse was notified of the findings. The resident's name was added to a list for the wound care nurse to manage the treatments and continue skin assessments. LPN #2 stated he was not sure how the ongoing weekly assessments were conducted for residents who did not have a pressure ulcer on admission. LPN #2 stated treatments and interventions for wounds were listed on the resident's TAR. LPN #2 indicated he had seen a nurse practitioner look at R9's wounds about a month ago because the wounds were getting worse, and the wound care nurse was not responding to the concerns expressed by the nursing staff. LPN #2 stated the wound care nurse was not providing the resident's treatments as ordered, and nursing staff tried to take care of the resident if they discovered the treatments had not been completed. The wound care nurse had been reported to the DON and the Administrator but always came up with excuses. LPN #2 stated all the wounds in the building worsened because the wound care nurse did not do her job. LPN #2 stated that at the end of [DATE], R9 had a small Stage 2 on the sacrum. LPN #2 moved to work on another hallway for a few weeks and when he returned to R9's hallway, the wound was horrible, undermined, tunnelling, and it was much bigger. LPN #2 indicated at that time, the resident also started to decline, and no one was assessing the wounds, and the wounds just got worse. According to LPN #2, R9 did not get an air mattress because the wound care nurse did not ensure a mattress was ordered. During an interview on [DATE] at 10:39 AM, LPN #4 stated she conducted a body audit (skin assessment) when a resident was admitted to the facility and normally had a second nurse assist with the assessment, so as not to miss any wounds. LPN #4 further stated body audits were required to be completed weekly, and if there was a pressure ulcer, another form was initiated so the location of the concern could be documented, and a description entered. When new skin concerns were found, they were entered into the physician's book and the wound care nurse was notified. The wound care nurse entered treatment orders and when she was not available, nursing staff would cover the wound with a foam dressing. LPN #4 stated nursing staff did not stage pressure ulcers and the wound care nurse was responsible for managing the treatments/interventions for all wounds. However, LPN #4 stated the wound care nurse had not been assessing wounds and was very inconsistent on how she managed the wounds. LPN #4 stated she did not normally provide care for R9 and had not seen the resident until right before the resident was admitted to hospice. She stated a Certified Nursing Assistant (CNA) told her the wound to R9's sacrum had not started out bad but became much worse. LPN #4 stated she had changed the dressing to the sacral wound and packed the wound per the physician's order but really did not have a reference point for the wound other than what the CNAs had told her. During an interview on [DATE] at 11:26 AM, CNA #2 stated nursing staff directed CNA staff on resident care, if there were any changes, and which residents needed frequent turning/repositioning. CNA #2 stated R9 had suffered for a long time. CNA #2 stated they tried to position R9 off the wound, but the wound just kept getting worse. According to CNA #2, she did not think anyone was addressing the resident's sacral wound because it was draining a lot and the dressing became soaked and needed more frequent changes. NA #2 stated R9's sacral wound was deeper and started to smell, beginning about two months ago. CNA #2 stated she went to nursing staff, but they told her it was the wound care nurse's job. During an interview on [DATE] at 2:47 PM, LPN #5 stated she had changed R9's wound dressings and thought the resident's wounds had worsened. According to LPN #5, after the wounds worsened, the resident's physical condition worsened. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:14 PM, the Plant Operations Director (POD) stated staff contacted him when an air mattress was needed. He stated if the facility had one in stock, the request would be fulfilled immediately. If they had to get an air mattress, they could get one within 24 hours from a rental company, and it took two to three days to get an air mattress if the facility had to purchase one. The POD reviewed documentation to see if a bed had been provided to R9 when requested between [DATE] and [DATE]. According to the POD, he had not rented or purchased an air mattress during that time, which would mean the facility had an air mattress available in stock. However, the POD did not keep records regarding fulfilment of a mattress order if one was already available. He stated he did not remember any concerns obtaining an air mattress for R9. During an interview on [DATE] at 11:07 AM, the Nurse Practitioner (NP) stated she had recently returned to the facility after taking leave between [DATE] and [DATE]. The providers who had attended to R9 during her absence were no longer employed with the facility. In addition, the NP stated there was not a wound care physician available to assess and monitor residents' wounds. During an interview on [DATE] at 12:08 PM, the current wound care nurse (WCN) stated her first day at the facility was on [DATE], which was the first time she had seen R9's wounds. The WCN stated she contacted MD #2 and let her know R9's wounds were going to be hard to heal, and difficult to prevent new wounds because of the resident's co-morbidities and being on hospice. MD #2 agreed with the WCN's assessment and stated she would sign an order documenting the wounds were unavoidable even though MD #2 had not observed R9's wounds. During an interview on [DATE] at 11:25 AM, the Medical Director (MD) #2 stated she started working at the facility on [DATE]. MD #2 stated she [TRUNCATED]

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34575 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure there was ongoing and consistent communication and collaboration between the facility and the dialysis clinic in accordance with professional standards of practice for 1 (Resident (R)1) of 3 sampled residents reviewed for dialysis services. Findings included: A review of an undated facility policy titled Hemodialysis, revealed The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include: ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The policy also indicated, The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form. 1. A review of an Admission Record revealed R1 had diagnoses that included rheumatoid arthritis, osteoarthritis, end stage renal disease, lupus (a chronic disease that causes inflammation and pain in any part of the body), dependence on dialysis, and anemia. The admission record indicated the facility discharged the resident on 05/20/22. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/12/22, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The MDS indicated the resident received dialysis while a resident at the facility. Review of a care plan, dated as initiated 02/01/22, revealed R1 required hemodialysis. The interventions included monitoring the resident for side effects and signs of renal insufficiency. Review of R1's clinical record revealed no evidence of any post-dialysis communication with the dialysis center. During an interview on 11/03/22 at 2:30 PM, Licensed Practical Nurse (LPN)1 stated the nursing staff did not usually receive communication back from dialysis. The LPN indicated the facility would send a pre-communication form to the dialysis center but never received it back. During an interview on 11/05/22 at 8:40 AM, LPN6 stated the night shift prepared a folder to send to dialysis that included a pre-communication form. The LPN stated when a resident would return from dialysis, the form should come back completed by the dialysis center. LPN6 further stated the returned forms were to be placed in a binder at the nursing station. Review of the binder at this time revealed there were only two completed forms. LPN6 stated this was normal. During an interview on 11/05/22 at 12:30 PM, the Director of Nursing (DON) and the Administrator both stated it was their expectation that communication would go both ways between the facility and the dialysis center. The DON stated dialysis should send back their information and any orders they would need to initiate.

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F 0710 Level of Harm - Actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 34575 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure pressure ulcer treatment plans were consistently supervised by a physician, to include regular evaluation of the condition of wounds to determine if the currently ordered treatment plan was effective or required alteration for 2 (Resident (R)9 and R1) of 5 sampled residents reviewed for wound care management. Findings included: A review of the facility's Medical Director Agreement revealed the Medical Director would review individual resident cases to evaluate the quality of care or problematic situations and take appropriate steps to resolve the situation, as necessary. Review of an undated facility policy titled, Pressure Injury Prevention and Management, revealed the attending physician will be notified of the presence of a new pressure injury upon identification; progression towards healing, or lack of healing, of any pressure injuries weekly; any complications (such as infection, development of a sinus tract, etc.) as needed. 1. Review of R9's medical record revealed R9 developed four pressure injuries during their stay in the facility, including a sacral wound and deep tissue injuries (DTIs) to the right hip and both heels. Further review of R9's clinical record revealed the resident was assessed by a consulting wound care physician on 08/24/22, during which the physician evaluated a necrotic pressure ulcer to the sacrum and provided treatment recommendations. There was no evidence the resident's wounds were evaluated by a physician after 08/24/22, prior to the resident's death in the facility on 11/05/22, at which time the resident's record indicated the resident continued to have a sacral wound (which was noted to be a Kennedy terminal ulcer) and DTIs to the right hip and both heels. Refer to F686 for further details. During an interview on 11/04/22 at 11:07 AM, the Nurse Practitioner (NP) stated she had recently returned to the facility after taking leave between 07/24/22 and 10/15/22. The providers who had attended during her absence were no longer employed with the facility. The NP further stated there was not a wound care doctor in the facility to assess and monitor wounds after 08/25/22. During an interview on 11/05/22 at 11:25 AM, Medical Director (MD)2 stated she started working at the facility on 08/27/22. MD2 stated she had not seen R9's wounds. The MD indicated she was aware the facility had been having problems with wounds, and she depended on the NP to oversee wounds and notify her if there were problems. MD2 stated R9 was never on her list to see and indicated she did not know what was happening with the resident's wounds and had not been asked to look at the wounds. During an interview on 11/05/22 at 12:30 PM, the Administrator stated she was not aware the physician was not looking at R9's wounds, and her expectation was the Medical Director and providers would lay eyes on the wounds. The Administrator stated she was made aware of R9's wounds on or around 09/07/22 and became more aware of the concerns/challenges with the resident's wounds on 10/12/22. The Administrator did not believe the former Director of Nursing (DON) or former wound care nurse brought the wounds to the attention of the attending providers. (continued on next page)

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Ashley River Healthcare	1137 Sam Rittenberg Blvd Charleston, SC 29407

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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 0710 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/09/22 at 12:31 PM, the NP stated if she had written an order for a wound treatment, she would pass that care over to a specialist, such as a wound care nurse or wound doctor. The NP further stated she would expect that person to monitor the wound. During an interview on 11/09/22 at 2:14 PM, MD2 confirmed she had never seen R9's wounds and did not know how the wound nurse determined the status of a wound other than through experience. MD2 stated she had just accepted the wound care nurse's assessment that the sacral wound was a Kennedy terminal ulcer and had signed off on that diagnosis. 2. Review of R1's Physician Orders revealed a physician order dated 04/14/22 for a wound care consult for a Stage 2 wound on toes at right and left foot, second toe. The order was signed by the Nurse Practitioner (NP) on 04/14/22. The order was confirmed by a Licensed Practical Nurse (LPN) that was no longer employed at the facility. Review of the resident's medical record revealed on 05/10/22, R1 was assessed by Medical Doctor (MD)1 while at dialysis. MD1 documented the resident had a right great toe ulcer with purulent drainage, and there were no reports from the facility regarding the wound. MD #1 further documented she would notify the facility and request the resident be sent to vascular surgery and receive a consult for wound care. Review of a Progress Note dated 05/10/22 by the NP revealed no reference to the wound. The resident's medical record contained no documented wound evaluations by the NP or attending physician. The resident was discharged from the facility on 05/17/22. Refer to F686 for further details. During an interview on 11/04/22 at 11:07 AM, the NP stated her role was to evaluate and assess residents and write orders. The NP stated she did not do skin assessments, as she could not roll people, and she did not look at feet every visit. The NP stated if a nurse mentioned something to her about a resident's feet she would look. With all new admits she checked pulses, but she did not look at the skin on the feet. The NP further stated there was no wound doctor in place at the facility to look at wounds. The NP stated R1 was on dialysis and was having a significant medical decline. The NP confirmed she had written the order dated 04/14/22 for a wound care consult. The NP indicated in April 22, there was a wound care doctor coming to the facility on e to two times each week, and her expectation was if she had written an order for a wound care consult, the wound doctor would have been asked to see the resident. The NP stated she did not follow up on the wound, and she had not received anything from the dialysis doctor about the worsening condition of the toe. The NP stated she had not looked at R1's toe because the resident was not in the building the day she wrote the note. She assumed the wound care doctor saw the resident on his next visit to the facility. During an interview on 11/04/22 at 2:00 PM, MD1 stated that whenever there were concerns regarding wounds or wound care, she would have the dialysis center's nursing staff contact the facility. MD1 stated R1 had multiple ulcerations, including a decubitus ulcer, and was unsure if they were taken care of by the facility. MD1 stated she did not have the resident information readily available and was unable to provide specifics. During an interview on 11/05/22 at 11:25 AM, an interview was conducted with MD2, the attending physician and acting Medical Director at the facility. MD2 stated she had started working at the facility the end of August 22 and there had been an issue with wound care for a while. MD2 was unable to contribute any information about R1's wounds. The attending physician and other providers who may have provided care to R1 between 04/12/22 and 05/17/22 no longer worked for the facility and would not speak with the surveyor. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/05/22 at 12:30 PM, with both the Administrator and the Director of Nursing (DON) in attendance, the DON stated she had been in her role for about three weeks. The DON stated if there were wounds, there should be an assessment with staging and a plan for management of the wounds with treatments. The Administrator stated the attending nurse and the doctor should both look at any wounds. The attending physician was responsible for looking at the wounds to ensure the orders were appropriate based on the staging of the wounds and to promote wound healing. The Administrator further stated there should have been documentation scanned into R1's clinical record to evidence the resident had been seen by the wound doctor as ordered, but the provider should still have observed the wound to assess the progress of healing.

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F 0835 Level of Harm - Actual harm Residents Affected - Few	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** 34575 Based on interviews, record reviews, document reviews, and facility policy review, the facility failed to provide oversight and leadership that ensured effective prevention, monitoring, and assessments of pressure injuries and that ensured physicians/providers provided ongoing supervision of plans of treatment for pressure wounds. The Administrator was aware that the wound care nurse was not completing wound/skin assessments for residents per facility policy; however, the wound care nurse continued to be responsible for wound care management without oversight. R9 developed multiple pressure ulcers/injuries that worsened from admission on 08/04/22 through 11/02/22. (Refer to F686 and F710 for further details). Findings include: Review of an undated facility policy titled, Pressure Injury Prevention and Management, revealed, Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after newly identified pressure injury. Findings will be documented in the medical record. A review of an undated facility policy titled Documentation of Wound Treatments, revealed, Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the presence of skin loss if non-pressure (partial or full thickness) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) iv. Presence, amount, and characteristics of wound drainage/exudate v. Presence or absence of odor vi. Presence or absence of pain 3. Wound treatments are documented at the time of each treatment. If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry intact). 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and effectiveness of current intervention c. Any treatments for pain, if present d. Modification of treatments or interventions e. Notifications to physician or responsible party regarding wound or treatment changes. A review of the facility's Wound Care Nurse job description revealed the major duties and responsibilities included, Identifies, manages, and treats specific skin conditions, such as pressure injuries, diabetic, venous, or arterial ulcers and traumatic or complicated wounds. Provides wound care on assigned residents, in accordance with physician orders, following manufacturer recommendations and appropriate techniques. Completes a thorough and accurate wound assessment upon notification of wound. Completes follow-up assessments weekly and as needed. Documents all assessments in the medical record. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	A review of a Personnel Consultation Form for a date of occurrence of 09/07/22, revealed the facility counseled the wound care nurse on 10/11/22 for failure to do an admission body audit for a resident who had a wound. The form indicated the resident's family was upset. The corrective action was for the wound care nurse to complete and document a body audit for all residents on admission and notify the resident's family of any findings. A review of a Performance Improvement Plan Action Plan dated 10/11/22 revealed the areas of concern for the wound care nurse were wound monitoring, documentation, consistent treatment regimen, weekly reporting, and monthly Quality Assessment Performance Improvement documentation. Improvement goals included All new admissions will have a body audit, orders, care plans, evaluations and documentation noted when appropriate. These tasks will be completed within 24 hours. Any new wound noted by staff will be followed up on by the wound care nurse to include evaluations, care plans, treatment orders and documentation within 24 hours. All wound care notes with measurements will be completed in [facility's electronic medical record program] and reported to DON/ADM [Director of Nursing/Administrator] weekly. Further review revealed the wound care nurse had an improvement goal to establish a form of communication for floor nurses to know which wounds were the wound care nurse's responsibility versus the floor nurses' responsibility. A review of an All-Inclusive Admission with Baseline Care Plans assessment dated [DATE] at 11:15 AM revealed R9 had no pressure ulcers on admission to the facility but was at moderate risk for pressure ulcers. A review of nurse's Progress Notes revealed R9 had a sacral wound that was healing. The facility had no documented evidence as to when the sacral wound developed, nor measurements/assessment of the wound as required by facility policy. However, a review of a wound physician's Initial Wound Evaluation & Management Summary dated 08/24/22 revealed the sacral wound was an unstageable pressure area due to necrotic (dead) tissue to the sacrum. The pressure ulcer covered a surface area of 10.50 centimeters (cm), measuring 3.0 cm long by (x) 3.5 cm wide x 0 cm deep, and had a moderate amount of serous exudate. The physician surgically debrided the necrotic tissue from the pressure sore. Further review of Progress Notes revealed R9 developed a deep tissue injury (DTI) (an injury to the tissue below the skin from prolonged pressure which appears as an unopened wound that looks purple or dark red) to the left heel on approximately 09/15/22, a DTI to the right heel on approximately 09/29/22, and a DTI to the right trochanter (hip) on 11/02/22. A review of a Skin & Wound Evaluation dated 11/04/22, revealed the DTI to the right trochanter (hip) measured 4.9 centimeters (cm) long by (x) 4.7 cm wide x 0 cm deep, on 11/02/22. Further, a wound evaluation dated 11/04/22, revealed the pressure ulcer to the sacrum had increased in size to a surface area of 47.7 cm and measured 7.6 cm long x 7.9 cm wide x 0.4 cm deep with 3.0 cm undermining. In addition, another wound evaluation dated 11/04/22 revealed the DTI to the left heel had also increased in size. The facility had no documented evidence that full body audit (skin assessments) were completed for R9 weekly and no evidence that R9's pressure ulcers were assessed and measured at least weekly in accordance with facility policy. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/04/22 at 11:07 AM, the Nurse Practitioner (NP) stated she had recently returned to the facility after taking leave between 07/24/22 and 10/15/22. The NP stated the providers who had attended during her absence were no longer employed with the facility and the facility did not have a wound care physician to assess and monitor wounds. During an interview on 11/05/22 at 11:25 AM, the Medical Director (MD)2 stated she started working at the facility on 08/27/22. MD2 stated she had not seen R9's wounds but was aware the facility had been having problems with wounds. She stated she did not know what was happening with the resident's wounds and had not been asked to look at them. During an interview on 11/05/22 at 12:30 PM, the Administrator stated she was notified of concerns with the wound care nurse on approximately 09/07/22 and became more aware of the concerns/challenges with R9's wounds on 10/12/22. The Administrator stated she did not believe the DON nor wound care nurse at that time brought the wounds to the attention of the attending physician. Despite the Administrator's knowledge of the wound care nurse, no action was taken, and the wound care nurse continued to work autonomously.