STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. Building B. Wing	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Village Care	136 Davis Lane Lafollette, TN 37766

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460 Based on facility policy review, medical record review, review of facility investigations, and interviews the facility failed to prevent resident to resident abuse for 3 residents (#9, #10, #15) of 15 sampled residents for abuse. The findings included: Review of facility policy OPS300 Abuse Prohibition revised 10/24/2022 showed .Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter 'patient') property, and exploitation for all patients. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms .Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Benign Prostatic Hyperplasia, Pseudobulbar Affect, and Major Depressive Disorder, Recurrent. Medical record review of Resident #8's annual Minimum Data Set (MDS) dated [DATE] revealed the resident had both short and long term memory loss.The resident required extensive assistance for bed mobility and activities of daily living (ADLs) with 2-person assist. Medical record review of Resident #8's comprehensive care plan revealed the facility identified the resident exhibited behavioral symptoms of wandering in and out of other residents' rooms and had the potential to exhibit physical behaviors towards others related to cognitive loss and dementia. Facility implemented interventions included to provide resident with opportunities for choice during care and activities, divert resident through activities, assess reasons for wandering, and redirect as needed. Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Diabetes Type 2, Acute Kidney Failure, Hypertension, Major Depressive Disorder, and Dementia. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review of Resident #9's admission MDS dated [DATE] revealed Resident #9 had a BIMS score of 6 which indicated a severe cognitive impairment. The resident required supervision for bed mobility, transfers, and eating with 1-person assist. Review of a nurse note dated 11/28/2022 at 2:15 PM revealed .CNAs [Certified Nurse Assistants] were doing a round when CNA heard someone saying 'help me'. CNAs entered room and Res [resident] [Resident #8] was standing over another resident with a walker in his hand hitting other res [Resident #9] .CNA took walker from res while another CNA was trying to sit res down & during that interaction res twisted CNA fingers. Other res stated that res was trying to take his blanket and he wouldn't let him. Residents have been separated and aggressor was 1-on-1 until staff got his room changed to a private room . Review of a facility investigation dated 11/28/2022 showed Resident #8 and Resident #9 were roommates beginning 11/17/2022. On 11/28/2022, Resident #9 was heard yelling for help. Staff entered the room and Resident #8 was observed hitting Resident #9 on the nose with his walker. The residents were separated. The residents were assessed for injury with none noted. Resident #8 was placed on one-to-one (1:1) supervision until he could be moved to a private room. Resident #9 was followed by psychological services and facility social services with no psychosocial concerns identified. Interview on 1/25/2023 at 1:10 PM with CNA #17 confirmed she had been working on 11/28/2022 and confirmed Resident #8 hit Resident #9. CNA #17 stated CNA #18 stayed with Resident #8 until he was moved to a private room. Medical record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including: Alzheimer's Disease, Rheumatoid Arthritis, and Anxiety. Medical record review of Resident #10's comprehensive care plan dated 1/7/2023 showed the facility identified the resident had potential to exhibit verbal behaviors related to cognitive loss and dementia. Medical record review of Resident #10's Significant Change in Condition MDS dated [DATE] revealed a BIMS score of 3 which indicated the resident was severely cognitively impaired. The resident required extensive assist for bed mobility, transfers, and ADLs with 2-person assist. Review of a facility investigation dated 1/25/2023 revealed Resident #10 was seated in her wheelchair in the dining room. Resident #8 entered the dining room walked up to Resident #10 and hit her on the right side of the head with his fist. The residents were immediately separated and assessed for injury with no injuries noted. Resident #8 was placed on 1:1 supervision until he was transferred to an inpatient geropsychiatric unit. The facility conducted neurological checks for Resident #10 for 72 hours with no concerns identified. Observation and interview on 1/31/2023 at 1:10 PM with Resident #10's family member confirmed there was no bruising to Resident #10's head. Interview with the family member revealed Resident #10 did not recall the incident and Resident #10 had not exhibited a change in behavior after the incident with Resident #8. Interview on 1/31/2023 at 2:40 PM with CNA #15 confirmed she had escorted Resident #8 back to his room on 1/25/2023 and stayed with him until he was transferred to the hospital. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Asthma, and Shortness of Breath. Medical record review of Resident #15's quarterly MDS dated [DATE] revealed a BIMS score of 9 indicating moderate cognitive impairment. The resident required extensive assist with bed mobility, transfers and ADLs with 2-person assist. Review of a facility investigation dated 2/1/2023 showed Resident #15 was seated in her wheelchair talking with other residents. Resident #6 wheeled up to the nurse station, leaned over, and grabbed Resident #15 by the arm tightly. The residents were immediately separated and assessed for injury. Resident #6 was placed on 1:1 supervision until he was transferred to an inpatient geropsychiatric unit. Resident #15 was noted to have a reddened area to her right arm, however no injury was noted. Medical record review showed Resident #6 was admitted to the facility on [DATE] with diagnoses including Diabetes Type 2, Dementia, Anxiety and Major Depressive Disorder, Recurrent. Medical record review of Resident #6's comprehensive care plan dated 7/1/2019 showed the resident exhibited or had the potential to demonstrate verbal behaviors of yelling and cursing at staff related to cognitive loss and dementia. The care plan also showed the resident had the potential to exhibit physical behaviors related to poor impulse control. Medical record review of the quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 3 which indicated a severe cognitive impairment. The resident required extensive assistance for bed mobility, transfers, and ADLs with 2-person assist. Interview on 2/3/2022 at 9:15 AM with LPN #17 confirmed she witnessed the incident between Resident #6 and #15. The nurse stated she saw Resident #8 roll up to the nurse station and did not appear to be agitated. LPN #17 confirmed Resident #6 reached out and grabbed Resident #15 by the arm and called her names.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policies, medical record review, review of manufacturer instructions, and interviews, the facility failed to prevent pressure ulcers for 1 resident (#3) of 3 residents reviewed for wounds, of 15 sampled residents. The facility failures to closely monitor and document changes in Resident #3's integumentary status, the resident's compliance with the treatment plan, and the status of pre-existing wounds in accordance with facility policy, led to the failure to timely detect and intervene to address changes in the condition of a pre-existing sacral pressure ulcer and to prevent the development of new pressure ulcers. The facility's failure resulted in harm to Resident #3, who was hospitalized on [DATE] due to sepsis (blood stream infection) attributed to an infected chronic sacral ulcer and infected bilateral, unstageable pressure ulcers of the ischial tuberosities. Resident #3 underwent surgery under general anesthesia on 12/6/2022 to treat the infected wounds. The findings included: Review of the facility policy Treatments, effective 6/1/2009, revised 6/1/2021, showed .Policy .A licensed nurse .will perform ordered treatments .accepted standards of practice will be followed .Document . Administration on Treatment Administration Record (TAR) .Patient's response .refusal of treatment if applicable .Notification of Physician .if applicable . Review of the facility policy, Skin Integrity and Wound Management, effective 7/1/2001, revised 2/1/2023, showed .Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed .Identify patient's skin integrity status and need for prevention or treatment interventions through review of appropriate assessment and information .The Nursing Assistant will observe skin daily and report any changes or concerns to the nurse .The Licensed nurse will .evaluate any reported or suspected skin changes or wounds .Document newly identified skin/wound impairments as a change in condition . document skin/wound findings in the 24 hour report .Perform and document skin inspection on all newly admitted /readmitted residents .weekly thereafter .and with any significant change in condition .Perform daily monitoring of wounds or dressings for presence of complications or declines .Document daily monitoring of ulcer/wound site with or without dressing .Monitor .status of the dressing .status of the tissue surrounding the dressing .adequate control of wound associated pain .signs of decline in wound status .if unanticipated decline in wound, surrounding tissue, or new or increased .pain .complete a wound re-evaluation, change in condition .notify interdisciplinary team members .notify the physician .obtain orders . Review of the facility policy Changes in Condition: Notification of, effective 11/28/2016, revised 6/1/2021, showed .A center must immediately inform the patient .consult with the patient's physician .when there is .a significant change in the patient's physical, mental or psychological status .a deterioration in health .or clinical complications .when making notification of above .the Center must ensure all pertinent information is available and provided upon request of the physician . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Medical record review showed Resident #3, had a history of spinal cord injury, secondary to a motor vehicle crash in 2020, and was admitted to the facility on [DATE] with diagnoses including Unspecified Quadriplegia, Stage 4 Pressure Ulcer (the most severe form of pressure ulcer, with wound involvement reaching the muscles, ligaments or bones) of the Sacral Region, Polyneuropathy, Neuromuscular Bladder Dysfunction, Major Depression and Unspecified Constipation. Continued medical record review showed Resident #3 was also diagnosed with Autonomic Dysreflexia (a syndrome that emerges after spinal cord injuries that results in exaggerated reflexive increases in blood pressure in response to a stimulus, usually bowel or bladder distention, originating below the level of the neurological injury, causing severe headaches, slowed heart rates, sweating, pallor, cold skin, and hypertensive crisis, a potentially life-threatening complication). Medical record review of the admission Minimum Data Set (MDS) dated [DATE] showed Resident #3 was cognitively intact and independent in decision making, with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. Resident #3 was paralyzed below the levels of the 4th through 6th cervical vertebrae (base of the neck), had an indwelling urinary catheter, was incontinent of bowel and was dependent upon one or two persons for all activities of daily living (ADLs). Review of the Admission Skin and Wound Evaluation performed by the facility wound nurse Registered Nurse (RN) #5 dated 11/15/2022 showed Resident #3 was admitted to the facility with a non-healing Stage 4 Pressure ulcer of the sacrum. The wound had undermining present from the 9 o'clock position to the 5 o'clock position. Continued review showed no signs of swelling, or induration (thickening or hardening of the periwound skin), and no signs of infection were documented as present. No additional wounds, or skin breakdown in other areas were noted. Review of the Nurse Practitioner (NP) progress note dated 11/16/2022 showed .Initial Evaluation .admitted to [facility] following hospitalization .available records reviewed and indicate treatment for abdominal pain secondary to constipation .community acquired pneumonia .stage 4 sacral ulcer .present on hospital admission .BM [bowel movement] documented yesterday and BM present during wound care .Wound care RN present for dressing change .Wound Type .sacral pressure ulcer .stage 4 .size 3.08 [centimeters, cm] [length] by 2.17cm [width] by 2 cm [depth] .status new evaluation .wound base .granulation, scant area of slough .wound edges rolled [an indicator of chronic, non-healing wounds] .no erythema [redness] .odor .none .exudate .small. serous .periwound [tissue surrounding a wound], intact .Plan .Will order to continue to clean sacral wound with normal saline, pat dry, pack with silver alginate [a specialty wound product to prevent infection] then cover with bordered dressing .change daily and PRN [as needed] .will order to report any decline in wound . Continued review of the NP progress note showed Resident #3 with an abrasion to the . left posterior thigh . Continued review showed .will order to apply Sure Prep [skin protectant] to the dried abrasion .until healed .order .report any decline in area . Review of the Care Plan for Resident #3 showed .provide preventative skin care i.e. lotions and barrier creams as ordered .assist resident by turning and positioning every 1 to 2 hours .Observe skin for signs of skin breakdown .evaluate for any localized skin problems .observe skin condition daily with ADL care and report abnormalities . Review of the corresponding Treatment Administration Record (TAR) for November 2022, showed the NP orders for wound care were transcribed accurately and were documented as performed daily per the care plan. No PRN dressing changes were documented as having been required on the TAR. No skin abnormalities or changes in condition reported to the Physician were noted on the TAR. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the daily narrative nursing notes from 11/16/2022 through 11/21/2022 (5 days) showed no specific references to Resident #3's sacral wound. There were no entries related to Resident #3's sacral wound appearance, wound healing, condition of the peri wound skin, status of the dressings in use to treat the sacral ulcer, or references to Resident #3's abrasion on the posterior left thigh or its condition documented by floor nursing staff assigned to Resident #3's care. There were no references to integumentary status in her gluteal region or elsewhere documented, or of preventative measures used or reports of changes in condition to the Physician documented. During this 5- day period, 4 different Licensed Nurses cared for Resident #3. Review of ADLs documentation (Documentation Survey Report V-2) for November 2022 showed Certified Nurse Aides (CNAs) did not document preventative skin care provided on 11/17/2022 and 11/22/2022 on the day shift and did not document preventative skin care provided on 11/19/2022 and 11/21/2022 on the evening shift. Continued review showed staff did not assess and document the status of Resident #3's pressure relieving mattress and chair cushions in use on the day shift of 11/17/2022 and 11/19/2022 and on the evening shifts of 11/19/2022 and 11/21/20222, and on the overnight shift of 11/15/2022. Continued review showed staff also did not document incontinence care in the electronic medical record, on the day shifts of 11/17/2022 and 11/22/2022, and the evening shift of 11/19/2022 and 11/21/2022. Review of a Nurse Practitioner Progress Note dated 11/20/2022 showed Resident #3 was re-evaluated for chief complaints of Bladder Spasms, Nausea, and Allergic Rhinitis. There were no references to Resident #3's pressure ulcer or integumentary status in the review of systems portion of the assessment and no indications of staff reported issues with Resident #3's skin or wound to the Advance Practice Nurse. Review of the daily narrative nursing notes dated 11/22/2022 and 11/23/2022 showed documentation indicative Resident #3 was non-compliant with turning and positioning, and ADLs/incontinence care. Resident #3 was documented to have refused turning and positioning and other pressure relief modalities on the day and evening shift of 11/22/2022 and 11/23/2023. Review of nursing notes dated 11/22/2022 at 3:16 PM showed .Resident refused all Q2 HR [every 2 hours] repositioning this 7 to 3 shift [7:00 AM to 3:00 PM shift], Resident will only allow staff to pull up in bed .refuses to be turned on either side to relieve pressure to buttocks . Review of the nursing note dated 11/22/2022 at 11:40 PM showed .Resident educated on advantages of turning off wound, Resident continues to refuse Q [every] 2 hour turning and repositioning this 3-11 [3:00 PM to 11:00 PM] shift . Continued review of the nursing notes showed no evidence Resident #3's non-compliance was reported to the Physician or Advance Practice Nurses, and no documentation pertinent to the appearance of the sacral wound, the wound dressing in use at the time, or impacts of Resident #3's non-compliance on the sacral wound or skin integrity to her gluteal area or abrasion on the left thigh, were documented by the floor nurse who wrote both notes. Review of the Weekly Skin and Wound Evaluation note dated 11/22/2022, completed by the facility wound nurse RN #5, showed the nurse documented Resident #3's sacral wound was filled 100 percent with granulation tissues and had no signs of infection. Two centimeters of undermining were noted as still present consistent with the initial wound assessment. Moderate amounts of wound exudate were present. The wound was free of odor with non-attached wound edges. Continued review revealed RN #5 documented the presence of erythema (redness of the skin) in tissues surrounding the wound. The nurse documented there was no induration present or edema to the wound and documented the wound was slow to heal or stalled, but stable. RN #5 documented the NP was informed of Resident #3's wound status. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a staff activity sheet showed between 11/23-24/2022 multiple CNAs and Licensed Nurses documented services rendered to Resident #3. Resident #3's non-compliance with turning and positioning was noted on the sheet once on 11/23/2022, twice more on 11/24/2022. CNAs documented incontinence care and other routine services provided with signatures of the involved personnel. Continued review showed Resident #3 received incontinence care multiple times during this period. No notations of skin breakdown were documented on the form. There was no evidence nursing staff were informed of Resident #3's continued non-compliance. Review of the TAR for 11/24/2022 to 11/28/2022 showed all ordered wound care to Resident #3's sacral pressure ulcer and abrasion to the posterior left thigh was documented as performed per the care plan. There were no indicators Resident #3 required extra dressing changes during this time. Review of the corresponding narrative nursing notes dated between 11/24/2022 through 11/28/2022 showed on 11/25/2022 at 4:24 PM, nursing staff documented education to Resident #3 related to continued non-compliance with turning and positioning interventions to prevent skin breakdown. There were no references to Resident #3's wound status, general skin condition, or treatments given in the entry, and no evidence Resident #3's non-compliance was reported to the Physician or NP on 11/25/2022. Review of narrative nursing notes dated 11/26/2022 to 11/28/2022 revealed no documentation related to Resident #3's integumentary status at all. Nor were there any specific references to the treatments administered to Resident #3's sacral wound, abrasion to the thigh and surrounding skin. There was no information noted in relation to the appearance of Resident #3's sacral wound, the dressings in use, her compliance status or responses to recent compliance teaching, and no evidence any complications at her wound site or skin breakdown were detected or reported to nursing staff by the CNA staff. Between 11/24/2022 and 11/28/2022, 4 different Licensed Nurses provided care to Resident #3. Review of the Nurse Practitioner Progress Note dated 11/28/2022 revealed Resident #3 was evaluated by the NP for complaints of insomnia, depression and Vitamin D deficiency. There were no indications the NP was informed of Resident #3's continued noncompliance with pressure ulcer prevention measures and ADLs. The NP noted the presence of Resident #3's sacral ulcer in the medical history portion of the note. Review of the Review of Systems section of the assessment showed .positive chronic sacral wound . but no evidence the NP evaluated the appearance of the wound was documented. The NP assessed Resident #3's insomnia, antidepressant regimen and history of Vitamin D use at home, ordered labs, reviewed the medication regimen and documented the resident's depression was stable and no changes were required, her insomnia was stable, and no changes were required, and ordered a Vitamin D level obtained on 11/29/2022. No changes to the wound care regimen were ordered. Review of the ADLs documentation (Documentation Survey Report V-2) for the time period 11/24/2022 to 11/29/2022 showed multiple CNA staff rendered incontinence care, positioning, and other personal hygiene to Resident #3. Continued review showed during this time Day shift (7:00 AM to 3:00 PM) staff documented they did not apply protective lotions or creams to Resident #3's skin per the care plan on 11/24/2022 and 11/25/2022. Overnight shift staff did not apply protective lotions or creams per the care plan on 11/24/2022, 11/26/2022, and 11/29/2022. Resident #3 refused application of protective creams on the overnight shift of 11/27/2022. Overnight shift staff also did not document the status of Resident #3's pressure reducing mattress on 11/24/2022, 11/26/2022, 11/28/2022 and 11/29/2022. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the weekly Skin and Wound Evaluation Form dated 11/28/2022 showed the wound treatment nurse (LPN #12) performed an assessment of and treatment to Resident #3's sacral wound. LPN #12's documentation of the sacral ulcer included, under the heading depth as not applicable and noted under the heading undermining as not applicable (which was inconsistent with the findings of the previous two weekly wound evaluations performed by RN #5). LPN #12 documented the sacral wound was free of signs of infection with moderate exudate and noted the wound edges to be rolled edge and noted the wound not healing. LPN #12 documented periwound tissues at the sacral ulcer site were normal at that time. Continued review showed LPN #12 documented the presence of 2 new unstageable pressure ulcers, located bilaterally at the location of the ischial tuberosities. Both lesions were documented to have slough and eschar (non-viable tissues) present in the wound bed. The right-side lesion was noted to be 2.3 cm by 3.3 cm by 0.1 cm in size. The date of onset on the form was left blank. The lesion was noted to have 50 % slough and 50% eschar in the wound bed, with light serous drainage and no odor after cleansing. The left side lesion was documented to be 3.8 cm by 2.1 cm with depth noted as not applicable and noted to have 50% slough and 50 % eschar in the wound bed with moderate serous drainage and no odor after cleansing. The date of onset for this lesion was also left blank. LPN #12 documented the Nurse Practitioner was advised of the new wounds, along with other members of the interdisciplinary team. Photographs of both wounds were obtained by LPN #12 and entered into the electronic record keeping system. Orders for treatment on the new wounds were obtained. Continued review showed the new wounds were treated by LPN #12 by application of Santyl Ointment (an enzymatic debriding agent) to both sites. The right sided lesion was covered with a composite primary dressing. The left side lesion was covered with a composite primary dressing, augmented by a dry foam secondary dressing. Review of the TAR showed 2 updated orders dated 11/29/2022, which read .Santyl External Ointment, 250 unit/gram .collegenase [an enzyme used to break down collagen in damaged tissue] .Apply to L [left] ischial tuberosity topically .every day .shift for open area .Santyl External Ointment 250 unit/gram .collegenase . Apply to R [right] ischial tuberosity every .day shift .for open area . Continued review showed no concurrent orders to cover the new wounds or interventions for protection of periwound skin at the new lesion sites with appropriate dressings once Santyl was applied to the lesions. Review of the Manufacturer Instructions as posted online and updated 2/3/2023 for the application of Santyl Ointment, read .Step 1 .Cleanse .2 .Apply Santyl directly to the wound surface once a day .at 2 mm [millimeter] thickness .about the thickness of a nickel .3. Cover .Wounds with sufficient .fluid will have enough moisture for product to be effective .dry wound may require additional moisture .add moisture, as with a saline moistened gauze .4. Change dressings daily as instructed . Review of the TAR entries dated 11/29/2022 to 12/2/2022 showed Santyl ointment was applied to Resident #3's bilateral ischial tuberosity wounds daily as directed in the orders transcribed by LPN #12. However, no evidence dressings were applied to the wounds after application of the enzymatic debriding agent were noted. Review of the corresponding narrative skilled nursing notes for 11/30/2022 through 12/2/2022 showed no references to Resident #3's wound care regimen, the status of any of her 3 wounds, no references to treatments performed, dressings applied, the response to treatment, or monitoring of her compliance with pressure reducing modalities. Review of the Change in Condition (SBAR) Summary for Providers dated 12/2/2022 at 2:30 PM showed Resident #3 was transported to a local emergency room by ambulance for evaluation of a suspected exacerbation of Autonomic Dysreflexia, which included alterations in Resident #3's vital signs, profuse sweating, and complaints of discomfort. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of hospital emergency room records from the local hospital showed Resident #3 was evaluated by the attending emergency room Physician at 3:55 PM. The physician documented .is an unfortunate .with a past history of quadriplegia secondary to MVA [motor vehicle accident] who presents to the emergency department with complaints of headache, infected decubitus ulcers to the sacrum and bilateral glutes, and hematuria in foley catheter .she states .she was admitted at .was discharged to a skilled nursing facility at [named the facility] .States since she has been there that she has not received adequate care .she had incontinence of her bowels that cause her to have stools in her wounds .wounds have become very painful . Review of the emergency room Physician Note, Physical Examination showed .To the patient's sacrum she has a stage 4 decubitus ulceration that is roughly 8 cm by 4 cm .is oval shaped .borders are separated . significant amount of tunneling .do not appreciate any drainage from this ulceration .patient does have additional pressure ulcerations to bilateral inferior glutes .They are similar in size .approximately 4 cm by 4 cm and round in nature. Both of these do have a darkened appearance in the wound bed that does appear to be necrotic tissues .there is a foul-smelling purulent drainage coming from both of these wounds as well . Wound borders are erythemic but blanchable .does not appear to be tunneling at this time . Review of the hospital emergency records showed Resident #3 underwent numerous medical tests while in the emergency department which culminated in her admission to the intensive care unit pending transfer to a regional hospital the next morning. Resident #3 was diagnosed with Sepsis from infected sacral ulcer, and a Non-ST Elevation Myocardial Infarction (NSTEMI, a type of heart attack) of unknown etiology or time of onset. She was started on intravenous (IV) antibiotics and provided supportive care for the cardiac condition, then transferred by ambulance to a regional hospital affiliated with the local facility the following day. Review of regional hospital records showed Resident #3 arrived there at 1:06 PM on 12/3/2022. The Chief Complaint and Admission Diagnoses were listed as Sepsis, Multiple Decubitus Ulcers, and Autonomic Dysreflexia. The Admitting Physician noted foul smelling discharge from Resident #3's sacral and ischial wounds. Continued review revealed .Assessment .Sepsis due to sacral decubitus and bilateral ischial ulcers infection . Continued review showed .Stage 4 Decubitus ulcer and unstageable bilateral buttocks ischial ulcers .consult wound care .consult general surgery to evaluate for debridement and diverting ostomy . Review of the regional hospital discharge summary showed Resident #3 was admitted on [DATE], administered additional IV antibiotics, wound care, and stabilized for surgery. Resident #3 underwent surgical treatment for wounds on 12/6/2023. Resident #3 also underwent surgery for diverting colostomy (a surgical opening into the colon to divert wastes to an appliance affixed to the abdomen) as recommended to facilitate wound healing. Review of the discharge surgical summary revealed Preoperative Diagnosis, Sacral Decubitus Wounds, Bilateral Ischial Wounds, Quadriplegia .Postoperative Diagnosis .same .Operation . Laproscropic diverting loop sigmoid colonostomy creation .debridement of skin and subcutaneous tissue on right ischial wound totaling 3x2 cm .debridement of skin and subcutaneous tissue on left ischial wound totaling 3x2 cm .findings .right ischial wound with nonviable skin and subcutaneous tissues .left ischial wound with nonviable skin and subcutaneous tissues .sacral decubitus wound with clean healthy base, no sign of infection . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. Building B. Wing	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Village Care	136 Davis Lane Lafollette, TN 37766

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the regional hospital discharge records showed Resident #3 was discharged home to the care of a significant other, with outpatient follow-up on 12/16/2023, after post-operative care, which included completion of antibiotic therapy, wound care and additional wound and general medical consultations. Interview with LPN #12 (the wound treatment nurse) on 2/2/2023 at 11:30 AM in the conference room revealed LPN #12 reported he performed sacral wound care on Resident #3, five consecutive days before discovery of the bilateral ischial tuberosity wounds. LPN #12 reported Resident #3 was frequently noncompliant with pressure offloading interventions and frequently required multiple sacral wound dressing changes in the same day due to fecal incontinence and at times also refused timely incontinence care which contributed to the onset of skin breakdown. LPN #12 did not recall if he performed PRN dressing changes on Resident #3 when asked. When asked why medical records reviewed did not reflect him performing dressing changes as he reported, based upon the only documents presented to the surveyor which were weekly wound assessments, one of which bore his electronic signature, LPN #12 reported though he frequently performed treatments on Resident #3, he had not documented them in the electronic records. When asked to explain why, LPN #12 reported the laptop he used to document care had broken, and not been replaced by the facility, then reported he used the nursing station computers or computers located off the clinical units to document care. When asked again why then were there no written records of him providing daily wound care in the skilled nursing notes reviewed as he stated he performed, LPN #12 reported frequently he would perform the treatments and then rely upon floor nursing staff to document the care. LPN #12 reported he performed daily treatments for Resident #3 on the sacral wound and insisted no skin breakdown was present in the area of her lower gluteal region until 11/28/2022. The photos of Resident #3's wounds were reviewed with LPN #12 on the conference room computer. LPN #12 reported the new lesions identified appeared to have occurred in areas of scarring caused by prior pressure ulcers. The photos bore this out. When asked why this wasn't documented in the initial wound assessments or any other place in the facility electronic records, and why there was no documentation present by floor nurses indicative of monitoring Resident #3's wounds or documenting PRN dressing changes, LPN #12 had no explanation. LPN #12 reported he did not mark off treatments as completed on the TARS, as that was the floor nurse responsibility. LPN #12 reported on days he performed wound treatments for Resident #3, floor nursing staff marked off the TAR themselves despite not observing the wounds/treatments themselves. Interview with Registered Nurse (RN) #20, the unit manager, on 2/2/2023 at 2:05 PM in the conference room revealed she was familiar with Resident #3 and her case history. RN #20 reported she provided wound care a couple of times to Resident #3 but could not recall exactly when. RN #20 reported nursing staff were expected to chart changes in wound conditions on the daily skilled notes, and mark off TARS when care was given, but did not recall if any narrative charting due to changes in condition was performed for Resident #3. The unit manager reported the facility electronic record keeping system had a component integrated within it which allowed staff to photograph wounds and note care provided, and this was done when changes in wounds occurred routinely. RN #20 could not recall any reports of changes in Resident #3's wound status before 11/28/2022. RN #20 reported to her knowledge no clinical staff (CNAs or Licensed Nurses) had reported deterioration of Resident #3's wounds prior to transfer to the hospital and stated had she been aware of that situation she would have informed the Physician or Nurse Practitioner herself. RN #20 reported she was aware of Resident #3's noncompliance with pressure reduction strategies and ADLs but did not recall assessing Resident #3's gluteal region or sacral wound in the days immediately before Resident #3 was hospitalized or reporting any concerns to the Nurse Practitioners herself. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) and review of the facility medical records on 2/4/2023 at 11:45 AM in the conference room, revealed the DON confirmed the facility nursing documentation on Resident #3's wounds and wound treatments provided did not adhere to the facility wound care policy. The DON agreed it was unlikely that wounds such as the ones identified on Resident #3's ischial tuberosities could have emerged overnight with no indicators of looming skin breakdown beforehand, given Resident #3's noncompliance with offloading interventions as LPN #12 stated in his interview. Continued interview revealed the DON confirmed there were no other electronic records available which indicated floor staff had assessed and documented the appearance and condition of the wound themselves as required in the facility policy, and additional copies of staff activity sheets made after 11/24/2022 to document Resident #3's noncompliance had been lost and were not recoverable. The DON confirmed the facility failed to follow its wound care policy related to Resident #3, and confirmed the facility wound documentation as presented to the surveyor was inadequate to assert compliance or Resident #3's new pressure ulcers were clinically unavoidable. Interview with NP #1 on 2/5/2023 at 11:05 AM in the conference room revealed NP #1 reported she relied on facility nursing notes and reports from staff to remain updated on resident conditions and needs for evaluation. NP #1 reported facility staff had not reported concerns with Resident #3's skin integrity or changes in her sacral wound status to her when she evaluated Resident #3 for symptoms of upper respiratory infection several days prior to her hospitalization . NP #1 reported she always followed-up on changes in condition in residents when they were reported and stated had concerns with Resident #1's skin integrity or compliance issues been reported to her, she would have personally assessed her wounds and attempted to intervene by educating Resident #3 herself on the need for compliance with offloading and ordering additional treatments to prevent skin breakdown. Interview with NP #2 (the admitting NP who assessed Resident #3 on admission with the wound nurse) on 2/5/2023 at 12:00 PM in the NP office, revealed she too reported facility staff had not informed her of any concerns with Resident #3's compliance with wound care modalities, offloading, or skin integrity prior to her development of new pressure ulcers on 11/28/2022. NP #2 stated she too relied on the facility electronic nursing records and reports from staff prior to every evaluation to determine areas of focus for each examination. NP #2 reported the facility wound care staff had not reported concerns with Resident #3 and no indicators of persistent compliance issues were present in the nursing notes she reviewed before each visit with Resident #3. NP #2 reported had she been aware of Resident #3's noncompliance with offloading and ADLs, she too would have attempted to intervene. When asked if Resident #3's ischial wounds were clinically unavoidable, NP #2 reported in her professional judgment they were not unavoidable. NP #2 reported during the initial wound evaluation she performed on 11/16/2022, in the presence of the wound nurse, she did not detect any signs of skin deterioration near the sacral wound and noted the abrasion to Resident #3's posterior left thigh was healing normally at the time and reported Resident #3 had no signs of skin breakdown near her gluteal region.