STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. Building B. Wing	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Center	20 Westwood Medical Park Bluefield, VA 24605

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 28169 Based on staff interview and facility document review, the facility staff failed to assist the resident representative to transfer the resident to a facility of their choice for 1 of 33 residents in the survey sample, Resident #199. The findings were: The facility staff failed to assist the resident's representative with transferring Resident #199 to a nursing home in [NAME] Virginia per their preference. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use. The clinical record contained a document titled, Physician Determination of Capacity which the resident's attending physician signed indicating the resident lacked sufficient mental or physical capacity to appreciate the nature and implications of health care decisions. The document was dated 01/20/22. A grandchild was listed as Emergency Contact #1 and POA - medical (power of attorney - medical) on the admission record. The resident's daughter was listed as Contact #2. Under the assessments within the clinical record, a document titled Post Admission Patient-Family Conference - V 3 with an effective date of 12/17/21 was reviewed. The document was completed by one of the facility's social services employees. Within the Expectation portion of the document, it read the resident/resident representative would like to see if a contracted Veteran's Administration (VA) Long Term Care placement would be available and if not, they would like placement in a [NAME] Virginia skilled nursing home. The next social services assessment and documentation found in the clinical record was dated 01/13/2022 and read within the discharge planning/social service plan that social services would assist the family with their preference of transferring the resident to a facility in [NAME] Virginia, preferably a VA contract facility. Resident #199 remained in the facility until being transferred to an acute care hospital approximately three (3) months after admission. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator was notified of clinical record findings during an in-person interview in her office on 3/14/23 at 1:15 p.m. The surveyor requested to speak with the social services employee involved with Resident #199. The administrator reported that social worker was no longer employed at the facility but would have her call the surveyor if possible. The facility's current social worker was not employed at the facility during Resident #199's stay. On 3/20/23, the administrator provided an email from the facility's social worker to a [NAME] Virginia nursing home which read the social worker was following up on a referral request. The email was dated 2/21/22 and indicated the [NAME] Virginia nursing home had not received any earlier referral and had been having difficulties with their faxes. The social worker (SW - not a current facility employee) who completed the Post Admission Patient-Family Conference was interviewed via phone on 3/16/23 at 2:56 p.m. At the time of Resident #199's admission, her sole responsibility was to complete the Post Admission document. She recalled finding out the resident was not service - connected enough to be in a Veteran's Administration facility. She reported that after the resident became Covid positive on 1/25/22, he could not be transferred for 20 days. When asked why a transfer was not facilitated between his admission and becoming Covid positive (over 6 weeks), she reported that a different social worker had the primary responsibility for the facility residents' social service needs during that time. That social worker was not currently employed at the facility and could not be interviewed. These findings were discussed with the administrator in the conference/family room on 03/19/23 in the afternoon.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22218 Based on staff interview and clinical record review, facility staff failed to initiate a care plan within 48 hours that addressed the resident's clinical needs for 2 of 33 residents, Resident #36 and #149 1. For Resident #36, facility staff failed to implement a baseline care plan to address the resident's needs as evidenced by failure to address surgical wounds on the care plan within 48 hours of admission. Resident #36 was admitted to the facility with diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, morbid obesity, obstructive sleep apnea,muscle weakness, hypertensive heart and chronic kidney disease with heart failure, local infection of the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus infection, chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, sepsis due to escherichia coli, and bacteremia. On the minimum data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status, and was assessed as being without signs of delirium, psychosis, or behaviors affecting care. The surveyor interviewed the resident on 3/12/23 concerning life in the facility. The resident had no complaints. When questioned about wound care (the right lower leg ended in a stump covered with a sock) the resident said staff usually changed the dressing on the leg wound daily. Clinical record review revealed two recent hospitalization s with wound infections: 12/2722 through 1/3/23 and 1/14 through 1/20/23. Prior to the hospitalization on [DATE], clinical record review revealed A physician order dated 11/7/22 through 1/3/23 for Cleanse area to right stump with WC/VASHE. Apply xeroform, then cover with border foam every day shift Tue, Thu for wound care. The treatment was not documented as completed 12/1, 6, 8,13,15, and 22. The resident was hospitalized for sepsis and right below the knee amputation infection on 12/27. The resident was hospitalized [DATE] through 1/3/23. Per the hospital discharge, the resident was admitted with sepsis, right BKA (below knee amputation) infection, fever, and more. The surgeon assessed the right BKA wound and determined there was no need for surgical intervention. Dressings continued per surgeon orders. On 1/3/23, the resident returned to the facility. No orders for wound care were entered in the system. Nursing documentation included no skin assessments from 12/28/22 through 1/20/23. The resident was hospitalized from 1/14/23 through 1/20/23. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility nursing note dated 1/20/23 documented]Note: Resident returned via non-emergent BLS ambulance service. Resident is awake, alert, oriented, and able to make his needs known per his usual. A double lumen PICC line is in place in right upper arm. Resident will be receiving IV Invanz and Zyvox by mouth for VRE and Proteus bacteremia. Resident's buttocks are reddened, but blanchable, and dressing over RLE/foot amputation site is CDI. Enhanced barrier precautions are in place, and staff is aware of the need to glove and gown before providing care, and resident is aware that he needs to sanitize his hands before leaving his room, and notify the nurse if his dressing becomes soiled or loose while he is out of his room. No orders for wound care/dressing changes were entered in the system at the time of return from the hospital. An order was entered dated 1/24/23 for Cleanse wound to RLE with IHWC (in house wound cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage every day shift for wound healing. Wound care was not documented as completed on 1/25, 26, 28, and 29. The resident's comprehensive care plan did not address not address actual skin integrity intervention to monitor wound for worsening signs of infection and notify PCP until a revision on 1/26/23. There was no evidence of care plan revision as the resident was hospitalized with infections and experienced surgical interventions to treat wounds and wound-related infections. The most recent intervention revision was provide treatment as ordered dated 7/1/22. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. There was no mention of initiating or revising the resident's comprehensive care plan. The surveyor notified the administrator and director of nursing during a summary meeting on 3/20/23 that the baseline care plan did not provide enough information for staff to provide wound care and monitoring for the first 6 days in the facility. 2. For Resident #149, facility staff failed to initiate a baseline care plan to include the minimum healthcare information necessary to care for a resident as evidenced by absence of surgical wound treatment on the baseline care plan. Resident #149 was admitted to the facility with primary diagnosis encounter for orthopedic aftercare following surgical amputation. Secondary diagnoses included diabetes mellitus due to underlying condition with diabetic nephropathy, atrial fibrillation, hypertensive heart disease with heart failure, asthma, infection following a procedure-superficial incisional surgical site-subsequent encounter, muscle weakness, and difficulty walking. On the admission minimum data set assessment (MDS) with assessment reference date 1/19/2023, the resident scored 13/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The MDS also documented the resident had surgery during the prior 100 days, recent surgery requiring SNF care, infection of the foot, surgical wounds, and surgical wound care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's comprehensive care plan documented under Focus: Actual skin impairment R/T (related to) surgical amputation of toes to right foot .is at risk for complications R/T said amputations (revised 1/24/23 by DON the surveyor requested history of changes, but did not receive it prior to the end of the survey) Interventions initiated 1/14/23: Weekly skin check, Dressing changes will be provided per PCP orders, obtain skilled PT/OT evaluation, and dietician consult as needed. Dressing changes were not initiated until 1/19/2023. A family nurse practitioner (FNP) note dated 1/16/23 indicated an acute visit for follow-up foot pain after amputation of toes on right foot. FNP plan was to continue current pain regimen and for wound of right foot -Follow-up with surgeon on wound orders. A FNP note dated 1/18/23 indicated an acute care visit at the request of the family and nursing to address right foot pain and reported vivid dreams and hallucinations. The FNP noted personally calling the surgeon's office to obtain wound care orders. New orders written for Neurontin for pain; laboratory testing for infection or chemical imbalances, wound dressing changes and intramuscular antibiotic rocephin for 3 days. The resident's Treatment Administration Record (TAR) documented an order to Cleanse Right Foot, surgical site, with warm soap & H2O. Pat Dry. Cover with sterile dry dressing every day shift (12 hour 6 A) for wound care. The treatment was documented as administered 1/19, 1/20, 1/21, 1/22, 1/24, and 1/25. The nurse, LPN #5 was unavailable for interview to determine whether the 1/23 treatment was performed. Per the facility record, the resident was sent to the hospital on 1/25/23 and was admitted for complications after amputation. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. The surveyor spoke with the FNP on 3/20/23 concerning the resident's wound care and infection. The FNP stated that the wound care nurse was instructed to call the physician for wound orders on 1/16/23. The FNP called the surgeon on 1/18/23 because the resident still had no wound or dressing orders. The FNP stated that failure to perform dressing changes could contribute to infections. The surveyor notified the administrator and director of nursing during a summary meeting on 3/14/23 that the baseline care plan did not provide enough information for staff to provide wound care for the first 6 days in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview, clinical record review, facility document review, the facility staff failed to review and revise the comprehensive person-centered plan of care for 1 of 33 residents in the survey sample, Resident #299. The findings included: For Resident #299, the facility staff failed to revise the comprehensive person-centered plan of care following the development of a pressure injury. This was a closed record review. Resident #299's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Aftercare following Joint Replacement Surgery, Dislocation of Internal Right Hip Prosthesis, Chronic Obstructive Pulmonary Disease, Unspecified Dementia, and Type 2 Diabetes Mellitus. The admission minimum data set (MDS) with an assessment reference date (ARD) of 10/25/22 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired. The resident was coded as being at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. Resident #299 was coded for the presence of a surgical wound and moisture associated skin damage (MASD). A review of Resident #299's clinical record revealed a nursing progress note dated 10/23/22 at 11:00 am which stated in part . Stage 3 noted to coccyx. Pt [patient] states 'yeah, it's sore'. Orders placed . A new physician's order to cleanse coccyx with wound cleanser, pat dry, apply zguard, place non-adhesive optifoam on every 3 days or as needed was started on 10/24/22. Surveyor was unable to locate documentation describing the area to the coccyx when noted on 10/23/22. Resident #299 was seen by the family nurse practitioner (FNP) on 10/24/22, the progress note stated in part . Wound care to buttocks per stage 2 protocol. Dr. [name omitted] consult for stage 2 wound with slough to buttocks . This Surveyor was unable to locate any subsequent documentation of the area to the coccyx until 11/01/22 at which time the wound was photographed, measured, and assessed. At that time the area was documented as an unstageable pressure area to the sacrum measuring 9.15 cm in length and 4.91 cm in width with 100% slough. This Surveyor reviewed Resident #299's comprehensive person-centered plan of care and was unable to locate documentation of a pressure injury to the resident's coccyx/buttocks/sacral area. The plan of care included a focus area stating resident has excoriation to coccyx related to decreased activity and intermittent incontinence of bowel and bladder created on 10/18/22. According to the clinical record, Resident #299 was admitted to the facility on [DATE] and the nursing admission assessment entitled Nursing Documentation - V 11 dated 10/18/22 at 11:07 pm documented the presence of moisture associated skin damage (MASD) to the coccyx. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/23 at 9:55 am, surveyor spoke with the Clinical Reimbursement Coordinator (CRC) regarding Resident #299's plan of care. Surveyor informed the CRC they were unable to locate documentation of the pressure injury on Resident #299's plan of care. CRC reviewed the resident's plan of care and stated, it's not on here anywhere. This Surveyor asked the CRC if the pressure area should have been on the plan of care, and they stated it probably should have been updated. Surveyor asked the CRC how they were notified when a plan of care needed to be revised and they stated staff talk about changes during morning meetings and care plans are reviewed during the MDS review. Surveyor requested and received the facility policy entitled Skin Integrity and Wound Management which read in part .The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed .11. Review care plan and revise as indicated . On 3/20/23 at 2:57 pm, the survey team met with the administrator, director of nursing, and the market clinical lead and discussed the concern of staff failing to revise Resident #299's comprehensive person-centered plan of care to reflect the development of an unstageable pressure injury. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/20/23.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34307 Based on observation, staff interview, resident interview, family interview, clinical record review, facility document review, the facility staff failed to provide wound management as evidenced by the absence of assessments, monitoring, and/or treatment for of 5 out 33 residents. This resulted in wound infections and/or wound deterioration for Resident #10, Resident #4, Resident #42, Resident #36, and Resident #149. The facility also failed to implement provider orders at the time they were ordered for 1 of 33 residents reviewed, Resident #199. On 3/15/23 at 3:50 PM, the surveyors notified the facility of the Immediate Jeopardy determination, Level IV Pattern. The facility staff implemented an abatement plan that was verified by the survey team through additional observations, interviews, and document reviews. The facility staff was notified that the Immediate Jeopardy was removed on 3/17/23 at 4:09 PM. The findings included: 1. For Resident #10 the facility staff failed to provide wound management resulting in a wound infection. Resident #10's face sheet listed diagnoses which included but not limited to anemia, chronic obstructive pulmonary disease, dementia, basal cell carcinoma of skin, and hypertension. Resident #10's most recent minimum data set with an assessment reference date of 02/07/23 coded the resident as 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section M, skin conditions, subsection M1040, Other Ulcers, Wounds, and Skin Problems coded the resident as having open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion). Resident #10's comprehensive care plan was reviewed and contained a care plan for Resident at risk for skin breakdown r/t (related to) decreased mobility, incontinence, fragility of skin, oxygen use . Interventions for this care plan include Observe skin condition daily with ADL's (activities of daily living) and report abnormalities, provide wound treatment as ordered, and weekly skin checks by license nurse. Resident #10's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part Cleanse growth the center of back with Dakin's solution, pat dry, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing, change BID (twice a day) and PRN (as needed) every day shift for wound care and Cleanse scalp wound (exposed skull) with soap and water, cleanse periwound with Dakin's solution, pat dry, apply TAO to irritated periwound and cover entire scalp wound with dry dressing BID and PRN every day and night shift for wound care. Resident #10's treatment administration record (TAR) for the month of March 2023 was reviewed and contained entries as above. The entry for Cleanse growth to center of back . only had one section for initials on the TAR. These entries were initialed as being completed as ordered. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This surveyor observed Resident #10 on 03/12/23 at 3:30 pm. Resident was resting in bed; no dressing was observed in place to scalp wound. Exposed skull was observed by surveyor. Resident #10's clinical record contained a Physician's Telephone Order form dated 02/06/23, which read in part Keflex 500 mg TID (three times a day)-wound infection top of head x 10 days. This surveyor, along with licensed practical nurse (LPN) #1 and certified nurse's aide (CNA) #1 observed Resident #10 on 03/13/23 at 1:00 pm. Surveyor observed dressing in place to resident's scalp at this time. CNA #1 and LPN #1 rolled resident onto side, and surveyor observed dressing in place to lesion on resident's upper back. Surveyor asked LPN #1 if dressing had a date on it, and LPN #1 first stated that it did not, then stated Oh, yeah, it does. Surveyor asked LPN #1 what the date on the dressing was, and LPN #1 stated March 9th. Surveyor requested to see the dressing once it was removed and observed the date on the dressing to read 03/09/23 7a-7p along with initials. When LPN #1 removed the dressing from Resident #10's wound, surveyor observed moderate amount of drainage both on the dressing and wound bed. Dressing had a dark brown ring, with drainage in the center of the ringed area. Surveyor asked LPN #1 to describe the wound, and LPN #1 stated greenish-brown, foul-smelling discharge. LPN #1 stated to the surveyor that, according to the date on the dressing, that it appeared that 7 dressing changes have been missed to resident's back lesion. Surveyor asked LPN #1 if lesion had worsened since they last observed it, and LPN #1 stated, It definitely has more drainage. LPN #1 removed the dressing from resident's scalp and stated to surveyor that scalp wound was not supposed to have a dressing on it. This Surveyor observed scant amount of greenish discharge on scalp dressing. LPN #1 later informed surveyor that Resident #10 should have a dressing on scalp lesion. Review of Resident #10's clinical record revealed that resident was placed on oral antibiotic for wound infection starting 03/14/23. This surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #10's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident receiving wound care. This surveyor reviewed Resident #10's clinical record and could not locate any wound assessments, including measurements, description of wounds, or skin assessments. The survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. DON stated that weekly skin assessments were to be performed on all residents and recorded in clinical record. This Surveyor reviewed Resident #10's clinical record and could not locate any skin assessments. The survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing wound management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. For Resident #4 the facility staff failed to provide wound management which resulted in the resident being treated for a wound infection. Resident #4 was admitted the facility on 02/13/21 and readmitted on [DATE]. Resident #4's face sheet listed diagnoses which included but not limited to multiple sclerosis, depression, anxiety, and contractures of muscles. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 02/06/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section M, skin conditions, coded the resident as having one stage 1 pressure ulcer that was present upon admission. Section M, subsection M1040, other ulcers, wounds and skin problems coded the resident as none of the above present. This subsection includes surgical wounds. Section M of Resident #4's admission MDS with an ARD of 02/20/21 coded the resident as having one stage III pressure ulcer present upon admission, one stage IV pressure ulcer present upon admission and one unstageable pressure ulcer present upon admission. Resident #4's comprehensive care plan was reviewed and contained a care plan for Resident at nutrition risk r/t (related to) . Wounds: Surgical PI Open wound to Rt. (right) hip skin fold, healing. PI Rt. Heel . and . is at risk for continuing impaired skin integrity related to diagnosis of MS (multiple sclerosis), impaired mobility . Type: Pressure ulcers. Interventions for both care plans included Provide wound treatment as ordered and Labs per orders. This Surveyor spoke with Resident #4 on 03/12/23 at 3:10 pm. Resident stated they have wounds to right hip and heel and that wound care is supposed to be done twice a day, but there are some nurses that don't do it. Resident #4 stated, I'm lucky if they do it once a day. Resident #4 was concerned that wound care was not being done as ordered. Surveyor spoke with Resident #4 on 03/13/23 at 11:30 am, and asked resident if their wound care had been completed, and resident stated, the dressing was changed yesterday (03/12/23) around lunch time and hasn't been changed since. This Surveyor, along with licensed practical nurse (LPN) #1 and certified nurse's aide (CNA) #1 observed Resident #4's dressing on R hip wound on 03/13/23 at 11:45 am. When CNA #1 rolled resident over, and dressing became visible, CNA #1 stated to LPN #1, it (dressing) don't have a date on it. Surveyor asked LPN #1 if dressing should be dated, and LPN #1 stated that it should be. Surveyor observed that dressing was not dated. LPN #1 removed the dressing, and stated, well, that tells me it's not been changed. Surveyor asked LPN #1 how they could tell dressing had not been changed, and LPN #1 stated by the color of the gauze and the amount of drainage on the dressing. Resident #4's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part Cleanse post-surgical wound to right hip with Dakin's solution, pat dry, apply collagen powder to wound bed, cover with calcium alginate and secure with dry dressing BID (twice a day) every day and night shift for Wound Right Hip Order Date 02/28/2023 Start Date 02/28/2023 and Wound(s): Monitor site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), If applicable, Additional Documentation in NN (nurse's notes) as needed every day shift. Order Date 03/12/2023. Start Date 03/13/2023. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #4's TAR for the month of March 2023 was reviewed and contained entries which read in part, Cleanse post-surgical wound to right hip with Dakin's solution, pat dry, apply collagen powder to wound bed, cover with calcium alginate and secure with dry dressing BID (twice a day) every day and night shift for Wound Right Hip. Order Date 02/28/2023. Start Date 02/28/2023, Cleanse are to right heel with IHWC. Apply betadine, let dry and apply skin prep every night shift for wound care and Wound(s): Monitor site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), If applicable, Additional Documentation in NN (nurse's notes) as needed every day shift. Order Date 03/12/2023. Start Date 03/13/2023. These entries were initialed as having been completed for all ordered times. This Surveyor reviewed Resident #4's clinical record from January to present for documentation of wound treatment provided to the right hip, right heel, and healing progress of the wounds. Resident #4's clinical record contained an Acute Care summary form dated 01/25/23, which read in part Chief complaint/Nature of Presenting Problem: Follow-up wounds. Location: Right hip fold. Duration: Chronic. Modifying Factors: Culture done and results pending. Quality: Stable. Review of Systems Skin: Open wound to right hip skin fold. Physical Exam Skin: Wound to right hip skin fold is tender to touch. There is yellow/white drainage to wound, and a foul odor is noted. Optifoam patch in place. Labs/Radiology/Tests. Labs: Wound culture has been collected and results pending per nursing. No results received today. Diagnosis, Assessment and Plan: .Open wound of right hip. Continue current wound treatment. This was signed by the family nurse practitioner (FNP). Resident #4's clinical record contained a physician's telephone order form dated 01/30/23, which read in part (1) Culture R (right) hip wound-redness, drainage, foul odor (2) After culture, start Bactrim DS-1 tab PO (by mouth BID (twice daily) x 10 days wound infection. This order was signed by the FNP. Resident #4's clinical record contained a laboratory report dated 02/10/23 for wound culture which indicated the presence of Proteus mirabilis, a gram-negative bacterium. Resident #4's treatment administration record (TAR) for the month of January 2023 was reviewed and contained and entry which read in part, Cleanse right hip with IHWC (wound cleanser), pat dry, apply Maxsorb, and place Optifoam on wound every night shift for wound healing. This entry had a start date of 01/30/23 listed and was initialed as being completed. There were no previous wound care orders related to right hip noted on this TAR. The TAR for January also contained entries which read in part Cleanse area to right heels with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam) gauze or optifoam for cushion. every day shift Mon, Wed, Fri, Sun for wound care-start date-01/04/2023, -D/C (discontinue) date-02/02/2023, Cleanse area to right heel with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam for cushion. every night shift for wound care-start date-01/30/2023, -D/C date-02/09/2023 and Wound(s): Monitor site(s) daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), if applicable, every day shift. The treatment to the heel wound was not initialed as completed on 01/02, 01/03, 01/06, 01/15, 01/18, and 01/23. Resident #4's TAR for the month of February was reviewed and contained entries which read in part, Cleanse right hip surgical wound with Dakin's solution, pat dry. Apply skin prep to peri-wound. Wet-to-dry dressing using Dakin's to wound bed. Secure with dry dressing. two times a day for wound healing-Start Date-02/09/2023 2000 -D/C Date-02/27/2023 2000, not initialed as completed on 02/18/23 at 8 pm. The TAR for February did not contain any entry for wound monitoring. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The TAR for February also contained entries which read in part, Cleanse area to right heel with IHWC. Apply 4 x 4 boarder (sic) gauze or optifoam for cushion. every night shift for wound care-start date-01/30/2023, -D/C date-02/09/2023 and Cleanse area to right heel with IHWC. Apply betadine, let dry and apply skin prep every night shift for wound care. This treatment was not initialed as completed on 02/18/23. Resident #4's clinical record contained a physician's telephone order form dated 02/16/23, which read in part (1) Rocephin 1 gm I.V. q (every) day (2) Repeat wound culture x 7 (3) [NAME] consult wound vac R hip. This order was signed by the physician. Resident #4's clinical record also contained a physician's order summary for the month of February 2023, which read in part Culture wound to Right hip one time only for Wound Infection for 1 day This order had a start date of 02/25/23. Surveyor could not locate results of this wound culture. This Surveyor spoke with the assistant director of nursing (ADON) on 03/17/23 at 12:50 pm regarding Resident #4's wound cultures. ADON stated the culture order on 01/30/23 was collected 3 times, and when the lab was contacted for results, they were told the lab did not have a specimen. ADON stated they could not locate results for culture ordered to be done on 02/25/23. This Surveyor spoke with medical technician (MT) at the contracted lab on 03/20/23 at 10:15 am regarding Resident #4's wound cultures. MT stated that the only wound culture orders and specimens they had received were on 01/17/23 and 02/10/23. MT stated they had received no other orders or specimens for wound cultures for Resident #4. This Surveyor spoke with FNP on 03/20/23 at 1:25 pm. Surveyor asked FNP when they expected the wound culture ordered on 01/30/23 to be done, and FNP stated they expected it to be done on the order date. FNP said when they asked about the results, couple of nurses stated they had done it and lab lost it. Surveyor asked FNP if they expected the repeat wound culture to have been done, and FNP stated they did. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. This Surveyor spoke with the ADON on 03/14/23 at 10:50 am regarding Resident #4's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per director of nursing (DON), facility policy did not state that dressings needed to be dated. This Surveyor requested and was provided with a facility policy entitled Wound Dressings: Aseptic which read in part, 2. Gather supplies: 2.7 Prepared label or secondary dressing with date and initials. 27. Apply prepared label. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what apply prepared label meant, and DON stated they did not know. Surveyor asked DON if Resident #4's hip wound was pressure related and DON stated that Resident #4's hip wound was surgical rather than pressure. Surveyor asked DON what type of surgery the resident had had to the hip and DON stated, Looks to me like he/she has had a hip replacement at some point. He/She has about an 18 scar on that hip. This Surveyor reviewed Resident #4's clinical record and could not locate any wound assessments, including measurements or description of wounds. This Surveyor requested and was provided with Skin Integrity Report forms, which were contained in a notebook housed in the DON's office. The Skin Integrity Report forms for Resident #4 indicated that wound to right hip was both pressure and surgical. The form did not indicate an initial wound date and contained measurements beginning on 01/30/23 and continuing weekly until 03/08/23 that indicate the wound is decreasing in size. A second form with an initial wound date of 02/09/23, indicated a pressure area to right heel, staged as a deep tissue injury. Wound was marked as in-house acquired, with measurements beginning on 02/09/23 and continuing weekly through 03/09/23. These measurements indicate no change to wound. This Surveyor requested evidence that Resident #4's hip wound was surgical rather than pressure and was provided with a surgical consult form which read in part Appt. Date/Time 02/26/2021. Chief Complaint: Skin lesion. HPI (history of present illness): Patient has bilateral hip decubitus ulcers that are necrotic. He/She needs debridement of both. He/She also has been noted to be anemic with hemoglobin in the eight. We will admit him/her to outpatient surgery for transfer transfusion before morning debridement. Plan transfer back to nursing home after surgery. Probable wound VAC application. Patient has severe lower extremity contracture secondary to advanced MS. The concern of not providing wound management for Resident #4 was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 3. For Resident #42 the facility staff failed provide wound management, resulting in a wound infection. Resident #42's face sheet listed diagnoses which included but not limited to hypertensive heart disease, heart failure, chronic kidney disease, type 2 diabetes mellitus, peripheral vascular disease, and anxiety. Resident #42's most recent minimum data set with an assessment reference date of 02/04/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. Section M, skin conditions coded the resident as having five stage II pressure ulcers that were present upon admission, and no other skin conditions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #42's comprehensive care plan was reviewed and contained a care plan for Resident has actual skin breakdown related to top of right foot, right heel, left upper buttocks, left lower buttock, right buttock, coccyx, and sacrum related to decreased activity, incontinence. Interventions for this care plan included Observe skin for signs/symptoms of skin breakdown, provide wound treatment as ordered, weekly skin checks by licensed nurse, and weekly wound assessment to include measurements and description of wound. Resident's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part . consult for necrotic wound to R ankle. Needs to be done as soon as possible, Cleanse area to top of right foot with Dakin's solution, 25%, pat dry. Apply Santyl on nonstick pad to wound bed. Cover with dry dressing daily and prn (as needed) every day shift for wound care, Cleanse stage 3 PU (pressure ulcer) to L (left) lower buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID (twice a day) and PRN every day and night shift for wound care, Cleanse stage 3 PU to L upper buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse stage 3 PU to R buttocks with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse unstageable PU on coccyx with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse unstageable PU to center sacrum with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 10 days, Cleanse unstageable PU to R heel with Dakin's solution, pat dry, apply skin prep to periwound, apply Santyl on nonstick pad and secure with dry dressing BID and PRN every day and night shift for wound care for 14 days, and Bactrim DS oral tablet 800-160 mg (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth one time a day for wound infection for 14 days. Resident #42's clinical record contained a Physician's Telephone Orders form dated 02/27/23, which read in part (1) DC (discontinue) Macrobid. (2) Bactrim DS 1 tab PO (by mouth) BID (twice a day) x 10 days-wound infections R ankle, foot. This order was signed by the family nurse practitioner (FNP). Resident #42's treatment administration record (TAR) for the month of March 2023 was reviewed and contained entries as above. Each of these entries had not been initialed as completed on two separate occasions. Resident #42's February 2023 TAR contained entries, which read in part Cleanse area to right heel with IHWC (wound cleanser), pat dry and apply bordered foam dressing every day shift for open area, Cleanse area to right posterior thigh with IHWC, pat dry, and apply 4 x 4 bordered foam dressing every day shift for open area, Cleanse top of right foot with IHWC, pat dry, and apply bordered foam dressing every day shift for abrasion, and Cleanse area to coccyx with IHWC, pat dry, and apply bordered foam dressing every day shift for open area. Each of these entries had not been initialed as completed on three separate occasions. This Surveyor, along with licensed practical nurse (LPN) #1 observed Resident #42's dressings to sacrum, coccyx, and buttocks on 03/13/23 at 2:30 pm. Dressing to sacrum did not have a date on it. Dressings to resident's foot, heels, and ankles all had dates and initials. LPN #1 stated they had completed wound care to these area's earlier in the day. Surveyor asked LPN #1 how they knew when the dressings to the sacral area had last been changed, and LPN #1 stated that without a date, there was no way to know when wound care was last completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #42's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per DON, facility policy did not state that dressings needed to be dated. This Surveyor requested and was provided with a facility policy entitled Wound Dressings: Aseptic which read in part, 2. Gather supplies: 2.7 Prepared label or secondary dressing with date and initials. 27. Apply prepared label. The Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what prepared label meant, and DON stated they did not know. This Surveyor requested and was provided with Skin Integrity Report forms, which were contained in a notebook housed in the DON's office. This notebook contained six forms for Resident #42, which addressed unstageable pressure areas to right heel, right achilles, sacrum/coccyx, right buttock, left outer thigh/lower buttock and a stage II pressure areas to upper left buttock. Each of these areas were marked as present upon admission, with weekly measurements beginning on 02/01/23 and continuing through 03/14/23. These measurements indicated the right heel wound was unchanged, right achilles wound had decreased from 2.5 cm x 1.7 cm to 2.1 cm x 1.3 cm, sacram/coccyx wound had decreased in length from 2 cm to 1 cm, but increased in width from 1 cm to 2.6 cm and went from a depth of 0 to .25 cm. Right buttocks wound decreased in length from 1 cm to 0.8 cm, and increased in width from 0.5 cm to 0.6 cm, and went from a depth of 0 to 0.25 cm. Right outer thigh wound decreased in length from 2 cm to 1.4 cm, and increased in width from 1 cm to 1.5 cm, anad went from a depth of 0 to .25 cm. Left buttock wound decreased in length from 2 cm to 1.8 cm, increased in width from 1.5 cm to 1.7 cm, and went from a depth of 0 to 0.25 cm. Two surveyors, along with LPN #1 observed Resident #42's wounds on 03/14/23 at 4:45 pm. LPN #1 stated that areas to the top of resident's right foot and right ankle/lower leg were arterial rather than pressure. Resident's right heel had dark brown eschar and LPN #1 stated that area was unstageable pressure ulcer. Areas to resident's sacral area (sacrum, coccyx, buttocks) were red with slough present in wound bed. This Survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing wound management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 22218 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. For Resident #36, facility staff failed to provide ordered wound care to promote healing. Resident #36 was admitted to the facility with diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, morbid obesity, obstructive sleep apnea, muscle weakness, hypertensive heart and chronic kidney disease with heart failure, local infection of the skin and subcutaneous tissue, methicillin resistant staphylococcus aureus infection, chronic obstructive pulmonary disease with acute exacerbation, atrial fibrillation, sepsis due to escherichia coli, bacteremia. On the minimum data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. This surveyor interviewed the resident on 3/12/23 concerning life in the facility. Clinical record review revealed two recent hospitalization s with wound infections: 12/27/22 through 1/3/23 and 1/14 through 1/20/23. Prior to the hospitalization on [DATE], clinical record review revealed A physician order dated 11/7/22 through 1/3/23 for Cleanse area to right stump with WC/VASHE (wound cleanser). Apply xeroform, then cover with border foam each day shift Tue, Thu for wound care. The treatment was not documented as completed 12/1, 12/6, 12/8, 12/13, 12/15, and 12/22. The resident was hospitalized for sepsis and right below the knee amputation infection on 12/27. A nursing progress note dated 12/26/22 stated Note: Resident noted to have scab on LLE front lower area. Redness, swelling and pain surrounding scabbing with bleeding present. This nurse contacted Dr. with new orders: 1) Culture wound in AM 2) CBC (complete blood count) and BMP (basic metabolic panel) 3) Keflex PO BID x 7 days. The most recent prior mention of the wound was a nursing progress note dated 12/21/22: The following skin injury/wound(s) were previously identified and were evaluated as follows: Other(s): Description: diabetic ulcer to right posterior calf. Another note dated 12/21/22 - Late Entry: Note: An improving diabetic wound in-house acquired Location: Right Calf was assessed today. Prognosis: Monitor/Manage: Wound healing not achievable due to untreatable underlying condition. Resident/Responsible Party Notified: 1 The practitioner has been notified: 1. A third note dated 12/21/22 Note: A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Pressure Area(s): Location(s): Diabetic wound to right stump. TX in place. The resident was hospitalized [DATE] through 1/3/23. Per the hospital discharge, the resident was admitted with sepsis, right BKA (below knee amputation) infection, fever, and more. The surgeon assessed the right BKA wound and determined there was no need for surgical intervention. Dressings continued per surgeon orders. On 1/3/23, the resident returned to the facility. No orders for wound care were entered in the system. Nursing documentation included no skin assessments from 1/3/23 through 1/20/23. A facility nursing progress note dated 1/14/23 documented resident flushed, vomiting, low BP and went to hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The resident was hospitalized again from 1/14/23 through 1/20/23. Per the hospitalist discharge summary, discharge diagnoses included ESBL proteus and Vancomycin resistant enterococcus bacteremia. The summary indicated the facility staff had been notified the resident would need Intravenous antibiotics for 13 additional days. A facility nursing note dated 1/20/23 read: Resident returned via non-emergent BLS ambulance service. Resident is awake, alert, oriented, and able to make his needs known per his usual. A double lumen PICC line is in place in right upper arm. Resident will be receiving IV Invanz and Zyvox by mouth for VRE and Proteus bacteremia. Resident's buttocks are reddened, but blanchable, and dressing over RLE (right lower extremity)/foot amputation site is CDI (clean/dry/intact). Enhanced barrier precautions are in place, and staff is aware of the need to glove and gown before providing care, and resident is aware that he needs to sanitize his hands before leaving his room, and to notify the nurse if his dressing becomes soiled or loose while he is out of his roo [TRUNCATED]

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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** 47299 Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide the necessary treatment and services to promote wound healing and prevent infection for four of 33 residents in the survey sample, Resident #37, 42, 299, 199. Resident #37 experienced harm due to the development of osteomyelitis and the subsequent invasive treatment procedures that were required. The findings include: 1. For resident #37, the facility failed to provide treatment as ordered to the resident's left heel pressure ulcer leading to osteomyelitis (inflammation of bone caused by infection). In the course of treating the infection, resident #37 received a surgical wound debridement, insertion of a peripherally inserted central catheter (PICC line) for intravenous (IV) antibiotics and two wound cultures. Each of these procedures were invasive and placed the resident at risk for further discomfort and stress. Resident #37's diagnoses included but were not limited to the following: Diabetes type 2, congestive heart failure, chronic kidney disease and difficulty walking. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/6/22 assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15, indicating minor cognitive impairment. Under the functional ability section of the MDS, resident was coded as being independent with ambulation, with ambulation only occurring once or twice in the lookback period. Under the pain assessment interview section of the MDS, resident reported a pain level of 7 out of 10 on a numeric scale and reported that pain interfered with sleeping and limited their day-to-day activities. On 3/13/23 at 11:30 am surveyor observed resident #37 lying in bed with left foot exposed. Surveyor noted that resident had a wound on their heel that was open with slight drainage. Resident stated that the wound had been there, a good while and that the nurse was coming to see about it. Surveyor asked if the area was painful and resident stated, oh yeah, it hurts most of the time. During the clinical record review, surveyor noted that resident #37 was admitted to the facility on [DATE]. The Nursing Documentation Assessment for 8/31/22 was reviewed. The nurse documented that the skin was assessed and there were no wounds identified. There is another section that speaks specifically to the feet and the nurse marked no to the presence of redness, maceration or breakdown on the heels. The first mention of the left heel wound was by the nurse practitioner (NP) on 9/2/22 in a progress note that stated resident had a wound to the left heel. A provider order was received on the same date, 9/02/22, to treat the left heel wound by cleansing with wound cleanser and applying a wet to dry dressing daily. According to the September 2022 treatment administration record (TAR) this treatment was not done on 9/3/22 and 9/10/22 as there were blanks for those days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The NP saw resident #37 again on 9/13/22, the progress note documented in part, wound has healed except one area of peeling skin, which should require minimal treatment. A provider order was received on 9/13/22 to change the frequency of the treatment to every Tuesday, Thursday and Saturday. The October 2022 TAR indicated that the treatment to the left heel wound was not provided 10/6/22, 10/11/22, 10/22/22, and 10/29/22. The November 2022 TAR indicated treatment was also not provided on 11/10/22, 11/15/22, 11/17/22, 11/22/22, and 11/29/22. On November 11, 2022, the NP documented in a progress note that the left heel wound was draining brown drainage and gave an order for the antibiotic Bactrim DS 800-160 mg to be given orally twice daily for 10 days. The December 2022 TAR indicated that treatments to the left heel wound were not provided on 12/1/22, 12/6/22, 12/8/22, 12/13/22, 12/15/22, 12/22/22, 12/27/22, and 12/29/22. The January 2022 TAR indicated that treatment to the wound was not provided on 1/3/23, 1/12/23, 1/17/23, and 1/19/23. On 1/6/23 a provider order was received to x-ray the left foot. The conclusion in the radiology report stated, Subtle osteolysis/erosive changes at the posterior inferior calcaneus concerning for infection/osteomyelitis. An MRI was recommended. A wound culture of the left heel wound was ordered 1/11/23 which revealed the wound was infected with methicillin resistant staphylococcus aureus (MRSA). Bactrim DS 800-160 mg twice daily for ten days was again ordered for the infection. The wound culture was repeated per provider order on 1/23/23 which was positive for the presence of infection. Surveyor was unable to locate the sensitivity report in the clinical record. On 1/30/23 the NP documented in a progress note, ulcer has worsened with foul odor and black areas on edges as well as redness. On 2/1/23 another round of the antibiotic Bactrim DS was ordered twice daily for ten days. The MRI was done 2/3/23 and the report impression was large heel wound with osteomyelitis of the posterior calcaneus. Resident #37 underwent a surgical procedure to debride the wound on 2/6/23. On 2/9/23 resident #37 had a PICC line placed, and a wound vac was applied to the left heel. On 2/13/23 the NP documented in a progress note left foot wound was originally a diabetic ulcer that healed and then developed into a pressure ulcer due to the patient's habit of laying in the bed and friction on the foot. On 2-23-23 a new provider order was received to administer the antibiotic Vancomycin HCL intravenous solution, 1.5 grams every two days for six weeks for a diagnosis of osteomyelitis of the left heel. On 3/16/23 at 12:53 PM surveyor interviewed Licensed Practical Nurse (LPN) #3 regarding resident #37 and asked what the blanks on the TAR ' s indicated. They stated, if there's a blank for those days, it means the treatment wasn't done. Surveyor reviewed with LPN #3 the missing treatments and the progression of the wound and asked them what their professional opinion was. LPN #3 stated, I think the lack of treatment caused the wound to get worse. On 3/16/23 at 2:16 PM, surveyor asked the Director of Nursing (DON) for any wound measurements for resident #37's left heel from their admission 8/31/23 to current. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/20/23 at 11:44 am surveyor interviewed DON regarding the lack of documentation on admission of the left foot wound. DON stated they were not employed at the facility at that time. DON stated the wound should have been captured on the admission assessment/nursing documentation per policy, and if it was not there, she cannot speak as to why. DON agreed that a wound on the heel should be considered as pressure rather than diabetic. DON also stated that resident #37 was constantly up walking on it and digging their heels in the bed and foot board, before the foot board was removed. Surveyor was provided with a policy entitled, Skin Integrity and Wound Management, with a revision date of 2/1/23, that reads in part, A comprehensive initial and ongoing nursing assessment of intrinsic an extrinsic factor that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The DON also provided surveyor with copies of wound assessments for resident #37's left heel from September 2022 to November of 2022, but these were labeled as being a wound to the Right heel, not the left. DON reported that they began measuring the wound in January 2023 and provided surveyor with a worksheet entitled, Skin Integrity Report. This report had measurements documented each week beginning 1/25/23. On 3/20/23 at 1:40 PM surveyor interviewed the NP, other staff member #11. Surveyor asked if they were aware of the missed treatments in the months leading up to the osteomyelitis diagnosis, NP stated, no I was not. Surveyor asked if the missed treatments might have caused the wound to deteriorate, NP stated, yes it definitely could have. The above concerns were discussed with the Administrator, Director of Nursing and Assistant Director of Nursing on 3/17/23 at 4:00 PM and again with the Administrator and administrative staff #4 on 3/20/23. No further information was provided to the survey team prior to the exit conference. 34307 2. For Resident #42 the facility staff failed to provide treatment to promote healing and prevent infection of pressure ulcers. Resident #42's face sheet listed diagnoses which included but not limited to hypertensive heart disease, heart failure, chronic kidney disease, type 2 diabetes mellitus, peripheral vascular disease, and anxiety. Resident #42's most recent minimum data set with an assessment reference date of 02/04/23 assigned the resident a brief interview for mental status score of 11 out of 15 in section C, cognitive patterns. Section M, skin conditions coded the resident as having five stage II pressure ulcers that were present upon admission, and no other skin conditions. Resident #42's comprehensive care plan was reviewed and contained a care plan for Resident has actual skin breakdown related to top of right foot, right heel, left upper buttocks, left lower buttock, right buttock, coccyx, and sacrum related to decreased activity, incontinence. Interventions for this care plan included Observe skin for signs/symptoms of skin breakdown, provide wound treatment as ordered, weekly skin checks by licensed nurse, and weekly wound assessment to include measurements and description of wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident's clinical record was reviewed and contained a physician's order summary for the month of March 2023, which read in part . consult for necrotic wound to R ankle. Needs to be done as soon as possible, Cleanse area to top of right foot with Dakin's solution, 25%, pat dry. Apply Santyl on nonstick pad to wound bed. Cover with dry dressing daily and prn (as needed) every day shift for wound care, Cleanse stage 3 PU (pressure ulcer) to L (left) lower buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID (twice a day) and PRN every day and night shift for wound care, Cleanse stage 3 PU to L upper buttock with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse stage 3 PU to R buttocks with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse unstageable PU on coccyx with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 2 weeks, Cleanse unstageable PU to center sacrum with Dakin's solution, pat dry, apply skin prep to periwound, apply Dakin's wet to dry dressing to wound bed and secure with dry dressing BID and PRN every day and night shift for wound care for 10 days, Cleanse unstageable PU to R heel with Dakin's solution, pat dry, apply skin prep to periwound, apply Santyl on nonstick pad and secure with dry dressing BID and PRN every day and night shift for wound care for 14 days, and Bactrim DS oral tablet 800-160 mg (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth one time a day for wound infection for 14 days. Resident #42's clinical record contained a Physician's Telephone Orders form dated 02/27/23, which read in part (1) DC (discontinue) Macrobid. (2) Bactrim DS 1 tab PO (by mouth) BID (twice a day) x 10 days-wound infections R ankle, foot. This order was signed by the family nurse practitioner (FNP). Resident #42's treatment administration record (TAR) for the month of March 2023 was reviewed and contained entries as above. Each of these entries had not been initialed as completed on two separate occasions. Resident #42's February 2023 TAR contained entries, which read in part Cleanse area to right heel with IHWC (wound cleanser), pat dry and apply bordered foam dressing every day shift for open area, Cleanse area to right posterior thigh with IHWC, pat dry, and apply 4 x 4 bordered foam dressing every day shift for open area, Cleanse top of right foot with IHWC, pat dry, and apply bordered foam dressing every day shift for abrasion, and Cleanse area to coccyx with IHWC, pat dry, and apply bordered foam dressing every day shift for open area. Each of these entries had not been initialed as completed on three separate occasions. Surveyor, along with licensed practical nurse (LPN) #1 observed Resident #42's dressings to sacrum, coccyx, and buttocks on 03/13/23 at 2:30 pm. Dressing to sacrum did not have a date on it. Dressings to resident's foot, heels, and ankles all had dates and initials. LPN #1 stated they had completed wound care to these area's earlier in the day. Surveyor asked LPN #1 how they knew when the dressings to the sacral area had last been changed, and LPN #1 stated that without a date, there was no way to know when wound care was last completed. Surveyor spoke with the assistant director of nursing (ADON) on 03/14/23 at 10:50 am regarding Resident #42's wound care. Surveyor asked ADON what their expectations were for wound care, and ADON stated they would expect the nurses to follow the physician's orders for each resident regarding wound care. Surveyor asked ADON if wound dressings should be dated, and ADON stated that they should be dated and initialed by the nurse completing the wound care. ADON later stated per DON, facility policy did not state that dressings needed to be dated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Wound Dressings: Aseptic which read in part, 2. Gather supplies: 2.7 Prepared label or secondary dressing with date and initials. 27. Apply prepared label. Survey team spoke with the director of nursing (DON) on 03/15/23 at 10:00 am regarding wound management. DON stated they measure wounds weekly, and that information is located in their office. Surveyor asked DON if dressings should be dated and initialed when changed, and DON stated that is not a part of the facility policy, but they were hoping to have that changed, as that is the expectation. Surveyor referred DON to aforementioned policy, and asked DON what prepared label meant, and DON stated they did not know. Surveyor requested and was provided with Skin Integrity Report forms, which were contained in a notebook housed in the DON's office. This notebook contained six forms for Resident #42, which addressed unstageable pressure areas to right heel, right achilles, sacrum/coccyx, right buttock, left outer thigh/lower buttock and a stage II pressure areas to upper left buttock. Each of these areas were marked as present upon admission, with weekly measurements beginning on 02/01/23 and continuing through 03/14/23. Two surveyors, along with LPN #1 observed Resident #42's wounds on 03/14/23 at 4:45 pm. LPN #1 stated that areas to the top of resident's right foot and right ankle/lower leg were arterial rather than pressure. Resident's right heel had dark brown eschar and LPN #1 stated that area was unstageable pressure ulcer. Areas to resident's sacral area (sacrum, coccyx, buttocks) were red with slough present in wound bed. Survey team spoke with family nurse practitioner (FNP) on 03/20/23 at 1:25 pm regarding wound management. Surveyor asked FNP if missed assessments and dressing changes not being done as ordered could contribute to wound infections and FNP stated that it could. The concern of not providing treatment to promote healing and prevent infection of pressure ulcers management was discussed with the administrator, DON, and Market Clinical Lead on 03/20/23 at 3:00 pm. No further information was provided prior to exit. 42353 3. For Resident #299, the facility staff failed to provide treatment as ordered to an area of excoriation that later developed into a pressure injury and failed to document an assessment of the pressure area at the time of discovery. This was a closed record review: Resident #299's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Aftercare following Joint Replacement Surgery, Dislocation of Internal Right Hip Prosthesis, Chronic Obstructive Pulmonary Disease, Unspecified Dementia, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The admission minimum data set (MDS) with an assessment reference date (ARD) of 10/25/22 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired. Resident #299 was coded as requiring extensive assistance with bed mobility, dressing and being totally dependent on staff with toilet use and bathing. The resident was coded as being at risk of developing pressure ulcers/injuries with no current unhealed pressure ulcers/injuries. Resident #299 was coded for the presence of a surgical wound and moisture associated skin damage (MASD). Resident #299 was admitted to the facility on [DATE], the nursing admission assessment entitled Nursing Documentation - V 11 dated 10/18/22 at 11:07 pm documented the presence of moisture associated skin damage (MASD) to the coccyx. A physician's order to wash coccyx with soap and water, pat dry, and apply Calazime paste every day and night shift for excoriation began 10/19/22. According to the resident's October 2022 Treatment Administration Record (TAR) the treatment to the coccyx was not administered on 10/19/22 nightshift, 10/21/22 dayshift, and 10/22/22 dayshift. A nursing progress note dated 10/23/22 at 11:00 am stated in part . Stage 3 noted to coccyx. Pt [patient] states 'yeah, it's sore'. Orders placed . A new physician's order to cleanse coccyx with wound cleanser, pat dry, apply zguard, place non-adhesive optifoam on every 3 days or as needed. Surveyor was unable to locate documentation describing the area to the coccyx. Resident #299 was seen by the family nurse practitioner (FNP) on 10/24/22, the progress note stated in part . Wound care to buttocks per stage 2 protocol. Dr. [name omitted] consult for stage 2 wound with slough to buttocks . Surveyor was unable to locate any subsequent documentation of the area to the coccyx until 11/01/22 at which time the wound was photographed, measured, and assessed. At that time the area was documented as an unstageable pressure area to the sacrum measuring 9.15 cm in length and 4.91 cm in width with 100% of the wound bed with slough. The assessment documented the resident's pain level as a 6 out of 10 stating the resident complains of pain during dressing change and when wet. The assessment also noted to schedule a consult with Dr. [name omitted] immediately. A nursing progress note dated 11/07/22 at 4:59 pm stated in part Consultation complete with Dr. [name omitted]. Resident is to have wound debridement next Tuesday 11/15/22 at 9 am . A nursing progress note dated 11/15/22 at 8:49 am documented in part Resident #299 departed facility for wound debridement. On 3/14/23 at 10:20 am, surveyor spoke with the Clinical Reimbursement Coordinator (CRC) who documented the 11/01/22 wound assessment and they stated they must have been working the floor that day and does not recall the resident's wound. Resident #299's unstageable area to the coccyx was again assessed and photographed on 11/08/22. The area was described as measuring 7.26 cm in length and 4 cm in width reflecting a decrease in size. The wound bed was described as having 100% slough with an intact serum filled blister. Surveyor attempted to interview the wound nurse at the time of Resident #299's admission, however, they were no longer employed by the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor requested and received the facility policy entitled Skin Integrity and Wound Management with an effective date of 7/01/01 and a revision date of 2/01/23 which read in part: 6. The licensed nurse will: 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. On 3/17/23 at 4:00 pm, the survey team met with the administrator, director of nursing, and assistant director of nursing and discussed the concern of the staff failing to provide treatment to Resident #299's area of excoriation to the coccyx on three separate occasions prior to area deteriorating into a pressure injury and failing to document an assessment of the area when the pressure area was discovered. 28169 4. The facility staff failed to ensure pressure ulcer assessments and treatments were complete for Resident #199. Resident #199's admission record listed his diagnoses included but were not limited to, Covid-19, Type 2 Diabetes Mellitus, and Encephalitis (inflammation of the brain) and Encephalomyelitis (inflammation of the brain and spinal cord). The minimum data set (MDS) with an assessment reference date of 12/16/21 coded the resident's brief interview for mental status (BIMS) a 01 out of 15 in Section C (cognitive patterns). Section G (functional status) coded him needing extensive assistance with bed mobility, eating, and toilet use. The clinical record contained a Transfer Summary Sheet from an acute care hospital dated 12/01/21 which described Resident #199's skin integrity as multiple skin tears and a stage 2 decubitus on his left buttock. An admission nursing documentation progress note described the resident's skin injury/wounds as multiple skin tears to bilateral arms and pressure: Stage 2 Left Buttocks. Weekly skin check documents, dated 12/17/21 through 03/04/22, were reviewed. The injury/wound regarding the buttocks was described as moisture associated skin damage until 1/21/22 and 1/28/22 when it was described as a pressure injury with treatment in place. The remaining weekly skin check documents described the left buttocks as moisture associated skin damage, and a pressure injury with one week (2/18/22) not noting the left buttock wound. There was no further description noted on the document or within the progress notes; no wound measurements were found. Provider orders for cleansing the stage 2 injury to the left buttock with wound cleanser, pat dry, and apply Optifoam every day shift was not documented for 12/20/21, 01/25/22, and 3/02/22. The administrator was informed of these findings on 3/14/23 during an interview in person on 3/14/23 and again on 3/19/23. On 3/14/23 at approximately 4:45 p.m., the director of nursing (DON) acknowledged she did not find any wound measurements or further wound/injury descriptions for Resident #199. No further information was provided prior to the exit conference.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34307 Based on observation, staff interview and clinical record review the facility staff failed to ensure one out of 21 residents were free from medication errors, Resident #104. The findings included: For Resident #104 the facility staff administered the medications enalapril and metoprolol outside the physician ordered parameters on separate occasions. Enalapril and metoprolol are both medications used to treat high blood pressure. Resident #104's face sheet listed diagnoses which included but not limited to essential (primary) hypertension (high blood pressure). The most recent minimum data set with an assessment reference date of 02/07/23 assigned the resident a brief interview for mental status score of 6 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #104's comprehensive care plan was reviewed and contained a care plan for Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN (hypertension), edema, increasing risk of CVA (cerebrovascular accident [stroke])/kidney disease. Interventions for this care plan included Administer meds as ordered and assess for effectiveness and side effects and report abnormalities to physician. Resident #104's clinical record was reviewed and contained a physician's order summary for the month of May 2023 which read in part, Enalapril Maleate Tablet 10 mg. Give 1 tablet by mouth one time a day for Hight Blood Pressure hold if SBP (systolic blood pressure) is less than 110 and Metoprolol Tartrate Tablet 100 mg. Give 1 tablet by mouth one time a day for High Blood Pressure. Hold if SBP is lower than 100. Resident #104's electronic medication administration record (eMAR) for the month of May 2023 was reviewed and contained entries as above. The entry for enalapril was initialed as given on 05//05/23 with a SBP of 102, 05/06/23 with a SBP of 100, and on 05/09/23 with a SBP of 82. The entry for metoprolol was initialed as given on 05/04/23 with a SBP 87. Resident #104's nurses' progress notes were reviewed, and surveyor was unable to find any notes related to the above dates. Surveyor requested and was provided with a facility policy entitled Medication Administration: Oral, which read in part 2.4 Verify medication order on Medication Administration Record (MAR) with mediation label for: 2.4.4 Special considerations Surveyor spoke with the director of nursing (DON) and resource nurse on 05/11/23 at 1:50 pm regarding Resident #104. Resource nurse stated that a QAPI (quality assurance performance improvement) plan was implemented on 05/04/23 due to identified issues with medication administration, documentation, etc. Resource nurse stated this plan was ongoing. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of administering Resident #104's blood pressure medications outside of physician ordered parameters was discussed with the administrator, DON, and resource nurse during a meeting on 05/11/23 at 5:15 pm. No further information was provided prior to exit.