STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675017	A. Building B. Wing	10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Country Healthcare Center	1514 Indian Creek Rd Brownwood, TX 76801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on interview and record review, the facility failed to ensure that the resident was free from neglect for 1 of 3 residents (Resident #1) reviewed for neglect. 1. The facility failed to implement new wound treatment orders and provide wound care to Resident #1's unstageable pressure ulcer to her right hip which had deteriorated to stage 4. Additionally, Resident #1 developed 3 other wounds in the following areas: a) Stage 3 right internal aspect upper thigh b) Unstageable left hip c) Unstageable right posterior aspect of lower thigh d) Unstageable left gluteal region. 2. The facility failed to ensure these multiple wounds on Resident #1 were identified, assessed, and treatment was provided to promote healing. 3. The facility failed to inform the physician of the Resident #1 pressure ulcers or obtained required orders to treat the resident's wounds. 4. The facility failed to document that Resident #1 had a pressure ulcer. An Immediate Jeopardy (IJ) was identified on 10/14/21. While the IJ was lowered on 10/15/21, the facility remained out of compliance at a severity level of actual harm that was not immediate jeopardy and a scope of isolated because the facility was still monitoring the effectiveness of their Plan of Removal. The failure could affect residents by placing them at risk of abuse or neglect not being investigated and protective measures put in place to prevent further abuse/neglect Findings included: (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was still in the hospital at the time of this investigation because she was lethargic and refused to eat. On 10/14/21 at 9:15a.m, surveyor attempted to go and see Resident #2. Surveyor was denied access because Resident #1 was on Covid-19 protocol in the hospital. The admission observation report dated 09/11/21 reflected the following: Skin: Skin temperature: warm Skin moisture: dry Skin color: Jaundiced Petechiae present: no Skin turgor: NORMAL Alterations in Skin? NO. Review of Resident #1's physician orders revealed the resident was a [AGE] year old female admitted to the facility on [DATE]. Her diagnosis includes alcohol abuse with alcohol-induced anxiety disorder, chronic pain, alcohol hepatic failure without coma, primary biliary cirrhosis and long-term drug therapy. Review of Resident #1's admission MDS assessment, undated revealed the resident was always continent of bowel/bladder and required limited assistance with most ADLs and transfer. The assessment reflected the resident was not at risk of developing pressure ulcer and had no pressure ulcers at the time of the assessment. The resident's BIMS score was 13 indicating intact cognition. Review of Resident #1's care plan dated 9/10/21 (when surveyor requested it) revealed the problem of pressure ulcer prevention was addressed with a goal to prevent/heal pressure sores and skin breakdown. Interventions included follow facility skin care protocol, preventative measures, report to charge nurse any redness or skin breakdown immediately and treat as ordered. The admission report revealed the facility did not know Resident #1 had pressure ulcers. Review of the facility wound management section used by the facility on the electronic record revealed it was blank. There was no information documented. Review of Resident #1's clinical records revealed there was no documented assessment of the wounds on 9/10/21 (admitted). Review of Resident #1's current Braden Scale (predicts risk for pressure ulcer development) dated 10/01/21, 21 days after admission (admitted [DATE]) reflected a score of 16, indicating the resident was at a mild risk for the development of pressure ulcers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's nursing nurse's notes dated 09/11/21 (a day after Resident #1 was admitted) did not indicate she had pressure ulcers. However, hospital transfer orders reflected an unstageable pressure ulcer on the right hip. The assessment did not reflect any description of the pressure ulcers to include color, measurement, or other characteristics. Review of the resident's clinical records revealed there was no documented assessment of the pressure ulcers on admission. In an interview with CNAA on 10/14/21 at 11:39a.m., she stated she provided care for Resident #1 on 10/09/21 and 10/10/21 as reflected in the facility's schedule. CNAA explained she was familiar and took care of Resident #1. She said the resident required limited assistance with most ADLs on admission. She had 1 wound on right hip on admission but developed others in the facility because she was picking on herself. CNAA explained Resident #1 cusses' aides out, was rude and not nice. She noted she refuses care sometimes. CNAA was asked who she told of Resident #1 wounds. She said everybody knew including the charge nurses and DON. During interview with CNAB on 10/14/21 at 2:15p.m, she said she took care of Resident #1 as reflected on the schedule dated 10/09/21and 10/10/21. She explained the resident almost always refuses shower because of pain. She said Resident #1 was moving around by self after admission but started declining. She was picking and scratching herself. She noted Resident #1 had multiple wounds with 2 major ones on the left leg and right hip. CNAB stated it was the facility protocol to report skin breakdown to the charge nurses. She said Resident #1 had the wounds for a long time and the nurses were aware of the multiple wounds. CNAB was asked if she documented skin condition after taking her a bath. She said she remembered the first time she took resident a bath and saw the wounds. She notified an agency nurse that was on duty. She cannot remember the name. They have a bath sheet that is mark done if the resident received shower and refused if they did not. Interview with CNAC on 10/15/21 at 11:39a.m revealed she took care of Resident #1 on 10/11/21 and 10/12/21 (day resident was transferred to the hospital). She explained Resident #1 required limited assistance when she was admitted . Resident #1 got worse scratching and picking at herself. She said the resident often refuses care including taking a shower because she was in pain most of the time. CNAC said she took the resident a bath on 10/12/21 (the day she went to the hospital. She noted resident multiple wounds with a big one on right hip. She could not exactly remember how many wounds. She notified the charge nurse of the different wounds. When asked which nurse, she said it was LVN D. CNAC said she did not document the Resident #1 condition. In an interview with LVND on 10/14/21 at 10:11a.m, she said she took care of Resident #1 on 10/11/21 and 10/12/21 (day she was transferred to the hospital). She was an agency nurse and did not work for the facility. She stated she was aware Resident #1 had multiple wounds. LVND said when she came on 10/12/21, the resident was not in good condition. She was jaundice (yellow in color), dry lips and could not get her to eat. Resident #1 was lethargic. She called the doctor and received an order to send Resident #1 to the hospital. LVND explained Resident #1 had multiple wounds which she dressed during the shifts. She was asked how she was able to provide Resident #1 wound care without physician orders or treatment notes? She said she received the information from the outgoing nurse. LVND was asked if she documented the treatment, she answered no. Review of Resident #1 clinical records did not show doctor's orders or wound treatment provided to Resident #1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with LVNE on 10/15/21 at 11:08a.m, she was an agency nurse that took care of Resident #1 on 10/09/21. LVNE explained Resident #1 had multiple pressure ulcers which was in bad shape. She said it appears the resident has had the wound a long time. She provided wound care to Resident #1 one time. LVNE was asked how did she know what to use to provide wound care without physician orders or treatment notes? She said she received verbal report from RN F and what the facility was using to dress the wounds. She was asked how many wounds did the Resident #1 have? LVNE stated she did not know and failed to document her treatment of Resident #1 pressure ulcers. Interview with RNF on 10/15/21 at 1:44 p.m revealed she has been working for the facility for 5 years. Presently she works every other weekend. RNF said she was responsible and took care of Resident #1 on weekends. She explained Resident #1 had one pressure ulcers that she was aware until last week when she saw her, at which time Resident #1 had more wounds. When she asked CNAA, she said Resident #1 had always had the wounds. RNF proceeded to dress the wound. She was asked if she called the doctor when she discovered the new pressure ulcer. She said she did not. RHF stated she used facility standing wound treatment order. RNF was asked if she documented the multiple wounds and her treatment. She said she did not. RNF was asked to descript the facility protocol on admission of a resident. She explained on admission, the charge nurse looks at discharge information. The resident is assessed including detailed skin observations. The wound or pressure ulcers are documented. The charge nurse will call the doctor and received treatment instructions. He/she will follow the doctor's order. RNF acknowledged the facility protocol was not followed for Resident #1 care and treatment of her wound. Review of records revealed the pressure developed from 1 on admission to 4. During interview with DON on 10/15/21 at 10:42a.m she acknowledged the following on the care or lack thereof of Resident #1 1) She assessed the resident on admission 2) Stated the resident skin was assessed as normal 3) No documentation of Resident #1 weekly skin assessments 4) No physician orders for the pressure ulcer 5) No documentation of wound treatment provided to Resident #1 over 21 days after admission 6) Facility wound management section was blank for Resident #1 7) Staffs did not follow the facility policy in providing the necessary care and services to Resident #1 particularly pressure ulcer care 8) The physician was not aware of Resident #1's pressure ulcer until he was notified on 10/11/21 that Resident #1 pressure ulcer may be infected. He ordered an antibiotic treatment with Bactrim 9) She failed to train agency nurses on the facility policy on wound care and documentation 10) No documentation of first transfer to the hospital on 9/14/21 and return on 9/16/21 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON explained Resident #1 did not let her look to complete assessment on admission day. She said she takes responsible for failure to document the resident assessment. The DON stated the facility was short of nurses and she had to do many tasks by herself. She was meant to train agency nurses but did not have time to do so. The DON said it was unfortunate that the agency nurses did not document as well. She was asked why there was no assessment after Resident #1 transfer to the hospital on 2 separate occasion. The DON said the facility just didn't. She stated, I dropped the ball. She noted there no physician orders to provide the necessary care and services to Resident #1. During interview with Physician Y on 10/14/21 at 2:25p.m, he said he was the primary for Resident #1. He explained he was not aware the resident had pressure ulcers. He knows Resident #1 had lots of itching. Physician Y said he was informed on 10/11/2021 that the resident pressure ulcers may be infected. He ordered an antibiotic treatment with Bactrim. The next day he gave order to transfer Resident #1 to the hospital due changes in her condition. Review of the facility abuse/neglect policy revised July 2017 reflected, All reports of resident abuse, neglect , exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will be also reported. Role of the Administrator: 1) If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual . 2) The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented . Review of the facility policy on pressure ulcers/skin breakdown-clinical protocol revised April 2018 reflected the following: 1) The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and history of pressure ulcer(s). 2) In addition, the nurse shall describe and document/report the following: a) Full assessment of pressure sore including location, stage, length, width and depth, presence of exu-dates or necrotic tissue: b) Pain assessment c) Resident mobility status d) Current treatments, including support surfaces: and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e) All active diagnoses 3) The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin condition. 4) The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 5) The physician will help identify and define any complications related to pressure ulcers. Review of the facility policy on wound care revised October 2010 reflected, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1) Verify that there is a physician's order for this procedure. 2) Review the resident's care plan to assess for any special needs of the resident a) For example, the resident may have PRN orders for pain medication to be administered prior to wound care 3) Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc. with alcohol pleget before opening, as necessary. (Note: This may be performed at the treatment cart.). An Immediate Jeopardy (IJ) was identified, and the Administrator was informed, on 10/14/21 at 6:02 p.m. IJ template was provided to the Administrator at that time. The Facility's Plan of Removal was accepted on 10/15/21 at 12:25 a.m. and reflected the following: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on October 14, 2021 for neglecting to provide treatment and services to prevent the development and worsening of pressure ulcers. 1. Action: To ensure identification of pressure sores, center licensed nursing staff conducted and documented a head-to-toe skin inspection of all center residents. If a new skin alteration is noted during skin inspection, the attending physician will be notified to obtain treatment orders as indicated and a change of care plan will be initiated. Actual skin alternation and potential risk factors will be care planned to meet individual resident needs. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Licensed Nurses (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Action: Nursing Administration to conduct education with licensed nursing staff regarding: 1) Notification of attending physician upon identification of resident change in condition to include skin alterations noted during admission/weekly skin inspections; and 2) Inspection and documentation of resident head-to-toe skin inspection upon admission and weekly thereafter. Beginning October 15, 2021, licensed nurses (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Regional Nursing Manager, Director of Nursing 3. Action: Nursing Administration to conduct education with certified/temporary nursing assistants regarding notification of charge nurse upon identification of resident change to skin. Beginning October 15, 2021, certified/temporary nursing assistants (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Completion Timeline: Beginning October 14, 2021 and ending October 16, 2021. Responsible: Regional Nursing Manager, Director of Nursing 4. Nursing Administration began auditing the electronic medical record of each resident to ensure weekly skin checks are scheduled to be performed by a licensed nurse. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Regional Nursing Manager, Director of Nursing 5. Action: Beginning on October 15, 2021 and for the next 30 days, the Director of Nursing will utilize the Daily Clinical Meeting Process to validate charge nurse compliance with inspection, notification, and documentation of resident skin checks which are to be conducted upon admission and weekly thereafter. QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Administrator, Director of Nursing Attachments- Daily Clinical Meeting Process To verify the facility implemented their plan of removal, the following observations, interviews and record review were conducted. Observations of 2 residents with pressure ulcers revealed they were correctly assessed for skin pressure ulcers/breakdown. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews conducted with 7 LVNs (LVND, LVN E, LVNG, LVNH, LVNK, LVNJ, LVNL) and 1 RN (RNF) across multiple shifts on 10/15/21 from 11:32 p.m. to 1:22 p.m. revealed the nurses verbalized comprehension of the in- service training. They stated they had been in-serviced on the facility's policy/procedure to include completing a full skin assessment on admission and weekly thereafter. The physician will be immediately notified of any skin alterations and obtain treatment orders. Weekly skin assessments were to be entered into the computer on admission and weekly skin assessments were now to be done by the charge nurses. The Director of nursing will use the clinical meeting process to validate charge nurse for compliance. Interviews conducted with 6 CNAs (CNAA, CNAB, CNAC, CNAM, CNAO, CNAP) across multiple shifts on 10/15/21 from 11:32a.m. to 1:32 p.m. revealed the CNAs verbalized comprehension of the in-service training. They stated they had received in-service training regarding monitoring skin every shift and entering observations in the resident's activity of daily living section. They stated they had been in-serviced on reporting any skin issues on the residents. The Administrator was notified on 10/15/21 at 11:26 p.m. that the Immediate Jeopardy was removed. While the IJ was removed on 10/15/21, the facility remained out of compliance at the severity level of actual harm that is not immediate jeopardy and a scope of Isolated because the facility was still monitoring their plan of removal.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observations, interviews, and record reviews, the facility failed to ensure a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (Resident #1) of three residents reviewed for pressure ulcers. 1. The facility failed to implement new wound treatment orders and provide wound care to Resident #1's unstageable pressure ulcer to her right hip which had deteriorated to stage 4. Additionally, Resident #1 developed 3 other wounds in the following areas: a) Stage 3 right internal aspect upper thigh b) Unstageable left hip c) Unstageable right posterior aspect of lower thigh d) Unstageable left gluteal region. 2. The facility failed to ensure these multiple wounds on Resident #1 were identified, assessed, and treatment was provided to promote healing. 3. The facility failed to inform the physician of the Resident #1 pressure ulcers or obtained required orders to treat the resident's wounds. 4. The facility failed to document that Resident #1 had a pressure ulcer. An Immediate Jeopardy (IJ) was identified on 10/14/21. While the IJ was lowered on 10/15/21, the facility remained out of compliance at a severity level of actual harm that was not immediate jeopardy and a scope of isolated because the facility was still monitoring the effectiveness of their Plan of Removal. These failures placed residents at risk of a potentially life-threatening infection, including sepsis which could manifest into other health complications, pain, worsening pressure ulcers and a decreased quality of life. Findings included: Resident #1 was still in the hospital at the time of this investigation because she was lethargic and refused to eat. On 10/14/21 at 9:15a.m, surveyor attempted to go and see Resident #1. Surveyor was denied access because Resident #1 was Covid-19 protocol at the hospital. Review of Resident #1's admission observation report dated 09/11/21 reflected the following: Skin: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Skin temperature: warm Skin moisture: dry Skin color: Jaundiced Petechiae (Small wound) present: no Skin turgor: NORMAL Alterations in Skin? NO. Review of Resident #1's physician orders dated 10/06/21revealed the resident was a [AGE] year old female admitted to the facility on [DATE]. Her diagnosis includes alcohol abuse with alcohol-induced anxiety disorder, chronic pain, alcohol hepatic failure without coma, primary biliary cirrhosis and long-term drug therapy. Review of Resident #1's admission MDS assessment undated received revealed the resident was always continent of bowel/bladder and required limited assistance with most ADLs and transfer. The assessment reflected the resident was not at risk of developing pressure ulcer and had no pressure ulcers at the time of the assessment. The resident's BIMS score was 13 indicating intact cognition. Review of Resident #1's care plan undated revealed the problem of pressure ulcer prevention was addressed with a goal to prevent/heal pressure sores and skin breakdown. Interventions included follow facility skin care protocol, preventative measures, report to charge nurse any redness or skin breakdown immediately and treat as ordered. The admission report revealed the facility did not document that Resident #1 had pressure ulcers. Review of the facility wound management section used by the facility on the electronic record revealed it was blank. There was no information documented. Review of Resident #1's clinical records revealed there was no documented assessment of the wounds on 9/10/21 (admitted). Review of Resident #1's current Braden Scale (predicts risk for pressure ulcer development) dated 10/01/21, 21 days after admission (admitted [DATE]) reflected a score of 16, indicating the resident was at a mild risk for the development of pressure ulcers. Review of Resident #1's nursing nurse's notes dated 09/11/21 (a day after Resident #1 was admitted) did not indicate she had pressure ulcers. However, hospital transfer orders dated 09/10/21 reflected an unstageable pressure ulcer on the right hip. The assessment did not reflect any description of the pressure ulcers to include color, measurement, or other characteristics. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNAA on 10/14/21 at 11:39a.m., she stated she provided care for Resident #1 on 10/09/21 and 10/10/21 as reflected in the facility's schedule. CNAA explained she was familiar and took care of Resident #1. She said the resident required limited assistance with most ADLs on admission. She had 1 wound on right hip on admission but developed others in the facility because she was picking on herself. CNAA explained Resident #1 cusses' aides out, was rude and not nice. She noted she refuses care sometimes. CNAA was asked who she notified of Resident #1 wounds. She said everybody knew including the charge nurses and DON. During interview with CNAB on 10/14/21 at 2:15p.m, she stated she took care of Resident #1 as reflected on the schedule dated 10/09/21 and 10/10/21. She stated the resident almost always refuses showers because of pain. She said Resident #1 was moving around by self after admission but started declining. She was picking and scratching herself. She noted Resident #1 had multiple wounds with 2 major ones on the left leg and right hip. CNAB stated it was the facility protocol to report skin breakdown to the charge nurses. She said Resident #1 had the wounds for a long time and the nurses were aware of the multiple wounds. CNAB was asked if she documented skin condition after taking her a bath. She said she remembered the first time she assisted resident with a bath and saw the wounds. She notified an agency nurse that was on duty. She cannot remember the nurses name. They have a bath sheet that is marked done if the resident received shower and refused if they did not. Interview with CNAC on 10/15/21 at 11:39a.m she stated she took care of Resident #1 on 10/11/21 and 10/12/21 (day resident was transferred to the hospital). She explained Resident #1 required limited assistance when she was admitted . Resident #1 got worse scratching and picking at herself. She said the resident often refuses care including taking a shower because she was in pain most of the time. CNAC said she assisted Resident #1 with a bath on 10/12/21 (the day she went to the hospital). She noted resident had multiple wounds with a big one on right hip. She could not exactly remember how many wounds. She notified the charge nurse of the different wounds. When asked which nurse, she said it was LVN D. CNAC said she did not document Resident #1's condition. In an interview with LVND on 10/14/21 at 10:11a.m, she stated she took care of Resident #1 on 10/11/21 and 10/12/21 (day she was transferred to the hospital). She was an agency nurse and did not work for the facility. She stated she was aware Resident #1 had multiple wounds. LVND said when she came on 10/12/21, the resident was not in good condition. She was jaundice (yellow in color), dry lips and could not get her to eat. Resident #1 was lethargic. She called the doctor and received an order to send Resident #1 to the hospital. LVND explained Resident #1 had multiple wounds which she dressed during the shifts. She was asked how she was able to provide Resident #1 wound care without physician orders or treatment notes? She said she received the information from the outgoing nurse. LVND was asked if she documented the treatment, she answered no. Review of Resident #1 clinical records did not show doctor's orders or wound treatment provided to Resident #1. During interview with LVNE on 10/15/21 at 11:08a.m, she stated she was an agency nurse that took care of Resident #1 on 10/09/21. LVNE explained Resident #1 had multiple pressure ulcers which were in bad shape. She said it appeared the resident has had the wound, a long time. She provided wound care to Resident #1 one time. LVNE was asked how did she know what to use to provide wound care without physician orders or treatment notes? She said she received verbal report from RNF and what the facility was using to dress the wounds. She was asked how many wounds did the Resident #1 have? LVNE stated she did not know and failed to document her treatment of Resident #1 pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RNF on 10/15/21 at 1:44p.m revealed she has been working for the facility for 5 years. Presently she works every other weekend. RNF said she was responsible and took care of Resident #1 on weekends. She explained Resident #1 had one pressure ulcers that she was aware until last week when she saw her, at which time Resident #1 had more wounds When she asked CNAA, she said Resident #1 had always had the wounds. RNF proceeded to dress the wound. She was asked if she called the doctor when she discovered the new pressure ulcer. She said she did not. RHF stated she used facility standing wound treatment order. RNF was asked if she documented the multiple wounds and her treatment. She said she did not. RNF was asked to describe the facility protocol on admission of a resident. She explained on admission, the charge nurse looks at discharge information. The resident is assessed including detailed skin observations. The wound or pressure ulcers are documented. The charge nurse will call the doctor and received treatment instructions. He/she will follow the doctor's order. RNF acknowledged the facility protocol was not followed for Resident #1 care and treatment of her wound. Review of hospital record dated 10/14/21 revealed the pressure ulcers developed from 1 on admission to 4. During interview with DON on 10/15/21 at 10:42a.m she acknowledged the following on the care or lack thereof of Resident #1 1) She assessed the resident on admission 2) Stated the resident skin was assessed as normal 3) No documentation of Resident #1 weekly skin assessments 4) No physician orders for the pressure ulcer 5) No documentation of wound treatment provided to Resident #1 over 21 days after admission. 6) Facility wound management section was blank for Resident #1 7) Staffs did not follow the facility policy in providing the necessary care and services to Resident #1 particularly pressure ulcer care. 8) The physician was not aware of Resident #1's pressure ulcer until he was notified on 10/11/21 that Resident #1 pressure ulcer may be infected. He ordered an antibiotic treatment with Bactrim. 9) She failed to train agency nurses on the facility policy on wound care and documentation 10) No documentation of first transfer to the hospital on 9/14/21 and return on 9/16/21 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON explained Resident #1 did not let her look to complete assessment on admission day. She said she takes responsible for failure to document the resident assessment. The DON stated the facility was short of nurses and she had to do many tasks by herself. She had meant to train agency nurses but did not have time to do so. The DON said it was unfortunate that the agency nurses did not document as well. She was asked why there was no assessment after Resident #1 transfer to the hospital on 2 separate occasion. The DON said the facility just didn't. She stated, I dropped the ball. She noted there no physician orders to provide the necessary care and services to Resident #1. During interview with Physician Y on 10/14/21 at 2:25p.m, he said he was the primary for Resident #1. He explained he was not aware the resident had pressure ulcers. He knows Resident #1 had lots of itching. Physician Y said he was informed on 10/11/21 that the resident pressure ulcers may be infected. He ordered an antibiotic treatment with Bactrim on 10/11/21. The next day on 10/12/21 he gave order to transfer Resident #1 to the hospital due being lethargic and refusing to eat. An Immediate Jeopardy (IJ) was identified on 10/14/21 at 6:02 p.m. The administrator was notified on 10/14/21 at 6:02pm of the IJ. The plan of removal was requested at that time and IJ template was provided to the Administrator. The Facility's Plan of Removal was accepted on 10/15/21 at 12:25 a.m. and reflected the following: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on October 14, 2021 for neglecting to provide treatment and services to prevent the development and worsening of pressure ulcers. 1. Action: To ensure identification of pressure sores, center licensed nursing staff conducted and documented a head-to-toe skin inspection of all center residents. If a new skin alteration is noted during skin inspection, the attending physician will be notified to obtain treatment orders as indicated and a change of care plan will be initiated. Actual skin alternation and potential risk factors will be care planned to meet individual resident needs. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Licensed Nurses 2. Action: Nursing Administration to conduct education with licensed nursing staff regarding: 1) Notification of attending physician upon identification of resident change in condition to include skin alterations noted during admission/weekly skin inspections; and 2) Inspection and documentation of resident head-to-toe skin inspection upon admission and weekly thereafter. Beginning October 15, 2021, licensed nurses (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Regional Nursing Manager, Director of Nursing (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Action: Nursing Administration to conduct education with certified/temporary nursing assistants regarding notification of charge nurse upon identification of resident change to skin. Beginning October 15, 2021, certified/temporary nursing assistants (agency, PRN, new hires) who have not received the above stated education will be educated by Nursing Administration prior to providing resident direct care. Completion Timeline: Beginning October 14, 2021 and ending October 16, 2021. Responsible: Regional Nursing Manager, Director of Nursing 4. Nursing Administration began auditing the electronic medical record of each resident to ensure weekly skin checks are scheduled to be performed by a licensed nurse. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Regional Nursing Manager, Director of Nursing 5. Action: Beginning on October 15, 2021 and for the next 30 days, the Director of Nursing will utilize the Daily Clinical Meeting Process to validate charge nurse compliance with inspection, notification, and documentation of resident skin checks which are to be conducted upon admission and weekly thereafter. QAPI Committee will be notified of identified non-compliance. QAPI Committee will develop a Performance Improvement Plan to address identified non-compliance to include staff education and/or disciplinary action. Completion Timeline: Beginning October 14, 2021 and ending October 15, 2021. Responsible: Administrator, Director of Nursing Attachments- Daily Clinical Meeting Process Review of the facility policy on pressure ulcers/skin breakdown-clinical protocol revised April 2018 reflected the following: 1) The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and history of pressure ulcer(s). 2) In addition, the nurse shall describe and document/report the following: a) Full assessment of pressure sore including location, stage, length, width and depth, presence of exu-dates or necrotic tissue: b) Pain assessment c) Resident mobility status (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d) Current treatments, including support surfaces: and e) All active diagnoses 3) The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin condition. 4) The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 5) The physician will help identify and define any complications related to pressure ulcers. Review of the facility policy on wound care revised October 2010 reflected, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1) Verify that there is a physician's order for this procedure. 2) Review the resident's care plan to assess for any special needs of the resident a) For example, the resident may have PRN orders for pain medication to be administered prior to wound care 3) Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc. with alcohol pleget before opening, as necessary. (Note: This may be performed at the treatment cart.). To verify the facility implemented their plan of removal, the following observations, interviews and record review were conducted. Observations of 2 residents with pressure ulcers revealed they were correctly assessed for skin pressure ulcers/breakdown. Interviews conducted with 7 LVNs (LVND, LVN E, LVNG, LVNH, LVNK, LVNJ, LVNL) and 1 RN (RNF) across multiple shifts on 10/15/21 from 11:32 p.m. to 1:22 p.m. revealed the nurses verbalized comprehension of the in- service training. They stated they had been in-serviced on the facility's policy/procedure to include completing a full skin assessment on admission and weekly thereafter. The physician will be immediately notified of any skin alterations and obtain treatment orders. Weekly skin assessments were to be entered into the computer on admission and weekly skin assessments were now to be done by the charge nurses. The Director of nursing will use the clinical meeting process to validate charge nurse for compliance. Interviews conducted with 6 CNAs (CNAA, CNAB, CNAC, CNAM, CNAO, CNAP) across multiple shifts on 10/15/21 from 11:32a.m. to 1:32 p.m. revealed the CNAs verbalized comprehension of the in-service training. They stated they had received in-service training regarding monitoring skin every shift and entering observations in the resident's activity of daily living section. They stated they had been in-serviced on reporting any skin issues on the residents. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified on 10/15/21 at 11:26 p.m. that the Immediate Jeopardy was removed. While the IJ was removed on 10/15/21, the facility remained out of compliance at the severity level of actual harm that is not immediate jeopardy and a scope of Isolated because the facility was still monitoring their plan of removal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33198 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (Resident #3) of two residents reviewed for infection control practices during incontinent care. CNA P failed to perform proper hand hygiene and glove changes while providing incontinence care to Resident #3. This failure could place residents at risk for the spread of infection. Findings included: Review of Resident #3's face sheet dated 10/15/21, revealed an 87- year- old male admitted to the facility on [DATE] with diagnoses including lower urinary tract symptoms, benign prostatic hyperplasia, altered mental status, chronic pain, Alzheimer's disease and dementia. Review of Resident #3's MDS assessment dated [DATE] revealed Resident #3 required extensive assistance with most activities of daily living (ADLs) and two-person physical assistance with transfer. Resident #3 was always incontinent of bowel and bladder. Review of Resident #3's Care Plan dated 09/30/21 revealed the facility did not address Resident #3's incontinence in the plan. Observations of incontinent on 10/15/21 at 1:05p.m revealed CNA P removed Resident #3's soiled brief. Resident #3's brief was soiled with urine and fecal matter. CNA P wiped the resident from front to back. Her gloves were visibly soiled with urine and fecal matter. CNA P did not change gloves, wash hands or perform hand hygiene before retrieving a clean brief and placed it underneath the resident and fastened it. The DON was present while CNA P was performing the incontinent care. Both washed hands before exiting Resident #3 room. In an interview on 10/15/21 at 1:17 p.m. with CNA P, she acknowledged she should have changed her gloves before retrieving a clean brief and placing it underneath Resident #3. CNA P stated she has been employed in the facility for 3 years and received infection control training about one month ago. She said the resident could acquire an infection when she did not follow good infection control practices including washing hands and changing gloves. When asked why she did not change gloves, she said she was not paying attention. During an interview with the DON on 10/15/21 at 1:30 p.m., she revealed she was aware of some of the concerns raised about infection control. She stated she expected the aides to follow the facility protocols during care, one of which was to ensure hand washing and change of gloves as needed. Review of the facility's Handwashing and Hand hygiene policy revised August 2019 reflected, The facility considers hand hygiene the primary means to prevent the spread of infections . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Some of the policy and implementations includes: 1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections 2)All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3) Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations a) When hands are visibly soiled: b) After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile .