STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345499	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Litchford Falls Health and Rehabilitation Center	**8200 Litchford Road , Raleigh, North Carolina, 27615**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 1/6/26 to 1/8/26. The following intakes were investigated: 2705874, 2684042, and 2709001. Event 1E0244-H1. Three of nine allegations resulted in deficiency.	F0000		01/20/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, Nurse Practitioner, and Physician, for a resident with multiple pressure sores, the facility failed to 1) have effective systems and communication in place to ensure treatment orders were entered correctly after assessments by the Wound Nurse Practitioner and Facility Wound Nurse and based on the correct anatomical site so that the plan of care would be clear and able to be followed by all staff 2) ensure a nurse knew where to access a wound vac so it could be applied per orders and 3) evaluate how a resident's nutritional status and significant weight loss were potentially contributing to multiple pressure sores developing in order to determine if additional interventions were	F0686	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F686 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is no longer in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a wound/wound vac have the potential to be affected. All residents will have a completed skin assessment and treatment orders audited to ensure anatomical site is correct. This was completed by the wound provider and DON/designee on 1/14/26. All residents with orders for wound vacs will be audited to ensure wound vac placement is applied per order. This will be completed by the DON or designee. All residents will be reviewed for significant weight loss to ensure interventions are in place. This will be completed by the RD, DON or designee. All audits will be completed by the date of compliance 2/5/26.	02/05/2026

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 reverse for further 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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F0686 SS = D	Continued from page 1 needed. This was for 1 of 3 sampled residents reviewed for pressure sores (Resident #1). The findings included: Review of a hospital discharge summary, dated 10/23/25, revealed the following information. Resident # 1 was 66 years of age and had a history of spondylosis (age related wear and tear in the spinal disk which can lead to pain and compression of nerves), multiple falls, and spinal cord compression. On 10/2/25 he underwent decompression (surgery which relieves pressure on the spinal cord or nerves). The decompression surgery was complicated by the development of an epidural hematoma (a collection of blood around the spinal cord) and another surgery to address the epidural hematoma was performed. This had resulted in “significant bilateral leg weakness.” While hospitalized he also became septic (when an individual’s body has an extreme reaction to an infection and organ and tissue damage can occur from the response) secondary to hospital acquired pneumonia. Other diagnoses, which were included on the discharge summary and a 10/2/25 hospitalist’s note, included the following: a history of traumatic brain injury with right frontal craniotomy and aneurysm clipping (brain surgery to place a metal clip on a bulging artery in order to prevent a stroke), chronic obstructive pulmonary disease, diabetes, hypertension, hyperlipidemia, carotid artery stenosis, chronic back pain, obesity, osteoarthritis, neuropathy, history of alcoholism. Additionally, upon hospitalization, Resident # 1 reported current illegal drug use to the hospitalist. The 10/23/25 hospital discharge summary noted Resident # 1’s last weight was 240 pounds and 4.8 ounces. Record review revealed Resident # 1 was admitted to the facility on 10/23/25. Review of Resident # 1’s facility admission weight revealed the resident weighed 226 pounds on 10/23/25. The DON (Director of Nursing) was interviewed on 1/8/26 at 12:05 PM and reported the following information. After admission residents were to be weighed weekly times four and then their weights were assessed, and a schedule was determined from looking at their first four weights. Review of facility labs revealed Resident # 1’s albumin registered 3.5 on 10/24/25. (Normal levels are 3.5 to 5.5 and abnormally low levels at times may indicate nutritional problems or other medical problems).	F0686	Continued from page 1 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The wound nurse and/or designee will round with the Wound Nurse Practitioner weekly to see all residents with a wound. The Wound Nurse Practitioner will submit a written report to include new treatment orders and/or changes to current orders. The wound nurse will review the Wound Nurse Practitioner report for order/changes and enter said changes into the electronic medical record to be carried out as ordered by the wound nurse and/or designee. The DON will review the wound report weekly and discuss changes with the interdisciplinary team and update the care plan as needed. The wound report will be shared with the Registered Dietician weekly for review and will enter orders needed related to nutritional status related to wounds and/or significant weight loss. Facility stores extra wound vacs in the medication room for use so that the wound vac can be applied as ordered/timely. When a new wound is identified, the charge nurse will follow the in-house wound protocol and initiate the standing order in the electronic medical record, to be reviewed by the wound nurse and/or designee the following day. All new wounds identified are seen by the Wound Nurse Practitioner weekly. All licensed nurses will be educated on how to enter a correct order on the correct anatomical site, and how to access and apply a wound vac per order. Education will be conducted by the SDC or designee. Any licensed nurse will not be allowed to work until education is received. The RDCS or designee will educate RD, and Nurse Leadership (DON, Unit Managers, SDC, Admission Nurse) on monitoring weight loss and ensuring interventions are in place. Any newly hired nurse leadership member will be educated as part of their orientation process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. All new wound treatment orders will be audited to ensure that they are entered correctly and based on correct anatomical site. This audit will be completed by the DON or designee 5x week x4 weeks, weekly x4 weeks and monthly x1 month. All patients with wound vacs will be audited by the DON or designee to ensure wound vac is applied according to orders 5x week x4 weeks, weekly x4 weeks and monthly x1 month. All	

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F0686 SS = D	Continued from page 2 Review of Resident # 1's care plan revealed the following information. On 10/23/25 staff included that Resident # 1 was at risk for pressure sores related to advanced age, chronic health conditions, dry fragile skin, and incontinence. Interventions on 10/23/25 included to assess the resident for risk for skin breakdown, keep his skin clean and dry as possible, and perform skin assessments as indicated. On 10/24/25 information was added to the care plan noting Resident # 1 was at risk for weight loss or malnutrition related to his recent acute illness and hospitalization and chronic disease. One of the interventions added on 10/24/25 was for an RD (Registered Dietician) consultation as needed. On 10/24/25 the facility Wound Nurse completed a skin observation assessment form which noted Resident # 1 was being seen for a skin admission check. The facility Wound Nurse documented Resident # 1 had moisture associated skin damage (MASD) with an open area to the right buttock and that zinc oxide would be applied twice per day. The facility Wound Nurse also documented that the resident was educated on turning and positioning for pressure relief and skin integrity. Review of orders revealed on 10/24/25 an order was entered into Resident # 1's electronic record for Petrolatum-Zinc Oxide to be applied to the resident's right buttock MASD and open area every day and evening shift. The facility Wound Nurse and Director of Nursing were interviewed on 1/7/26 at 1:50 PM. The facility Wound Nurse reported the MASD and open area referenced on 10/24/25 to the right buttock was on the left buttock and there had been an error in documentation. There were skin protocols which the facility could utilize, and she had started zinc for the area on the left buttock. At the time of Resident # 1's admission she was newer to the role of facility Wound Nurse. Resident # 1's 10/29/25 facility admission Minimum Data Set assessment coded Resident # 1 as cognitively intact. He was assessed to need substantial to maximum assistance with his hygiene and with turning in bed. He was assessed to have no pressures sores and was at risk for developing pressure sores. His height was 67 inches, and his weight was recorded as 226 pounds. On 10/29/25 information was added to the care plan that the resident expected to be at the facility for a short-term basis and was planning to return to a community setting.	F0686	Continued from page 2 residents with significant weight loss will be audited by the DON or designee to ensure interventions are in place 5x week x4 weeks, weekly x4 weeks and monthly x1 month. The DON or designee will audit each wound report submitted from the Wound Nurse Practitioner against the orders in the electronic medical record to ensure accuracy 5x week x 4 weeks, weekly x 4 weeks and monthly x 1 month. The DON will audit the Registered Dietician report against the orders in the electronic medical record to ensure accuracy 5x week x 4 weeks, weekly x 4 weeks and monthly x 1 month. These audits will begin on 2/2/26. Results will be reported by the DON to the Quality Assurance Committee monthly x 3 months for further resolution as needed. 5. Date of Compliance: 2/5/26	

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F0686 SS = D	Continued from page 3 On 10/29/25 the Wound NP documented she saw Resident # 1 and Resident # 1 had intact skin on that date. The Wound NP noted the resident was at moderate/high risk for skin breakdown. On 10/29/25 an order was entered into the electronic record for Petrolatum-Zinc Oxide to be applied to the resident's right buttock every day and evening shift for preventative skin care. This order was in effect until 11/3/25. On 10/30/25 the facility Wound Nurse documented on a skin assessment form that the resident's skin was intact and that the resident had MASD to both buttocks. The facility Wound Nurse documented that zinc oxide would be continued. During the facility Wound Nurse's interview on 1/7/26 at 1:50 PM, she reported Resident # 1 only had MASD on 10/29/25 and the open area was no longer present. On 10/31/25 the RD documented she reviewed Resident # 1, and he had MASD to his buttocks. He was on a diabetic diet and was consuming 50 to 75 % of his meals. His albumin was 3.5 and within normal limits. His intake did not seem to be consistently meeting his estimated nutritional needs, and she recommended the resident receive 90 milliliters of Med Plus 1.7 twice per day with his medications. (Med Plus is a nutritional supplement). According to the record there was no further documented follow up by the RD in the notes until 12/8/25. Review of the medical record revealed there was no physician order entered for the Med Plus nutritional supplement in October and November 2025. On 10/31/25 orders were entered into Resident # 1's electronic record for an indwelling urinary catheter. Interview with the facility Wound Nurse on 1/7/26 at 1:50 PM revealed Resident # 1 had been in and out catheterized since admission because of urine retention and the indwelling catheter order was written on 10/31/25 for the urine retention. According to the facility Wound Nurse the catheter continued throughout the remainer of Resident # 1's stay and therefore he was no longer incontinent of urine. On 11/3/25 the facility Wound Nurse documented on a skin assessment form the following information. Resident # 1 was being seen by the Wound NP for a report of an open area to the right buttock. The area would be cleansed and collagen particles with a border	F0686		

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F0686 SS = D	Continued from page 4 gauze would be applied daily. The resident reported lying on his back and having difficulty with repositioning even with staff assistance. A new order for a bariatric air mattress was placed. The right buttock pressure sore measured 6 cm (centimeters) x 8 cm X 0.1 cm and was a Stage II. (According to the Facility Wound Nurse's interview on 1/7/26 at 1:50 PM this right buttock pressure sore was on the left buttock). On 11/3/25 the Wound NP documented Resident # 1 had a Stage II pressure sore to the right buttock which measured 6 cm X 8 cm X 0.1 cm and was 70 % epithelium (the thin skin tissue on the outer layer body) and 30 % granulation tissue (new healthy skin and tiny blood vessels in a wound bed). The Wound NP referenced this pressure sore as "Wound 1" in her progress note and noted the treatment would be collagen with a border gauze daily. She also recommended an air mattress. (According to the Facility Wound Nurse's interview on 1/7/26 at 1:50 PM this right buttock pressure sore was on the left buttock, and the Wound NP also referenced the wrong anatomical site). On 11/3/25 orders were entered into Resident # 1's electronic record for the following: Bariatric air mattress. Cleanse right buttock open area with wound cleanser or normal saline. Pat dry. Apply collagen particles followed by bordered gauze. Change daily and as needed every daily shift. (According to the facility Wound Nurse's interview on 1/7/26 at 1:50 PM this order was for the left buttock pressure sore.) On 11/10/25 the facility Wound Nurse documented the following on a skin assessment form. The resident had four pressure sore sites. Two were listed on the left buttock and were not stageable, one was on the right gluteal fold and was not stageable, and there was a right buttock pressure sore that was a Stage II. There was no notation that the resident had a pressure sore on his coccyx in this note. In the narrative note on the form, the facility Wound Nurse documented the following. "Resident seen for wound care and weekly skin check. Continue current treatment to right buttock. Cleanse with wound cleanser/NS (normal saline). Pat dry. Apply collagen particles and cover with silicone bordered gauze. This wound noted to have some frank red bleeding today, wound bed is black in color. Resident noted to have discolored area under skin (2) areas to left buttock and (1) to right gluteal fold. Resident is awaiting air mattress placement as resident is non-compliant with side-to-side position. Resident often refuses to get OOB (out of bed). Resident reeducated regarding pressure relief of	F0686		

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F0686 SS = D	Continued from page 5 buttocks and importance of side-to side positioning." According to an interview with the Administrator on 1/8/26 at 4:13 PM she was not the Administrator at the beginning of November 2025 when the resident was ordered to have a bariatric air mattress on 11/3/25. The Administrator provided an order confirmation that the bariatric mattress was ordered on 11/3/25 and reported that since bariatric air mattresses were not kept on site at the facility, it could take some time for an order to be filled and shipped to them. Interview with the DON on 1/8/26 at 4:13 PM revealed all the facility mattresses were designed to provide pressure relief and although the bariatric air mattress had still not been available as noted by the facility Wound Nurse's 11/10/25 documentation, the resident did have a pressure relief mattress in place, and the bariatric air mattress did arrive by 11/12/25. There were no orders noted entered into Resident # 1's record on 11/10/25 for the new pressure sores identified on 11/10/25 in the facility Wound Nurse's note. Review of Resident # 1's November 2025 TAR (Treatment Administration Record) revealed the only documented treatment for pressure sores on 11/10/25 and 11/11/25 was the application of collagen particles to the right buttock (which was the left buttock per the Facility Wound Nurse's interview on 1/7/26). On 11/11/25 orders were entered into Resident # 1's electronic record for the following: Cleanse coccyx with normal saline or wound cleanser and apply collagen particle with a silicone bordered gauze daily and as needed. Apply skin prep to discolored areas on the left buttock and left gluteal fold daily for 21 days for wound prevention. According to the November 2025 TAR these orders were first carried out on 11/12/25. Interview with the facility Wound Nurse on 1/7/26 at 1:50 PM revealed the following information. The date of 11/10/25 corresponded to a Monday when the Wound NP normally made rounds, but she thought the Wound NP was not able to visit that day. It was difficult to recall specifically how the pressure sores looked and where they were anatomically, but she recalled the resident had developed new ones. She would have applied treatments on 11/10/25 and 11/11/25 per the wound facility protocol although it was not documented. The facility Wound Nurse was interviewed regarding how other nurses who might need to apply a treatment or dressing in her absence would know the plan if orders	F0686		

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F0686 SS = D	Continued from page 6 were not entered and replied, “that was a good question.” The Wound Nurse also reported the resident was not being compliant in turning and repositioning. On 11/12/25 the facility Wound Nurse documented the following information on a skin assessment form. Resident # 1 had a pressure sore to the left buttock which measured 5 cm X 3 cm X 0.1 cm and was not stageable. The resident had a pressure sore to the sacrum which measured 3 cm X 2 cm X 0.1 cm and was not stageable. The resident had a pressure sore to the right gluteal fold which was 4 cm X 3 cm X 0.1 cm and was a suspected deep tissue injury. The resident had a right gluteus pressure sore that measured 0 cm X 0 cm X 0 cm and was unstageable. The facility Wound Nurse also documented Resident # 1 was being seen by the Wound NP for worsening areas to the buttocks. The facility Wound Nurse wrote, “Resident noted to have DTI (deep tissue injury) to right gluteal fold. Resident has another discolored intact area to lateral gluteus medius. New order for skin prep. Resident coccyx/sacrum area is open. New order for hydrogel AG (silver) and cover with silicone bordered gauze. Change daily and PRN (as needed). Discontinue collagen to right buttock necrotic area. Start hydrogel AG (silver) and cover with silicone bordered gauze. Change daily and PRN. Resident noted to have foul odor from necrotic wound. APRN (Advanced Practice Registered Nurse) advised. APRN to look into resident treatment in chart and verbally states will order labs and broad spectrum ABT (antibiotic) at this time. Resident currently utilizing air mattress for pressure relief as resident has been non-compliant with T & P (turning and repositioning), even with staff assistance resulting in several pressure areas to buttocks as listed above.” On 11/12/25 the Wound NP documented a narrative note with the following information. Resident # 1 had a pressure sore which was referenced as “Wound # 2” to the buttock (it did not note which buttock). The pressure sore was new and was unstageable. It measured 5 cm X 3 cm X 0.1 cm and was 100 % epithelium with evidence of deeper tissue injury (maroon or darkened purplish discoloration). The treatment recommendation was for hydrogel silver with a bordered gauze daily. There was a new unstageable pressure sore, which was referenced as “Wound # 3” to the right buttock which measured 3 cm X 2 cm X 0.1 cm and which was 100% epithelium with evidence of deeper tissue injury (marron or darkened purplish discoloration). The treatment recommendations were for a hydrogel silver with a bordered gauze daily. There was a new unstageable pressure sore to Resident # 1’s left gluteal fold, which was referenced as “Wound # 4” and	F0686		

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F0686 SS = D	Continued from page 7 which measured 4 cm X 3 cm X 0.1 cm. This wound was 100 % epithelium with evidence of deeper tissue injury (maroon or darkened purplish discoloration). The treatment recommendation was for skin prep to the base of the wound three times per week. This narrative note did not mention “Wound # 1” which was noted by the Wound NP on 11/3/25. This narrative note did not mention pressure sores to the coccyx or sacrum nor foul odors from a wound which the Facility Wound Nurse had referenced in her documentation. On 11/12/25 the following orders were entered into Resident # 1’s electronic record. Cleanse the coccyx/sacrum with wound cleanser or normal saline and apply hydrogel AG and cover with silicon bordered gauze. Change daily and as needed. May use calcium alginate until hydrogel available. The collagen particle dressing to the coccyx was discontinued. Cleanse left buttock with normal saline or wound cleanser. Pat dry. Apply hydrogel AG and cover with silicone bordered gauze daily and as needed. May use calcium alginate until hydrogel available. According to the November 2025 TAR, treatment to the left buttock and left gluteal fold continued on 11/12/25 as daily skin prep. (This had been ordered on 11/11/25). On 11/12/25 the antibiotic, Amoxicillin Potassium Clavulanate 500-125 mg, was ordered to be given three times per day for 10 days for bacterial infection. During an interview with the facility Wound Nurse on 1/7/26 at 1:50 PM, the Facility Wound Nurse reported the left buttock pressure sore was necrotic with the foul odor which was the first pressure sore the resident originally developed. It had worsened by 11/12/25 and the resident was started on antibiotics. Review of labs, dated 11/13/25, revealed Resident # 1’s albumin level registered 3.0, which was an abnormally low level and signified a 0.5 drop in his albumin since the date of 10/24/25. An interview was conducted with Nurse # 1 on 1/8/26 at 3:50 PM, who reviewed weekly facility weights. Nurse # 1 reported the following information Resident # 1 was weighed on 11/14/25 but the weight had not been entered into the resident’s electronic record. Nurse # 1 referenced a list of resident’s weights and reported that the resident had weighed 197.2 pounds on 11/14/25 which reflected a significant weight loss from the weight of 226 pounds on 10/23/25. Nurse # 1 reported they had missed one of Resident # 1’s weekly weights	F0686		

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F0686 SS = D	Continued from page 8 which should have been obtained the week prior to 11/14/25. On 11/14/25 the facility Wound Nurse documented on a skin assessment form the following information. Resident # 1 was seen by the Wound NP on rounds and the current treatment to the left buttock would be continued. According to the facility Wound Nurse's notation this was for hydrogel silver with a silicone bordered gauze daily and as needed. On 11/14/25 the Wound NP made a notation in a narrative note that "Wound # 1" was stable with the current treatment and there was no treatment adjustments that visit. The Wound NP on 11/14/25 referred to "Wound # 1" as appearing on the left buttock. The documentation in the 11/14/25 NP's narrative note did not address the other pressure sores. Also, on a separate 11/14/25 "Wound Assessment Report" the Wound NP documented that the resident had a "Stage II" to the left buttock which had been present on admission and was 70% epithelial tissue and 30 % granulation tissue. This report was signed on 11/14/25 by the Wound NP. The Wound NP's note did not reflect the necrosis noted that the facility Wound Nurse reported during an interview on 1/7/26 at 1:50 PM was evident in the left buttock pressure sore and which according to the facility Wound Nurse was the first pressure sore that had developed and worsened. On 11/14/25 an order was entered into Resident # 1's electronic record for the right gluteal fold treatment to be changed to an application of collagen particles with a border gauze daily and as needed. On 11/14/25 orders for the daily application of skin prep to the left buttock and left gluteal fold were discontinued. On 11/17/25 the facility Wound Nurse documented the following information in a skin assessment. Resident # 1 was being seen by the Wound NP. "Current treatments as follows. Cleanse left buttock with NS/Wound cleanser. Pat dry. Apply hydrogel AG or calcium alginate until hydrogel becomes available to left buttock necrotic skin and cover with silicone bordered gauze. Change daily and PRN. Sacrum: cleanse with NS/Wound cleanser. Apply hydrogel AG or calcium alginate until hydrogel is available. Cover with silcone bordered gauze. Change daily and PRN. Right gluteal fold. Cleanse with wound cleanser NS, pat dry. Apply hydrogel AG may use calcium alginate until hydrogel is available, and cover with silicone bordered gauze. Change daily and PRN." On 11/17/25 the Wound NP noted in a narrative note that the resident's wounds were stable with current	F0686		

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F0686 SS = D	Continued from page 9 treatment and no adjustments were needed. In a separate wound assessment report the Wound NP documented the following areas had pressure sores: the left gluteal fold, the left buttock, the right buttock, and the buttock (with neither left or right delineated). On 11/17/25 an order was entered into Resident # 1's electronic record for a change in the right gluteal fold pressure sore dressing. The order was for hydrogel silver and a border gauze; calcium alginate could be used until the hydrogel was available. The application of collagen particles, which had been ordered on 11/14/25, was discontinued. Review of facility documented weights in the resident's record revealed Resident # 1 weighed 197.2 pounds on 11/19/25. On 11/22/25 at 2:00 PM Resident # 1 received his last dose of schedule Amoxicillin -Clavulanate per documentation on the November, 2025 TAR. On 11/24/25 the Wound NP noted she was seeing Resident # 1 and noted the following information. She began debridement of Wound # 1. There was an area of eschar (thick, dark dead tissue) moveable with small strands attached to adipose tissue. On exam underneath the tissue there was extensive slough (unhealthy tissue) and eschar covering the wound, making it difficult to assess and therefore, debridement was stopped with a recommendation for the resident to go for further evaluation and debridement of the wound. Review of hospital records revealed Resident # 1 was hospitalized from 11/24/25 to 12/5/25. The 12/5/25 hospital discharge summary noted the following information. Resident # 1 was admitted on 11/24/25 for a "worsening left-sided sacral decubitus ulcer, with CT (computerized tomography) of the pelvis showing a 6.1 X 7.5 X 2.7 cm ulcer extending to the bony sacrum without osseous erosion or abscess." The wound was malodorous and draining purulent material on presentation with cultures growing enteric flora and blood cultures negative throughout hospitalization. Resident # 1 underwent sharp debridement (removal of dead, infected, or unhealthy tissue from a wound bed) by PT (physical therapy) and wound care on 11/25, followed by initiation of negative pressure wound care on 11/26/25. (Negative pressure wound care is provided by a wound vac which pulls fluid and bacteria from a wound and thereby assists with healing). The wound was noted to be moderately cleaner by discharge, though moderate slough remained in the upper portion. Additional superficial pressure injuries were present at the	F0686		

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F0686 SS = D	Continued from page 10 coccyx, right sacral, and right ischial regions and were managed with topical therapy. The resident had received antibiotics while hospitalized. Upon discharge, the skilled nursing facility was to resume negative pressure wound therapy as soon as possible and the resident was to be on a low air loss bed surface. There were no specific orders for other pressure sores documented in the hospital discharge summary to be “superficial” and located on the coccyx, right sacrum and right ischial regions. The discharge summary further noted the following: The resident was recommended to have a planned wound Physician follow up assessment appointment in two to four weeks after discharge to ensure progress towards healing. The Wound Center could be called to make an appointment for surgery wound clinic if needed. The resident needed an air loss bed mattress and strict two hour turning. The resident should not sit until wound healing of the left sacral/buttock wound was well established. Once healing was established it was recommended the resident have a specialty cushion and only be out of bed twice daily initially for two hours with close monitoring. The resident should have greater than 100 grams of protein daily. The discharge summary also noted, “referral to plastic surgery placed for eventual consideration of coverage.” Review of the facility record revealed Resident # 1 returned on 12/5/25 (Friday) to the facility. There were no orders entered into the resident’s electronic record for his pressure sores until 12/8/25 (Monday). There were no documented treatments for Resident # 1’s pressure sores on 12/6/25 and 12/7/25. The resident’s weight registered 207.4 pounds on 12/5/25. Nurse # 1, who helped coordinate new admission residents, was interviewed on 1/7/26 at 3:40 PM and reported the following information. Resident # 1 had arrived at the facility late in the evening on 12/5/25 and she had only seen the resident “in passing.” She had not looked at his wounds or entered orders. She was also on-call during the weekend and thought she recalled getting a call from one of the nurses who reported either the wound vac was not available or was nonfunctioning. According to Nurse # 1 it was facility approved protocol that a wet to dry dressing could be applied if a wound vac was not available or there were problems with a wound vac. Nurse # 2, who had cared for Resident # 1 on 12/6/25 and 12/7/25, was interviewed on 1/8/26 at 10:35 AM and reported the following information. She thought that if	F0686		

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F0686 SS = D	Continued from page 11 a resident was ordered to have a wound vac that it needed to specifically be ordered for the resident. She did not know where to find one when she worked with Resident # 1 on 12/6/25 and 12/7/25. She did not recall calling anyone about not having the wound vac. The resident's wounds were very wide and long. She placed a wet to dry dressing on the wounds. Interview with the Director of Nursing on 1/8/26 at 9:55 AM revealed the following information. There was a wound vac in the treatment room at the facility on 12/5/25 when Resident # 1 returned. The treatment room had a code on the door, and all the nurses had been given a code to access supplies. She had not received any notice over the weekend that the resident was to have a wound vac and that the nurses did not know where to find one. Multiple nurses who worked over the weekend when Resident # 1 returned were trained in how to apply a wound vac and the wound vac should have been placed on the resident. Review of Resident # 1's care plan revealed a problem was added on 12/6/25 which noted Resident # 1 had behaviors and would refuse to get out of bed, refused medications, was easily agitated, and refused to consent for treatment from psychological services. Resident # 1's care plan was updated again on 12/8/25 to reflect the resident had a pressure sore on his sacrum, right buttock, and right gluteal fold and was at risk for worsening or development of further pressure sores due to advanced age, chronic health conditions, dry fragile skin, extended hospitalization, frequent incontinence, immobility, inability to turn and reposition independently, and MASD. Interventions included: providing an alternating air mattress which had been added to the care plan on 11/3/25, keeping the resident clean and dry which had been added on 11/3/25, assisting the resident to turn and reposition with a draw sheet while in bed which had been added on 11/3/25, pressure relieving cushion to chair which was added on 11/3/25, providing treatments per the TAR (treatment administration record) which was added on 12/15/25, wound reviews as indicated which was added on 12/15/25, skin assessments as indicated which was added on 12/15/25, supplement to promote healing which was added on 12/15/25, and referral to Wound Physician as indicated which was added on 12/15/25. Review of the facility Wound Nurse's skin assessment, dated 12/8/25, revealed the resident had a stage IV pressure to the left buttock which measured 6 cm X 7.5 cm X 3.0 cm, a stage III pressure sore to his right lower buttock which measured 3.0 cm X 1.0 cm X 0.1 cm to the right lower buttock, and a Stage III pressure	F0686		

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F0686 SS = D	Continued from page 12 sore to the right mid buttock that measured 6 cm X 4.5 cm X 0.1 cm. On 12/8/25 orders were entered into Resident # 1's electronic record to cleanse the mid buttock open area with normal saline or wound cleanser and apply calcium alginate with silver every Monday, Wednesday, and Friday and as needed. A wound vac was to be applied at 125 mm HG (milliliters of mercury) continuous pressure to the left buttock wound on Monday, Wednesday, and Friday. The lower right buttock was to be cleansed and calcium alginate with silver was to be applied Monday, Wednesday, and Friday and as needed. Review of the 2025 December TAR revealed the Wound Vac was documented as applied on 12/10/25, 12/12/25, and 12/15/25 to the left buttock pressure sore. A calcium Alginate Silver dressing was documented as applied to the lower right buttock and mid buttock wounds on 12/10/25, 12/12/15, and 12/15/25. Interview on 1/7/26 at 1:50 PM with the facility Wound Nurse revealed when she arrived on 12/8/25 (Monday) there had been no orders initiated in the electronic record for Resident # 1's pressure sores and the wound vac had not been in place. There had been a clean, wet to dry dressing on his pressure sores. She initiated the orders on 12/8/25 and started the wound vac. The worst pressure sore was still to the resident's left buttock area and in applying the wound vac and drape, the other areas would be covered to form a seal. Therefore, orders were initiated for all other pressures sores to be changed on Monday, Wednesday, and Friday with the wound vac change. On 12/8/25 the RD made her first documented assessment following 10/31/25. The RD noted the resident had experienced a more than 30-pound weight loss in the last 2 months which was considered a significant weight loss. His current weight of 207 pounds showed an increase from his weight on 11/19/25 but also showed a decrease of 18.6 pounds when compared to the resident's initial weight on first admission. The RD noted the resident had three pressure sores which were all present upon admission. He had increased nutritional needs to heal his wounds and his intake may not meet those needs. The RD recommended starting Med Plus 1.7 90 ml twice per day with medications, a daily multivitamin, Vitamin C 500 milligrams daily, and Zinc 220 milligrams daily. According to Resident # 1's Medication Administration record the supplements, which were recommended on 12/8/25 in the RD's note, were ordered and started on	F0686		

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F0686 SS = D	Continued from page 13 12/10/25. This was the first time the Med Plus was ordered following the RD's 10/31/25 recommendation to provide it. On 12/10/25 the Wound NP documented she saw Resident # 1 and noted the following information. "Wound # 1," which was on the left buttock was a Stage IV and measured 6 cm X 4 cm X 2.5 cm. The treatment recommendation was for a wound vac at 125 mm HG continuous therapy to the base of the wound to be changed three times per week. "Wound # 2" which was located on the resident's sacrum was a Stage III and measured 5 cm X 3 cm X 0.1 cm and was 50 % granulation tissue and 50% slough. The treatment recommendation was for hydrogel sliver to be applied daily. "Wound # 4," which was on the resident's right gluteal fold was unstageable and measured 2 cm X 1.5 cm X 0.3 cm with 50 % granulation tissue and 50% slough. The treatment recommendation was for calcium alginate to be applied three times per week with a border gauze. There were no new treatment orders entered into Resident # 1's electronic record on 12/10/25 for pressure sore care. On 12/12/25 an order was entered into Resident # 1's electronic record for metronidazole 500 mg to be crushed and inserted into the left buttock wound every Monday, Wednesday, and Friday. (Metronidazole is an antibiotic which when crushed and applied to pressures sores can help odors). On 12/16/25 the first physician order following the readmission date of 12/5/25 for the sacrum was entered into the record. The order was for hydrogel and sliver Monday, Wednesday, and Friday. On 12/17/25 according to the facility record, Resident # 1 was transferred to the hospital for evaluation of a change in mental status. According to 12/17/25 Emergency Department notations, the resident had multiple pressure sores in various stages. The resident's hospital discharge summary, dated 12/23/25, did not further classify the pressure sores. The discharge summary did note that the resident had undergone a CT while hospitalized that showed no osteomyelitis (infection of the bone) underneath the resident's sacral pressure sore. The resident did not return to the facility for care following 12/17/25. Unit Manager # 1 was interviewed on 1/8/26 at 2:15 PM and reported the following information. Resident # 1 would eat but he only ate about ½ of his portions. He would refuse to turn and say, "Why am I turning? I am	F0686		

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F0686 SS = D	Continued from page 14 not going to get better." He refused to have psychological services while at the facility. Nurse Aide # 2, who had cared for Resident # 1, was interviewed on 1/6/26 at 2:10 PM and reported the following information. She had cared for Resident # 1 while he resided at the facility. He did not want to turn. She tried to assist him and would prop him with pillows, but he was able to remove the pillows and then he would rotate back to his back. The Rehabilitation Director was interviewed on 1/7/26 at 12:40 PM and reported the following information. To some degree, Resident # 1 could turn himself. His ability varied but he required moderate to maximum assistance. He could use his upper body and then get some momentum in his hips to help turn. Some of it was dependent on what he wanted to do, and he was often not agreeable to a lot of things. At time of discharge, therapy continued to work with him in rehabilitation. The Wound NP was interviewed on 1/7/26 at 10:40 PM and reported Resident # 1 had developed pressure sores and areas of deep tissue injury to his buttocks and sacrum. He would lie flat on his back and would not cooperate with turning. She thought the areas he developed after admission appeared as Kennedy ulcers. (Kennedy Ulcers appear near death and can develop quickly and progress rapidly). His diet was poor and he liked to eat fast food and sugary drinks. His noncompliance in turning, his diet, his diabetes and chronic obstructive pulmonary disease had contributed to the development and non-healing of wounds. She was not aware of any problems with getting a wound vac for him when he was readmitted to the facility on 12/5/25. The facility's RD was interviewed on 1/8/26 at 2:46 PM and reported the following information. Resident # 1 did not seem to flag as a person who would be malnourished when he first came in. He was obese and not elderly. She did not recall if she talked to him personally or just reviewed his record. For a person to lose the amount of weight noted in the facility record, it would appear to her that there was some underlying cause rather than just not eating to have caused the change if the readings were correct. She did not know why nutritional support had not started on 10/31/25 when she documented that his intake was not meeting his nutritional needs and recommended Med Pass. According to the RD, a person's outward appearance did not always reflect their nutritional status. She thought she recalled asking for a reweight on Resident # 1 before he was hospitalized on 11/24/25. She did not recall evaluating the low albumin and weight loss prior to	F0686		

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F0686 SS = D	Continued from page 15 Resident # 1's 11/24/25 transfer to the hospital. She routinely reviewed residents who had weight loss and she routinely followed residents who had wounds. For residents who had wounds, she routinely saw them once per month to evaluate them. There was a wound report which would note if residents' wounds were worsening or improving and she would evaluate if they were getting enough nutrition for their wounds. She did not know what had happened that she did not evaluate Resident # 1 in November 2025. The RD stated Resident # 1's wounds would have increased his metabolic needs. During the interview with the facility Wound Nurse and Director of Nursing on 1/7/26 at 1:50 PM the Director of Nursing reported the following information. The Wound NP (Nurse Practitioner) visited and made weekly rounds on Mondays to see residents with pressure sores. On Wednesdays, the Wound NP also was at the facility and saw residents who had developed new pressures sores, or who were newly admitted. The facility did have approved wound protocols for treatments and the Wound NP also made rounds with the facility Wound Nurse. According to the DON, the facility's procedure was that the Wound NP would verbally communicate with the facility Wound Nurse and also compile a report with orders on the day that the Wound NP made rounds. The orders were then entered into the record by the facility Wound Nurse. According to the facility Wound Nurse, a resident's physician would then sign the wound orders because the Wound NP did not sign her orders electronically. The facility Wound Nurse indicated all of Resident # 1's electronic wound orders would have originated from the facility's protocols or from the Wound NP during the Wound NP's visit. The DON reported the Wound NP was newer to the facility in October and November. According to the DON, some of the lack of clarification of orders for specific anatomical sites may have originated from both the facility Wound Nurse being new with a new Wound NP, but she felt the resident was receiving treatments for the wounds. During an interview with the DON on 1/8/26 at 5:20 PM the DON also reported that when supplements were started on 12/10/25, Resident # 1 often refused them and if they had started nutritional supplementation earlier, she felt he would have refused also refused them at an earlier time. The DON and Nurse # 1 were not able to identify why the RD's 10/31/25 supplementation recommendation had been initially missed and not followed up on in October and November 2025. Interview with Resident # 1's physician on 1/8/26 at 11:45 AM and again on 1/8/26 at 5:15 PM revealed he had seen Resident # 1 on 12/16/25 (the day before he was discharged to the hospital). They had talked about his	F0686		

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F0686 SS = D	Continued from page 16 pain and his ulcers, but he had not seen the pressure ulcers. The Wound Care Nurse Practitioner would have handled that. Resident # 1 was a functional quadriplegic, and wounds could easily develop because of his neurological status. Other medical reasons could have been affecting his albumin levels for them to drop as they did. The resident had a history of alcohol abuse, and he could have some liver disease. When he had seen Resident # 1, the resident did not outwardly appear malnourished and was a larger resident. The facility's Medical Director was interviewed on 1/8/26 at 11:00 AM and reported that residents have the right not to turn off their back if that was a resident's preference. Not turning and relieving pressure would have affected the development and healing of pressure sores for Resident # 1. The Medical Director was also interviewed about the application on 12/6/25 and 12/7/25 of wet to dry dressings rather than a wound vac, and the Medical Director reported he felt the application of the wet to dry dressings was an appropriate treatment for Resident # 1's wounds. According to the Medical Director, the resident would not have had any negative consequences from two days of applying wet to dry dressings versus a wound vac.	F0686		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F0692	F692 Nutrition/Hydration Status Maintenance Based on record review and interviews with staff, Registered Dietician (RD), and Physician the facility failed to 1) initiate a supplement per the Registered Dietician's recommendation when the Registered Dietician noted the resident's intake was not consistently meeting nutritional needs and 2) obtain weights on a newly admitted resident per the facility's reported system to establish future individualized weight monitoring timeframes 3) evaluate a resident's significant weight loss and declining albumin levels for 1 of 3 residents whose weights were reviewed Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is no longer in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	02/05/2026

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F0692 SS = D	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Registered Dietician (RD), and Physician the facility failed to 1) initiate a supplement per the Registered Dietician's recommendation when the Registered Dietician noted the resident's intake was not consistently meeting nutritional needs and 2) obtain weights on a newly admitted resident per the facility's reported system to establish future individualized weight monitoring timeframes 3) evaluate a resident's significant weight loss and declining albumin levels for 1 of 3 residents whose weights were reviewed (Resident #1). The findings included: Record review revealed Resident # 1 was admitted to the facility on 10/23/25. Review of a hospital discharge summary, dated 10/23/25, revealed the following information. Resident # 1 was 66 years of age and had a history of spondylosis, multiple falls, and cord compression. On 10/2/25 he underwent decompression (surgery which relieves pressure on the spinal cord or nerves). The decompression surgery was complicated by the development of an epidural hematoma (a collection of blood around the spinal cord) and another surgery to address the epidural hematoma was performed. This had resulted in "significant bilateral leg weakness." While hospitalized he also became septic secondary to hospital acquired pneumonia. Other diagnoses, which were included on the discharge summary and a 10/2/25 hospitalist's note, included the following: a history of traumatic brain injury with right frontal craniotomy and aneurysm clipping, chronic obstructive pulmonary disease, diabetes, hypertension, hyperlipidemia, carotid artery stenosis, chronic back pain, obesity, osteoarthritis, neuropathy, history of alcoholism. Additionally, upon hospitalization, Resident # 1 reported current illegal drug use to the hospitalist. The 10/23/25 hospital discharge summary noted Resident # 1's last weight was 240 pounds and 4.8 ounces. Review of Resident # 1's facility admission weight revealed the resident weighed 226 pounds on 10/23/25. The DON (Director of Nursing) was interviewed on 1/8/26 at 12:05 PM and reported the following information. After admission residents were weighed weekly times four and then their weights were assessed, and a schedule was determined from looking at their first four weights. Usually, the RD was in the facility weekly, and any abnormalities in weights should be	F0692	Continued from page 17 All residents have the potential to be affected. All Registered Dietician recommendations from the last 30 days will be audited to ensure that they have been addressed. All new admissions in the last 30 days will be audited to ensure weekly weights are obtained for 4 weeks. All residents with significant weight loss will have their existing labs reviewed for declining albumin levels. These audits will be completed by the DON or designee. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Regional Director of Clinical Services (RDCS) or designee will educate Nurse Leadership (DON, Unit Managers, SDC, Admission Nurse) on reviewing and addressing all Registered Dietician recommendations to address nutritional needs. All licensed nurses will be educated by the SDC or designee on obtaining weekly weights x4 weeks on new admissions. The RDCS or designee will educate the RD on reviewing labs for declining albumin levels. Any resident with a declining albumin level will be reported to the Registered Dietician and Physician/Nurse Practitioner for further review as they are received from the lab. The Interdisciplinary team meets weekly to discuss weekly weights and the DON will report any significant weight loss to the Physician/Nurse Practitioner as well as the Registered Dietician. In the event the DON is out of the facility, the Unit Manager will be responsible for reporting any significant weight loss for further review. The Registered Dietician will enter any new orders/interventions into the Electronic Medical Record for the facility to implement. The facility will continue to follow the on-call process with the medical provider to report weight loss/abnormal labs and will enter any telephone orders as they are received into the electronic medical record. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. All Registered Dietician recommendations will be audited weekly x 8 weeks, and monthly x1 month to ensure that recommendations have been addressed. All new admissions will be audited weekly x8 weeks and monthly x1 month to ensure weekly weights are obtained.	

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F0692 SS = D	Continued from page 18 reviewed by the RD. The DON indicated Nurse # 1 helped oversee the weekly weights. Review of Resident # 1's laboratory test results revealed his albumin registered 3.5 on 10/24/25. (Normal levels are 3.5 to 5.5 and abnormally low levels at times may indicate nutritional problems or other medical problems). Review of Resident # 1's care plan revealed the following information. On 10/24/25 information was added to the care plan noting Resident # 1 was at risk for weight loss or malnutrition related to his recent acute illness and hospitalization and chronic disease. Interventions on the care plan included the following: RD consult as needed (added on 10/24/25 to the care plan), record meal % intake (added on 10/24/25 to the care plan); and review dietary preferences with the resident as needed (added on 10/24/25 to the care plan), and therapeutic diet as ordered (added on 10/24/25 to the resident's care plan). On 10/24/25 the facility Wound Nurse completed a skin observation assessment form which noted Resident # 1 was being seen for a skin admission check and Resident # 1 had moisture associated skin damage (MASD) and an open area to the right buttock. Resident # 1's 10/29/25 facility admission Minimum Data Set assessment coded Resident # 1 as cognitively intact. His height was 67 inches, and his weight was recorded as 226 pounds. He was not coded as having pressure sores. On 10/31/25 the RD documented she reviewed Resident # 1, and he had MASD to his buttocks. He was on a diabetic diet and was consuming 50 to 75 % of his meals. His albumin was 3.5 and within normal limits. He had no difficulty swallowing regular texture food items and required set-up of meals. His intake did not appear to be consistently meeting his estimated nutritional needs, and she recommended the resident receive 90 milliliters of Med Plus 1.7 twice per day with his medications. (Med Plus is a nutritional supplement). According to the October and November 2025 physician orders, the Med Plus was not ordered following the RD's recommendation on 10/31/25. The RD was interviewed on 1/8/26 at 2:46 PM and reported the following information. She did not know why nutritional support for Resident #1 had not started on 10/31/25 when she documented that his intake was not meeting his nutritional needs and recommended Med Plus.	F0692	Continued from page 18 All residents with significant weight loss will have their labs reviewed for declining albumin levels weekly x 4 weeks, weekly x1 month and monthly x1 month. These audits will be conducted by the DON or designee. These audits will begin on 2/2/26. Results will be reported by the DON to the Quality Assurance Committee monthly x3 months for further resolution as needed. 5. Date of Compliance: 2/5/26	

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F0692 SS = D	Continued from page 19 The RD indicated at times she would put the order into the computer herself, or she would ask a nurse to do so. On 11/10/25 the Facility Wound Nurse documented the following on a skin assessment form. The resident had developed four pressure sore sites. Three were listed as not stageable and one was listed as a Stage II. One was described as black and bleeding. On 11/12/25 the Facility Wound Nurse documented on a skin assessment form that Resident # 1 had multiple pressure sores on that date and was being seen by the Wound NP (Nurse Practitioner). The Facility Wound Nurse documented one of the resident's pressures sores was necrotic with a foul odor and that the Wound NP's plan was to order labs. Review of labs, dated 11/13/25, revealed Resident # 1's albumin level registered 3.0, which was an abnormally low level and signified a 0.5 drop in his albumin since the date of 10/24/25. On 11/12/25 at 3:36 PM the Facility Social Worker noted a care plan conference was held with the resident and a family member. The family member attended by phone. The care conference documentation included no notations that weight loss concerns or nutritional concerns were discussed. On 11/13/25 an intervention was added to the resident's care plan to give supplements as ordered. The Minimum Data Set Assessment Nurse was interviewed on 1/8/26 at 4:22 PM and reported she did update care plans but had not attended Resident # 1's care conference. Other staff members would have done so and given her any interventions to add to the care plan. She was not familiar with Resident # 1's weight loss and could not provide further information about weight loss interventions or why they were added. An interview was conducted with Nurse # 1 on 1/8/26 at 3:50 PM, who reviewed weekly facility weights. Nurse # 1 reported the following information. Resident # 1 was weighed on 11/14/25 but the weight had not been entered into the resident's electronic record. Nurse # 1 referenced a list of residents' weights and reported that Resident # 1 weighed 197.2 pounds on 11/14/25 which reflected a significant weight loss from the weight of 226 pounds on 10/23/25. Nurse # 1 further reported the following information. The facility had also missed weighing Resident # 1 during the first four weeks following his initial admission as they should	F0692		

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F0692 SS = D	Continued from page 20 have done because the 11/14/25 weight was the first weight she (Nurse #1) could find in any of the facility's records since 10/23/25 for Resident # 1. Nurse Aide # 1 usually started obtaining weights on Mondays and would make a list of the results. She (Nurse # 1) generally reviewed weights on Wednesdays. If there was a significant loss, then a reweight was supposed to be done. If the reweight was accurate, then she usually called the RD to discuss. Nurse #1 indicated she had been out of work for a part of November 2025 when the resident's weight loss and albumin level drop had occurred, and this could have contributed to the weight loss not being evaluated in November 2025. On 1/8/26 at 5:00 PM, Nurse Aide # 1, who had obtained Resident # 1's weights while he resided at the facility, was interviewed and reported the following information. She did not recall seeing what looked like fluid in the resident when he was being weighed. If she saw that a resident looked swollen from fluid, she typically would put a note beside the weight. He did seem larger when he was initially admitted and when she weighed him in following weeks, she noticed he appeared to be losing weight. Review of facility documented weights in the resident's record revealed Resident # 1 weighed 197.2 pounds on 11/19/25. (This represented a 12.7 % weight loss since admission) There was no documentation from 11/14/25 through 11/24/25 of an assessment of what was contributing to the resident's weight loss and low albumin and possible interventions. Review of hospital records revealed Resident # 1 was hospitalized from 11/24/25 to 12/5/25 due to worsening of his pressure sores. Review of the facility record revealed Resident # 1 returned on 12/5/25 (Friday) to the facility. The resident's weight registered 207.4 pounds on 12/5/25. On 12/8/25 the RD made her first documented assessment following 10/31/25. The RD noted the resident had experienced a more than 30-pound weight loss in the last 2 months which was considered a significant weight loss. His current weight of 207 pounds showed an increase from his weight on 11/19/25 but also showed a decrease of 18.6 pounds when compared to the resident's initial weight on first admission. According to the RD note, the 18.6 pound weight loss from admission to the 12/5/25 weight of 207.4 pounds was considered an 8.2%	F0692		

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F0692 SS = D	Continued from page 21 weight loss. The RD noted the resident had three pressure sores which were all present upon admission. The resident had increased nutritional needs to heal his wounds and his intake may not meet those needs. The RD recommended starting Med Plus 1.7 90 ml twice per day with medications, a daily multivitamin, Vitamin C 500 milligrams daily, and Zinc 220 milligrams daily. According to Resident # 1's Medication Administration Record (MAR) the supplements, which were recommended by the RD on 12/8/25, were ordered and started on 12/10/25. This was the first time the Med Plus order was transcribed to the MAR for staff to know to administer it since the RD's initial recommendation on 10/31/25. A review of the resident's consumption of the Med Plus 1.7 revealed that between 12/10/25 and 12/17/25 Resident # 1 consumed 25 % one time, 100 % two different administration times, and 50 % one administration time. Other times the resident did not consume the Med Plus. On 12/17/25 Resident # 1 was discharged and did not return to the facility. Unit Manager # 1 was interviewed on 1/8/26 at 2:15 PM and reported the following information. Resident # 1 would eat but he only ate about ½ of his portions. Although he had pressure sores, he would refuse to turn and say, "Why am I turning? I am not going to get better." He refused to have psychological services while at the facility to address any depression he had. During the interview with the facility's RD on 1/8/26 at 2:46 PM, the RD reported the following information. Resident # 1 did not seem to flag as a person who would be malnourished when he first was admitted on 10/23/25. He was obese and not elderly. She did not recall if she talked to him personally or just reviewed his record. For a person to lose the amount of weight noted in the facility record, it would appear to her that there was some underlying cause rather than just not eating to have caused the change if the weight readings were correct. The RD indicated she could only go by documented resident weights when she assessed a resident. According to the RD, a person's outward appearance did not always reflect their nutritional status. She also found that hospital weights were not always accurate. The RD thought she recalled asking for a reweight on Resident # 1 before he was hospitalized on 11/24/25. She did not recall evaluating the low albumin and weight loss prior to Resident # 1's 11/24/25 transfer to the hospital. The facility would give her residents' weights to review. She reviewed residents who had weight loss and she routinely	F0692		

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F0692 SS = D	Continued from page 22 followed residents who received enteral feedings, new admission residents, residents who had wounds, and residents whom the physician had asked for an evaluation. For residents who had wounds, she routinely saw them once per month to evaluate them. There was a wound report which would note if residents' wounds were worsening or improving and she would evaluate if they were getting enough nutrition for their wounds. She did not know what had happened that she did not evaluate Resident # 1 in November 2025. The RD stated Resident # 1's wounds would have increased his metabolic needs. Interview with Resident # 1's physician on 1/8/26 at 11:45 AM and again on 1/8/26 at 5:15 PM revealed he had seen Resident # 1 on 12/16/25 (the day before he was discharged). The resident had a history of alcohol abuse, and he could have had some liver disease. This could have been affecting his albumin levels. When he had seen Resident # 1, the resident did not outwardly appear malnourished and was a larger resident. He thought the resident did not particularly like the facility's food and his wounds were using some of the nutrients he did eat. According to the physician, the resident did not have fluid retention problems. The DON and Nurse # 1 were again interviewed on 1/8/26 at 5:20 PM. Nurse # 1 reported the resident had a history of actively using illegal drugs prior to his hospitalization and facility residency of 10/23/25. She felt this could have contributed to an individual having a poor appetite and not wanting to eat when their body was used to having drugs in their system. Nurse # 1 also reported that Resident # 1 would order out a lot of food. According to the DON, she felt if nutritional supplements had been started sooner, the resident still would not have been compliant in consuming the supplements. The DON and Nurse # 1 were not able to identify why the RD's 10/31/25 supplementation recommendation had been initially missed and not followed up on in October and November 2025	F0692		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use	F0842	F842 Resident Records - Identifiable Information 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #1 is no longer in the facility. Nurse #1 is no longer in the role of wound nurse and the Wound Nurse Practitioner (NP) is no longer with the facility.	02/05/2026

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F0842 SS = D	Continued from page 23 or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there	F0842	Continued from page 23 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with an SBAR (situation, background, assessment and recommendation form) and wounds are at risk. On 1/14/26, the Director of Nursing (DON), Unit Manager (UM) and new Wound NP reviewed all residents with wounds for accurate documentation of noted wounds in the electronic medical record (EMR). There were no discrepancies noted. The DON and UM reviewed all residents with an SBAR completed in the last 30 days for completion to include vital signs and a nurse's note with the change in condition noted. There were 4 discrepancies noted and corrected. 3. The measures that will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Education was started by the Staff Development Coordinator on 1/9/26 to all licensed nurses and Wound NP regarding accurate documentation of wounds in the EMR and completion of an SBAR to include current vital signs and a nurse progress note prior to sending a resident to the Emergency Room (ER). All licensed nurses and Wound NP will be educated by 2/5/26 by the SDC or designee. Any licensed nurse or Wound NP not receiving education will not be allowed to work until received. All licensed nurses and Wound NP hired after 2/5/26 will receive this education during orientation. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will observe 5 wound observations and review EMR for correct documentation of wounds 5 x weekly for 4 weeks, 3 x weekly x 4 weeks and weekly for 1 month. The DON will review all residents sent to the ER for completion of an SBAR to include vital signs and a nurse progress note daily x 4 weeks, 4 x weekly x 4 weeks and 2 x weekly x 4 weeks. These audits will begin on 2/2/26. Results will be reported by the DON to the Quality Assurance Committee (QAPI) x3 months for further resolution as needed. 5. Date of Compliance 2/5/26	

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F0842 SS = D	Continued from page 24 is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, the facility failed to ensure the resident's medical record was accurate and complete for 1 of 7 sampled residents (Resident # 1). The findings included: 1a. Resident # 1 was admitted to the facility on 10/23/25. Record review revealed on 12/17/25 Nurse # 2 completed a transfer form and a SBAR form (situation, background, assessment, and recommendation form) noting Resident # 1 was being transferred to the hospital for an altered mental status. Review of the vital signs on the transfer form dated 12/17/25 revealed vital signs obtained on and dated 12/16/25 were documented and included as the resident's vital signs. The same vital signs results, which were obtained on 12/16/25 also appeared on the SBAR form dated 12/17/25. On the SBAR form there was a place to include nursing notes (for additional information on the change in condition). The form was blank where additional information was to appear. There were no vital signs from 12/17/25 documented on the transfer form or the SBAR. Review of the medical record revealed there was no	F0842		

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F0842 SS = D	Continued from page 25 narrative note in the progress notes which noted vitals when the altered mental status was first observed. Nurse # 2 was interviewed on 1/8/26 at 10:35 AM and reported the following information. On 12/17/25 she had been assigned to Resident # 1 and was with the facility Wound Nurse in the resident's room when they both noticed the resident was not responding per his baseline. Usually, Resident # 1 was conversive, alert and oriented. On that day she told him her name and asked the resident what his name was. Instead of responding appropriately, the resident only repeated her (Nurse # 2's name). She recalled she had her blood pressure cuff, and she took the resident's blood pressure and pulse. He was not having labored breathing. She did not recall what the vitals she took registered and did not document them in the record. Nurse #2 indicated she had written them on a piece of paper, but she did not know what happened to the paper. According to an interview with the Director of Nursing on 1/8/26 at 9:55 AM the vital signs which Nurse # 2 took when the resident was observed with an altered mental status on 12/17/25 had not been included in his electronic medical record which made the record incomplete. 1b. Record review revealed the facility Wound Nurse completed a skin observation assessment form on 10/24/25 which noted Resident # 1 was being seen for an admission skin check. The facility Wound Nurse documented Resident # 1 had an open area to the right buttock. On 11/3/25 the facility Wound Nurse documented on a skin assessment form Resident # 1 was seen by the Wound Nurse Practitioner (NP) for a pressure sore to his right buttock. On 11/3/25 the Wound NP documented Resident # 1 had a Stage II pressure sore to the right buttock. Interview with the facility Wound Nurse on 1/7/26 at 1:50 PM revealed the following information. She was newer to the role of Facility Wound Nurse during October 2025. The facility Wound Nurse confirmed she did not document the correct location for Resident #1's open area on the skin observation assessment form dated 10/24/25. The facility Wound Nurse confirmed she and the Wound NP had inaccurately documented the open area was on the right buttock for several weeks when it was actually on the left buttock. The DON was also present on 1/7/26 at 1:50 PM during	F0842		

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F0842 SS = D	Continued from page 26 the interview with the Facility Wound Nurse. The DON reported the Wound NP was also newer to the facility in addition to the facility Wound Nurse being newer to her role. According to the DON, this may have led to the inaccurate documentation.	F0842		