STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	**401 N MORGAN STREET SHELBY, NC 28150**

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 02/20/23 through 02/24/23. The surveyor returned to the facility on 2/28/23 to validate the credible allegation and therefore the exit date was changed to 2/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# CB1G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/20/23 through 02/24/23. The surveyor returned to the building on 2/28/23 to validate the credible allegation therefore the exite was changed to 2/28/23. Event ID# CB1G11. Intake NC000197425 was investigated. 1 of the 2 complaint allegations resulted in a deficiency. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of (J) CFR $83.12 at tag F610 at a scope and severity of (J) The tags F600 and F610 constituted Substand Quality of Care. Immediate Jeopardy began on 11/14/2022 and was removed on 02/25/2023. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		3/24/23

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

Electronically Signed | 03/21/2023

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F 600	Continued From page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, Medical Director and staff interviews, the facility failed to protect a resident's right to be free from neglect when staff pushed a resident with diabetes in her wheelchair without shoes, and when the resident asked the staff person to stop because her foot was hurting, the staff kept pushing the wheelchair and the resident sustained an open area to her great left toe and an abrasion to her left heel due to her foot being caught under the wheelchair footrest and being dragged during the transport. The left great toe had to be treated for one month before it healed. This was for 1 of 1 resident reviewed for neglect (Resident #6). Immediate Jeopardy began on 11/14/22 when Transport Driver #1 continued to transport Resident #6 in her wheelchair after she told him to stop pushing her down the hall because he was dragging her foot and it hurt. The immediate jeopardy was removed on 02/25/23 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at	F 600	White Oak - Shelby does provide an environment Free from Abuse and Neglect Resident #6 foot dropped off the wheelchair foot pedal and became lodged under the foot pedal of the wheelchair. Resident alleges the transport driver who was pushing her failed to stop when she ask as a result this caused an abrasion to her right heel and an open area to her left great toe that measured 2x2 cm. On 12/14/22 those areas were healed and treatment was discontinued. An audit of residents that used wheelchair transport since November 2022 revealed no other incidents with residents being maneuvered in a wheelchair. This audit was completed on 2/23/23 by Administration and the Corporate Nurse Consultant. Another audit was completed by Nursing Administration on 2/23/23 to ensure residents are transported via the	

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F 600	Continued From page 2 a lower scope and severity level of a "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: Resident #6 was admitted to the facility on 02/22/16 with diagnoses which included diabetes mellitus, and coronary artery disease (CAD). Review of the quarterly Minimum Data Set (MDS) dated 9/21/22 revealed Resident #6 was moderately cognitively impaired and was dependent upon two staff members for transfers. Resident #6 was documented as able to make herself clear and understood. She was documented to also have a clear comprehension and understood others. The assessment revealed Resident #1 had no skin conditions or needed special footcare during the assessment period. On 2/22/23 at 12:03 PM an interview was conducted with Resident #6. She stated a few months ago a transport driver came into the facility to pick her up and was dragging her feet up the hallway to the front lobby. Resident #6 stated, "I was telling him to stop, I was telling him I was in pain, but he never said anything and kept pushing me forward". The interview revealed her foot was caught underneath the footrest of the wheelchair and he had dragged her left foot from her room to the front lobby of the facility. Resident #6 stated she just had socks on because shoes hurt her feet. She stated a staff member whom she did not know finally stopped him because her foot was bleeding. Resident #1 stated a nurse came and got her and dressed her foot before	F 600	proper device (i.e. standard wheelchair, geriatric chair, high back wheelchair, stretcher) for their safety. A further audit consisting of resident interviews to determine if the facility staff and outside providers stop what they are doing while transporting residents in a wheelchair when asked to stop or if the resident is vocalizing that they are in pain. This audit was completed by the social services department on 2/24/23. Interviews with residents were conducted asking the question if they ask the staff member to stop is their request honored and is the staff paying attention to their request. The interviews were completed by the social services department on 2/24/23. Interviewable and non-interviewable residents had skin audits completed by the Nursing Administration team on 3/7/2023. No concerns were noted. All facility staff including agency staff were re-educated on the abuse/neglect protocol that includes residents are free from abuse, neglect and exploitation, including the resident's right to be free from physical abuse/neglect. The nursing staff including agency staff will also be educated on ensuring that residents who are being transported in a wheelchair, that their body parts are stabilized including their feet on the foot pedals before being transported. The education also includes any staff transporting residents in a wheelchair to stop what they are doing when asked by the resident, no matter the	

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F 600	Continued From page 3 going out to her appointment. The interview revealed she told Nurse #3 and Nurse Aide #5 about the incident and that Transport driver #1 had dragged her foot underneath the pedal while she asked him to stop while Nurse #3 was dressing her foot. On 2/22/23 at 3:39 PM an interview was conducted with Nurse Aide (NA)#5. She stated on 11/14/22 she had gotten Resident #6 dressed and ready for an outside appointment. The interview revealed Resident #6 did not get out of the bed much per personal preference and did not want to wear shoes only socks. She stated she put regular socks on the resident because she did not see any gripper socks in her drawer. NA #5 stated it was approximately an hour after she had gotten Resident #6 dressed and in her wheelchair to the time she saw Nurse #3 bringing the resident back down the hallway and her foot was injured. NA #5 stated Resident #6 was saying the man from transport was rough with her when he was pushing her. Resident #6 stated she was in pain and NA #5 stated her left great toenail looked like it had been lifted or had a bubble underneath it. She stated Nurse #3 removed the residents sock and told her she was going to notify the Director of Nursing. NA #5 stated Resident #6 was very clear in stating it was the male transport driver who hurt her foot and that it happened when she was leaving the facility. NA #5 stated she did not tell anyone else about the incident because she knew Nurse #3 was handing the situation. On 2/23/23 at 8:50 AM an interview was conducted with Transport Driver #2. She stated she had been a full-time employee working for the facility but due to scheduling conflicts and the	F 600	circumstance. This education will be conducted by the Director of Nursing and Nursing Administration, and completed by 2/24/23. All facility staff/transporter including agency staff and the other outside transporters were educated on paying attention to the residents while transporting them in a wheelchair to include making sure the resident's body parts, such as their feet, are secured and not rubbing against the floor. This education also included stopping the wheelchair, if a resident complains of pain and notifying the facility licensed nursing staff in order to conduct an assessment and render treatment. This education was completed by the Director of Nursing and the transport company by 2/24/23. All facility staff/transporter including agency staff and other transporters will be educated on paying attention to the residents while transporting them in a wheelchair to include making sure the residents body parts, such as their feet, are secured and not rubbing against the floor. This education will be completed by the Director of Nursing and the transport company by 2/24/23. The wheelchair van transport company's transporters and the facility staff/transporter (on FMLA or vacation) that are not available for the education will not start working or care for residents until after the education is completed. Newly hired staff will receive this education as well prior to caring for residents. The Human Resources Director will inform the	

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F 600	Continued From page 4 number of residents with appointments the facility also had to use a contract company for transports. During the interview she stated on 11/14/22 she had a cancellation and returned to the facility. She stated when she was coming into the front lobby of the facility, she saw the contract company Transport Driver #1 pushing Resident #6 towards the door. She stated she saw the resident's foot was bleeding badly and stopped Transport Driver #1. Resident #6 stated, "he was dragging my foot, I told him to stop." Transport Driver #2 stated she asked the secretary to go and get Nurse #3 because the resident could not leave the facility in the condition, she was in. Transport Driver #2 stated Resident #6's foot was underneath the wheelchair and had been dragged by Transport Driver #1 when he pushed her to the lobby. The interview revealed Nurse #3 came to the front lobby and got Resident #6 to dress her foot. She stated Transport Driver #1 was impatient because it was delaying the transport. On 2/22/23 at 3:49 PM a voicemail message was left for the facility's previous secretary that was working during the time of the incident. A return phone call was not received. On 2/22/23 at 4:05 PM an interview was conducted with Transport Driver #1. He stated he worked for a contract company the facility used for transports. During the interview he stated he did not remember the incident with Resident #6 and was in the facility to transport one of the facilities residents to an appointment. The interview revealed he had continued to transport residents from the facility following the incident with Resident #6 on 11/14/22. Review of the facility initial allegation report dated	F 600	Director of Nursing of new hires, and the Director of Nursing will ensure the training is completed. The Human Resources Director was notified of this responsibility on 2/24/23 by the Administrator. The wheelchair transport company was given a copy of the education by the Director of Nursing to educate the transporters, and copies of the completion of this education will be given to the facility on 2/24/23. Transporters will also be asked if they received this education by the facility prior to transporting residents in a wheelchair by Nursing Administration. If education was not completed, the education will be completed at that moment by the Nursing Administration prior to handling the residents' transport in a wheelchair. Ongoing monitoring and compliance will be achieved by Resident interviews that will be conducted by the Social Services Department and the Transportation Monitoring Tool that will be conducted by Nursing Administration. Social Services Department will interview a minimum of 10 residents a week for 4 weeks to assure that there are no issues noted. Then 5 residents for 4 weeks and then 3 residents for 4 weeks. The facility Nursing Administration will monitor residents that are being transported in a wheelchair to outside appointments for proper wheelchair positioning for 4 weeks then 5 residents for 4 weeks, then 3 residents for 4 weeks.	

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F 600	Continued From page 5 11/14/22 revealed on this date at 1:45 PM Resident #6 returned from an outside appointment with an open area on her left great toe measuring 2 centimeters (cm) by 2 cm. Nurse #3 cleaned the area with normal saline and covered it with a bandage. The Nurse Practitioner (NP) was notified along with the residents Responsible Party (RP). Resident #6 denied pain and was in no distress per the report. Resident #6 also obtained a closed abrasion to her left heel. Resident #6 stated to Nurse #3 she had bumped it on something but could not remember what. Interventions to reduce risk of further skin conditions included a high back wheelchair for mobility. On 2/22/23 at 3:16 PM an interview was conducted with Nurse #3. She stated Resident #6 was scheduled to go out of the facility to an appointment, so Nurse Aide #5 had gotten her ready, and she was waiting in her room. Nurse #3 stated Transport Driver #1 went to the resident's room and began pushing her to the front of the facility. She stated the Secretary came to her and said Resident #6's foot was bleeding. The interview revealed when she saw Resident #6, the resident stated to her that she must have hit her foot on something but did not know what. Nurse #3 stated the Transport Driver told her he did not know what had happened. Resident #6 was noted to be wearing regular non grip socks with no shoes at the time of the incident. Nurse #3 stated Resident #6 did not normally wear shoes because she didn't get out of the bed unless she went to an appointment. The interview further revealed she had shoes in her room. Nurse #3 stated she took Resident #6 back to her room, removed the sock exposing a 2 cm by 2 cm open area to her left great toe and an	F 600	The results from this monitoring tool will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education. The Administrator and Director of Nursing are responsible for the ongoing compliance of F600. Completion date of 3/24/23.	

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F 600	Continued From page 6	F 600		

abrasion to her left heel. She cleaned the area and applied a dry dressing. Nurse #3 stated at the end of the sock there was bright red blood at the area of the residents left great toe. Resident #6 had footrests on her wheelchair along with a board (device used to prevent the residents foot from dropped off of the footrest), but the resident's foot had become lodged under the footrest. The interview revealed the staff had issues with Resident #6 sliding down in her wheelchair on previous occasions and after the incident Nurse #3 and Nurse Aide #5 had to pull Resident #6 up in her wheelchair because she had slid down causing her foot to drop off the footrest. She stated after she redressed the resident's foot, she pushed her back to the front lobby and Transport driver #1 took her to the scheduled appointment. The interview revealed she had made an error on the incident report by stating the incident occurred when the resident was out of the facility. Nurse #3 stated she filled out the incident report and placed it in the Director of Nursing's (DON) box, placed a note in the Nurse Practitioner's non emergent folder and notified the resident's Responsible Party following the incident.

A verbal physician order dated 11/14/22 written by Nurse #3 at 3:45 PM read to, "cleanse left great toe with normal saline, cover with a bandage. Cleanse open area to left great toe with normal saline and apply antibiotic ointment. Cover with a dry dressing daily.

A physician order dated 11/15/22 written by Wound Nurse #1 at 9:40 AM revealed to discontinue the current treatment to the left great toe. Cleanse left great toe with normal saline daily. Apply antibiotic ointment, cover with a

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F 600	Continued From page 7	F 600		

non-stick pad, wrap with gauze and secure with tape daily and as needed. Cleanse left heel with normal saline and apply antibiotic ointment. Cover with foam daily and as needed related to an abrasion.

The facility weekly wound report dated 11/30/22 revealed Resident #6 had obtained an acquired abrasion due to trauma on the left great toe measuring 0.9 cm by 1.0 cm and on the left heel measuring 1.2 cm by 1.0 cm.

The facility weekly wound report dated 12/14/22 revealed Resident #6 had obtained an acquired abrasion due to trauma on the left great toe measuring 0.5 cm by 0.5 cm and on the left heel measuring 0.5 cm by 0.5 cm.

A physician order dated 12/14/22 written by Wound Nurse #1 at 1:15 PM revealed to discontinue current treatment to left great toe and left heel. Apply skin prep daily to the left great toe and heel for a duration of 7 days.

The facility weekly wound report dated 12/21/22 revealed Resident #6 was not listed on the report for having a skin condition. The report revealed Resident #6 had been removed from the report due to the wound being healed.

The facility weekly wound report dated 2/15/23 revealed Resident #6 was listed as having a new skin condition identified on 2/13/23.

An observation was conducted on 2/23/23 at 8:56 AM of Resident #6's wound care with Wound Nurse #1. Resident #6 was observed to have a open area to the left great toe and third toe with a closed deep tissue injury to the base of the fifth

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toe. Wound Nurse #1 followed the physicians' orders for wound care along with following infection control protocol during the dressing change. No drainage was observed to the open areas.

On 2/23/23 an interview was conducted with the Director of Nursing (DON). She stated she found out about the incident the day after it had occurred because they go over the incidents from the previous day during stand-up morning meeting. She stated she normally would not have been informed earlier unless it was a serious injury. The interview revealed she felt the incident was minor at the time. She stated during stand-up meeting they discussed switching the resident to a Geri-chair to keep her feet elevated and prevent her from scooting down in her wheelchair. The team decided to initiate a therapy evaluation however after discussing with Resident #6's Responsible Party (RP) she stated she did not want the resident in a Geri chair. Once therapy saw the resident, she was transitioned into a high back wheelchair in which she still uses. The DON stated it was her understanding Nurse #3 had to go to the front lobby and get Resident #6 because her foot was bleeding and provide wound care before she could leave for the appointment. The interview revealed she did not know if Resident #6 had been seen following the incident for wound care by the Physician.

On 2/23/23 at 11:32 AM an interview was conducted with the Medical Director (MD). She stated she recalled being notified of the incident with the resident having a minor injury. She stated she knew the resident's wounds had improved after with healing. The MD stated it was Resident #6's left great toe and left heel in which a

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bandage had been applied with follow up wound care treatment by the nurses. She stated the wound from 11/14/22 had healed completely within a few weeks.

On 2/22/23 at 4:10 PM an interview was conducted with the Transportation Company. During the interview they stated they had not received any notification of issues with a resident during transport for the date of 11/14/22.

The Administrator was notified of immediate jeopardy on 02/23/23 at 4:30 PM.

The Credible Allegation for noncompliance dated 11/14/22 for immediate jeopardy removal as follows.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The identified resident is Resident #1's and her right foot dropped off from the wheelchair foot footrest and became lodged under the foot footrest of the wheelchair or rubbed against the floor while being rolled down the hallway by the transporter on 11/14/22. Resident #1 alleges the transporter failed to stop pushing the resident in her wheelchair from her room in the facility to the facility lobby after she told him to stop because her foot was hurting. This caused her to have an abrasion to her right heel and an open area at the end of the left great toe that measured 2x2 cm. Licensed nurse was notified of the area and the resident's right foot was treated and she was able to go to her appointment.

Other residents can potentially sustain a similar

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injury while being transported in a wheelchair. An audit was completed by nursing administration on 2/23/23 to ensure identified residents at risk for neglect are transported via the proper device (i.e. standard wheelchair, geriatric chair, high back wheelchair, stretcher) for their safety.
An audit of residents that used wheelchair transport since November 2022 revealed no other incidents with residents being maneuvered in a wheelchair. This audit was completed on 2/23/23 by Administration and the Corporate Nurse Consultant. Another audit was completed by Nursing Administration on 2/23/23 to ensure residents are transported via the proper device (i.e. standard wheelchair, geriatric chair, high back wheelchair, stretcher) for their safety. A further audit consisting of resident interviews to determine if the facility staff and outside providers stop what they are doing while transporting residents in a wheelchair when asked to stop or if the resident is vocalizing that they are in pain. This audit was completed by the social services department on 2/24/23.

Interviews with residents were conducted asking the question if they ask the staff member to stop is their request honored and is the staff paying attention to their request. The interviews were completed by the social services department on 2/24/23.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring, and when the action will be completed.

All facility staff including agency staff were re-educated on the neglect protocol that includes residents are free from abuse, neglect and

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F 600	Continued From page 11	F 600		

exploitation, including the resident's right to be free from physical neglect. The nursing staff including agency staff will also be educated on ensuring that residents who are being transported in a wheelchair, that their body parts are stabilized including their feet on the foot footrests before being transported. The education also includes any staff transporting residents in a wheelchair to stop what they are doing when asked by the resident, no matter the circumstance. This education will be conducted by the Director of Nursing and Nursing Administration and completed by 2/24/23. All facility staff/ transporter including agency staff and the other outside transporters were educated on paying attention to the residents while transporting them in a wheelchair to include making sure the resident's body parts, such as their feet, are secured and not rubbing against the floor. This education also included stopping the wheelchair, if a resident complains of pain and notifying the facility licensed nursing staff in order to conduct an assessment and render treatment. This education was completed by the Director of Nursing and the transport company by 2/24/23.

All facility staff/transporter including agency staff and the other transporters will be educated on paying attention to the residents while transporting them in a wheelchair to include making sure the resident's body parts, such as their feet, are secured and not rubbing against the floor. This education will be completed by the Director of Nursing and the transport company by 2/24/23.

The wheelchair van transport company's transporters and the facility staff/transporter (on

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F 600	Continued From page 12	F 600		

FMLA or vacation) that are not available for the education will not start working or care for residents until after the education is completed. Newly hired staff will receive this education as well prior to caring for residents. The Human Resources Director will inform the Director of Nursing of new hires, and the Director of Nursing will ensure the training is completed. The Human Resources Director was notified of this responsibility on 2/24/23 by the Administrator.

The wheelchair transport company was given a copy of the education by the Director of Nursing to educate the transporters, and copies of the completion of this education will be given to the facility on 2/24/23. Transporters will also be asked if they received this education by the facility prior to transporting residents in a wheelchair by Nursing Administration. If education was not completed, the education will be completed at that moment by the Nursing Administration prior to handling the residents' transport in a wheelchair.

The Administrator and Director of Nursing are responsible for the ongoing compliance of F600.

IJ Removal Date is 2/25/23.

On 2/28/23, the facility's credible allegation for immediate jeopardy removal effective 2/25/23 was validated by the following: Staff interviews revealed they had received education on resident abuse and neglect, ensuring residents are stabilized in their wheelchair prior to transport and to observe residents who are being transported by outside staff to ensure they are being handled appropriately. Device audits were conducted on all residents to ensure they were being

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F 600	Continued From page 13 transported in the proper device such as a standard wheelchair, geriatric chair, or high back wheelchair for their safety. Interviews were conducted with alert and oriented residents who had been transported since November 2022 with no concerns identified. No additional transportation incidents were identified since November 2022. The facility's action plan was validated to be completed as of 2/25/23.	F 600		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to follow their neglect policy in the areas of reporting immediately to administration, conducting a thorough	F 610	White Oak - Shelby does Investigate/ Prevent/ Correct Alleged Violations The Director of Nursing interviewed	3/24/23

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F 610	Continued From page 14 investigation and protecting residents. Transport driver #1 pushed Resident #6 from her room to the front lobby of the facility with her foot caught underneath the footrest of the wheelchair. Resident #6 stated to Transport driver #1 to stop however he kept pushing despite the resident being in pain resulting in an injury to the resident's foot. The incident was not immediately reported to Administration staff. The lack of reporting, investigating and protecting put all residents at risk for serious harm. This occurred for one of one resident reviewed for abuse (Resident #6). Immediate Jeopardy began on 11/14/22 an alleged perpetrator was allowed to continue to work without any corrective action. The immediate jeopardy was removed on 02/25/23 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: Review of the facility's "Abuse, neglect and Exploitation" policy dated 10-1-22 revealed in part that the facility will Identify, correct, and intervene in situations in which abuse, neglect, exploitation and/or misappropriation of resident property was more likely to occur. The policy read to respond immediately to protect the alleged victim by removing them from the alleged perpetrator and to immediately report the allegation to	F 610	resident #6 on 2/24/23 regarding the occurrence with the transporter pushing her in the wheelchair on 11/14/22. Resident #6 was reassessed for transportation device on 11/14/22 and new order was implemented for geriatric chair, and further evaluation and preference from resident resulted in an order for a high back wheelchair with foam wedge cushion, elevating leg rests and drop leg pad. The wheelchair transport company was notified on 2/23/23 to inform the owner that the identified transporter will no longer be able to transport residents from facility. Resident #6 has voiced no more concerns. Interviews with residents were conducted asking the question if they ask the staff member to stop is their request honored and is the staff paying attention to their request. The interviews were completed by the Social Services department on 2/24/23. An audit of residents that used wheelchair transport since November 2022 by the wheelchair van transport company and by the facility staff\transporter revealed no other incidents with residents being maneuvered in a wheelchair. This audit was completed on 2/23/23 by administration and the corporate nurse consultant. Another audit was completed by Nursing Administration on 2/23/23 to ensure residents are transported via the proper device (i.e. standard wheelchair, geriatric chair, high back wheelchair,	

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F 610	Continued From page 15 administration. The facility will conduct a investigation into the allegation. Resident #6 was admitted to the facility on 02/22/16 with diagnoses which included diabetes mellitus, and coronary artery disease (CAD). Review of the quarterly Minimum Data Set (MDS) dated 9/21/22 revealed Resident #6 was moderately cognitively impaired and was dependent upon two staff members for transfers. Resident #6 was documented as able to make herself clear and understood. She was documented to also have a clear comprehension and understood others. The assessment revealed Resident #1 had no skin conditions or needed special footcare during the assessment period. Review of the facility initial allegation report dated 11/14/22 revealed on this date at 1:45 PM Resident #6 returned from an outside appointment with an open area on her left great toe measuring 2 centimeters (cm) by 2 cm. Nurse #3 cleaned the area with normal saline and covered it with a band aid. The Nurse Practitioner (NP) was notified along with the residents Responsible Party (RP). Resident #6 denied pain and was in no distress per the report. Resident #6 also obtained a closed abrasion to her left heel. Resident #6 stated to Nurse #3 she had bumped it on something but could not remember what. Interventions to reduce risk of further skin conditions included a high back wheelchair for mobility. On 2/22/23 at 12:03 PM an interview was conducted with Resident #6. She stated a few months ago a transport driver came into the facility to pick her up and was dragging her feet	F 610	stretcher) for their safety. All facility staff including agency staff were re-educated on the abuse/neglect protocol that includes how to identify what is a reportable, to report immediately to administration if they see abuse/neglect, how to assess other residents and put protective measure in place, to immediately remove and/or suspend the perpetrator, while facility is conducting a thorough investigation. This education consists of the following: how to identify what is reportable, to report immediately to administration if they see abuse/neglect; how to assess other residents and put protective measures in place; to immediately remove and/or suspend the perpetrator; facility conducting a thorough investigation; ensure that residents are protected during any care, services and situation; to stop what they are doing while providing care and services to a resident when asked by the resident to stop; to stop care and services, if a resident complains of pain and notify the facility licensed nursing staff in order for them to conduct an assessment and render treatment; and the overall need to pay attention to the residents while providing care and services that the resident ask to stop, that staff does stop. This education was completed by the Corporate Social Services Consultant for the Administrator on 2/23/23. Then it was completed by the Administrator for the Director of Nursing and Nursing Administration. All facility	

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F 610	Continued From page 16 up the hallway to the front lobby. Resident #6 stated, "I was telling him to stop, I was telling him I was in pain, but he never said anything and kept pushing me forward". The interview revealed her foot was caught underneath the footrest of the wheelchair and he had dragged her left foot from her room to the front lobby of the facility. Resident #6 stated she just had socks on because shoes hurt her feet. She stated a staff member whom she did not know finally stopped him because her foot was bleeding. Resident #1 stated a nurse came and got her and dressed her foot before going out to her appointment. The interview revealed she told Nurse #3 and Nurse Aide #5 about the incident and that Transport Driver #1 had dragged her foot underneath the pedal while she asked him to stop while Nurse #3 was dressing her foot. On 2/22/23 at 3:39 PM an interview was conducted with Nurse Aide (NA)#5. She stated on 11/14/22 she had gotten Resident #6 dressed and ready for an outside appointment. The interview revealed Resident #6 did not get out of the bed much per personal preference and did not want to wear shoes only socks. She stated she put regular socks on the resident because she did not see any gripper socks in her drawer. NA #5 stated approximately an hour had lapsed from the time she got Resident #6 dressed and in her wheelchair to the time she saw Nurse #3 bringing the resident back down the hallway and her foot was injured. NA #5 stated Resident #6 was saying the man from transport was rough with her when he was pushing her. Resident #6 stated she was in pain and NA #5 stated her left great toenail looked like it had been lifted or had a bubble underneath it. She stated Nurse #3 removed the residents sock and told her she was	F 610	staff including agency staff were then educated by the Director of Nursing and Nursing Administration on 2/24/23. The wheelchair van transport company's transporters and the facility staff/transporter (on FMLA or vacation) that are not available for the education will not start working or care for residents until after the education is completed. Newly hired staff will receive this education as well prior to caring for residents. The Human Resources Director was notified on 2/24/23 by the Administrator to inform the Director of Nursing of new hires. The Director of Nursing will ensure training is completed. The wheelchair transport company was given a copy of the education by the Director of Nursing to educate the transporters, and copies of the completion of this education will be given to the facility on 2/24/23. Transporters will also be asked if they received this education by the facility prior to transporting residents in a wheelchair by Nursing Administration. If education was not completed, the education will be completed at that moment by the Nursing Administration prior to handling the residents' transport in a wheelchair. The Director of Nursing also re-educated the current licensed nursing including agency nurses on completing occurrence reports as soon as possible after an incident occurs. Occurrence reports to be completed after the resident is assessed	

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F 610	Continued From page 17 going to notify the Director of Nursing. NA #5 stated Resident #6 was very clear in stating it was the male Transport Driver who hurt her foot and that it happened when she was leaving the facility. NA #5 stated she did not tell anyone else about the incident because she knew Nurse #3 was handing the situation. On 2/23/23 at 8:50 AM an interview was conducted with Transport Driver #2. She stated she had been a full-time employee working for the facility but due to scheduling conflicts and the number of residents with appointments the facility also had to use a contract company for transports. During the interview she stated on 11/14/22 she had a cancellation and returned to the facility. She stated when she was coming into the front lobby of the facility, she saw the contract company Transport Driver #1 pushing Resident #6 towards the door. She stated she saw the resident's foot was bleeding badly and stopped Transport Driver #1. Resident #6 stated, "he was dragging my foot, I told him to stop". Transport Driver #2 stated she asked the Secretary to go and get Nurse #1 because the resident could not leave the facility in the condition, she was in. Transport Driver #2 stated Resident #6's foot was underneath the wheelchair and had been dragged by Transport Driver #1 when he pushed her to the lobby. The interview revealed Nurse #3 came to the front lobby and got Resident #6 to dress her foot. She stated Transport Driver #1 was impatient because it was delaying the transport. The interview revealed she did not tell Administration because she thought Nurse #3 was handling the situation. She stated she was never asked about the incident. On 2/22/23 at 3:16 PM an interview was	F 610	and appropriate treatment rendered. This education included the process of filling out an occurrence report that entails the following: generate occurrence report form; give description of the circumstances surrounding the occurrence; provide emergency care to the resident if needed; chart occurrence in the clinical record and enter it on acute board; notify the physician and resident representative; document all pertinent observations; obtain individual staff statements for current shift and at least two previous shifts for any/all occurrences not witnessed; investigate occurrence; and licensed nursing staff to complete report and submit completed occurrence report form to nursing administration as soon as possible during the specific shift. This education was completed on 2/24/23. The facility licensed nursing staff (on FMLA or vacation) that are not available for this education will not start working or care for residents until after the education is completed. The Director of Nursing will maintain a listing of staff that will need this education. Newly hired licensed nursing staff will receive this education as well prior to caring for residents. The Human Resources Director will notify the Director of Nursing of the new hires, and was notified of responsibility on 2/24/23 by the administrator. Occurrence reports are completed by the floor license nurse staff when an incident occurs. At that point, licensed safety nurse will report daily, Monday through Friday during morning meetings. Then it is	

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F 610	Continued From page 18 conducted with Nurse #3. She stated Resident #6 was scheduled to go out of the facility to an appointment, Nurse Aide #5 had gotten her ready, and she was waiting in her room. Nurse #3 stated Transport Driver #1 went to the resident's room and began pushing her to the front of the facility. She stated the Secretary came to her and said Resident #6's foot was bleeding. The interview revealed when she saw Resident #6, the resident stated to her that she must have hit her foot on something but did not know what. Nurse #3 stated Transport Driver #1 told her he did not know what had happened. Resident #6 was noted to be wearing regular non grip socks with no shoes at the time of the incident. Nurse #3 stated Resident #6 did not normally wear shoes because she didn't get out of the bed unless she went to an appointment. The interview further revealed she had shoes in her room. Nurse #3 stated she took Resident #6 back to her room, removed the sock exposing a 2 centimeter (cm) by 2 cm open area to her left great toe and an abrasion to her left heel. She cleaned the area and applied a dry dressing. Nurse #3 stated at the end of the sock there was bright red blood at the area of the residents left great toe. Resident #6 had footrests on her wheelchair along with a board (device used to prevent the residents foot from dropped off of the footrest), but the resident's foot had become lodged under the footrest. The interview revealed the staff had issues with Resident #6 sliding down in her wheelchair on previous occasions and after the incident Nurse #3 and Nurse Aide #5 had to pull Resident #6 up in her wheelchair because she had slid down causing her foot to drop off the footrest. She stated after she redressed the resident's foot, she pushed her back to the front lobby and Transport Driver #1 took her to the	F 610	determined by the Director of Nursing and the Administrator if further investigation is needed. This will be conducted by Nursing Administration and reported to the administrator. During the weekends and off hours, the director of nursing and administrator are contacted by phone and the determination is made for investigation. All residents and resident representatives are provided information and education on the resident rights that include the right to be free from abuse and neglect by the admissions department on or prior to admission to the facility. All staff members including agency staff are provided information and education on resident rights that include the right to be free from abuse and neglect by the Social Services Department and/or staff development coordinator upon hire and at least yearly thereafter. All staff members including agency staff are responsible for the protection of residents and the immediate removal of any harm to residents. This education is provided by the Social Services Department and/or Staff Development Coordinator upon hire and at least yearly thereafter. The Administrator and Director of Nursing received additional coaching and re-education of F610 by the corporate nurse consultant and the Corporate Social Services Consultant on 2/23/23. Ongoing monitoring and compliance will be achieved by resident interviews that	

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scheduled appointment. The interview revealed she had made an error on the incident report by stating the incident occurred when the resident was out of the facility. Nurse #3 stated she filled out the incident report and placed it in the Director of Nursing's (DON) box, placed a note in the Nurse Practitioner's non emergent folder and notified the resident's Responsible Party following the incident. The interview revealed she had not obtained statements from the staff members involved.

On 2/22/23 at 4:05 PM an interview was conducted with Transport Driver #1. He stated he worked for a contract company the facility used for transports. During the interview he stated he did not remember the incident with Resident #6 and was at the facility to transport a resident. The interview revealed he had continued to transport residents from the facility following the incident with Resident #6 on 11/14/22.

On 2/22/23 at 4:10 PM an interview was conducted with the Transportation Company. During the interview they stated they had not received any notification of issues with a resident during transport for the date of 11/14/22.

On 2/23/23 an interview was conducted with the Director of Nursing (DON). She stated she found out about the incident the day after it had occurred, on 11/15/22 because they go over the incidents from the previous day during stand-up morning meeting. She stated she normally would not have been informed earlier unless it was a serious injury. The interview revealed she felt the incident was minor at the time. She stated during stand-up meeting they discussed switching the resident to a geriatric chair to keep her feet

will be conducted by the Social Services Department and the Audit of Occurrence Reports Tool that will be conducted by Nursing Administration. Social Services Department will interview a minimum of 10 residents a week for 4 weeks to assure there are no issues noted. Then 5 residents for 4 weeks and then 3 residents for 4 weeks. The Nursing Administration will monitor residents by auditing of Occurrence Reports. Occurrence Reports will be reviewed for any concerns that need to be addressed for 4 weeks. Then 5 residents will be reviewed for 4 weeks, then 3 residents will be reviewed for 4 weeks.

The results from this monitoring tool will be discussed during weekly Quality Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education.

The administrator, Director of Nursing and Social Services Director is responsible for the ongoing compliance of F610.

Completion date of 3/24/23.

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F 610	Continued From page 20	F 610		

elevated and prevent her from scooting down in her wheelchair. The team decided to initiate a therapy evaluation however after discussing with Resident #6's Responsible Party (RP) she stated she did not want the resident in a geriatric chair. She stated Resident #6's RP also requested she not be transported by the contract company again following the incident. The interview revealed looking back the facility should have removed the transportation driver from the facility to ensure protection of other residents. Once therapy saw the resident, she was transitioned into a high back wheelchair in which she still uses. The DON stated it was her understanding Nurse #3 had to go to the front lobby and get Resident #6 because her foot was bleeding and provide wound care before she could leave for the appointment. The interview revealed she did not know if Resident #6 had been seen following the incident for wound care by the Physician. She stated she did not obtain statements regarding the incident or interview Resident #6, further stating the nurses on the floor that file the incident report should be obtaining the statements from all staff members involved. The interview revealed the incident should have been investigated more since it resulted in an injury to Resident #6. The DON stated Transport Driver #1 should have stopped pushing the resident when he asked him to.

The Administrator was notified of immediate jeopardy on 02/23/23 at 4:30 PM.

The Credible Allegation for immediate jeopardy removal dated 11/14/22 was as follows:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

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The identified resident is Resident #1 and on 11/14/2 the resident's right foot dropped off the wheelchair foot pedal and became lodged or caught under the foot pedal of the wheelchair or rubbed against the floor while being rolled down the hallway by the transporter. Resident #1 alleges the transporter failed to stop pushing the resident in her wheelchair from her room in the facility to the facility lobby after she told him to stop because her foot was hurting. This caused her to have an abrasion to her right heel and an open area at the end of the left great toe that measured 2x2 cm. Licensed nurse was notified of the area and the resident's right foot was treated and she was able to go to her appointment. The facility failed to identify that this incident was an abuse situation and staff failed to report to administration immediately. The facility further failed to assess other residents, put protective measures in place, and conduct a thorough investigation. The facility also failed to provide corrective actions for the named transporter as identified as the perpetrator.

The Director of Nursing interviewed resident #1 on 2/24/23 regarding the occurrence with the transporter pushing her in the wheelchair on 11/14/22. Resident # 1 was reassessed for transportation device on 11/14/22 and new order was implemented for geriatric chair, and further evaluation and preference from resident resulted in an order for a high back wheelchair with foam wedge cushion, elevating leg rests and drop leg pad. The wheelchair transport company was notified on 2/23/23 to inform the owner that the identified transporter will no longer be able to transport residents from facility.

Interviews with residents were conducted asking

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the question if they ask the staff member to stop is their request honored and is the staff paying attention to their request. The interviews were completed by the Social Services department on 2/24/23.

An audit of residents that used wheelchair transport since November 2022 by the wheelchair van transport company and by the facility staff/transporter revealed no other incidents with residents being maneuvered in a wheelchair. This audit was completed on 2/23/23 by administration and the corporate nurse consultant. Another audit was completed by Nursing Administration on 2/23/23 to ensure residents are transported via the proper device (i.e. standard wheelchair, geriatric chair, high back wheelchair, stretcher) for their safety.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring, and when the action will be completed.

All facility staff including agency staff were re-educated on the neglect protocol that includes how to identify what is a reportable, to report immediately to administration if they see neglect, how to assess other residents and put protective measure in place, to immediately remove and/or suspend the perpetrator, while facility is conducting a thorough investigation.

This education consists of the following: how to identify what is reportable; to report immediately to administration if they see neglect; how to assess other residents and put protective measures in place; to immediately remove and/or suspend the perpetrator; facility conducting a

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thorough investigation; ensure that residents are protected during any care, services and situation; to stop what they are doing while providing care and services to a resident when asked by the resident to stop; to stop care and services, if a resident complains of pain and notify the facility licensed nursing staff in order for them to conduct an assessment and render treatment; and the overall need to pay attention to the residents while providing care and services that the resident ask to stop, that staff does stop. This education was completed by the Corporate Social Services Consultant for the Administrator on 2/23/23. Then it was completed by the Administrator for the Director of Nursing and Nursing Administration. All facility staff including agency staff were then educated by the Director of Nursing and Nursing Administration on 2/24/23.

The wheelchair van transport company's transporters and the facility staff/transporter (on FMLA or vacation) that are not available for the education will not start working or care for residents until after the education is completed. Newly hired staff will receive this education as well prior to caring for residents. The Human Resources Director was notified on 2/24/23 by the Administrator to inform the Director of Nursing of new hires. The Director of Nursing will ensure the training is completed.

The wheelchair transport company was given a copy of the education by the Director of Nursing to educate the transporters, and copies of the completion of this education will be given to the facility on 2/24/23. Transporters will also be asked if they received this education by the facility prior to transporting residents in a wheelchair by Nursing Administration. If education was not

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completed, the education will be completed at that moment by the Nursing Administration prior to handling the residents' transport in a wheelchair.

The Director of Nursing also re-educated the current licensed nurses including agency nurses on completing occurrence reports as soon possible after an incident occurs. Occurrence reports to be completed after the resident is assessed and appropriate treatment rendered. The education included the process of filling out an occurrence report that entails the following: generate occurrence report form; give description of the circumstances surrounding the occurrence; provide emergency care to the resident if needed; chart occurrence in the clinical record and enter it on acute board; notify the physician and resident representative; document all pertinent observations; obtain individual staff statements for current shift and at least two previous shifts for any/all occurrences not witnessed; investigate occurrence; and licensed nursing staff to complete report and submit completed occurrence report form to nursing administration as soon as possible during the specific shift. This education was completed on 2/24/23. The facility licensed nursing staff (on FMLA or vacation) that are not available for this education will not start working or care for residents until after the education is completed. The Director of Nursing will maintain a listing of staff that will need this education. Newly hired licensed nursing staff will receive this education as well prior to caring for residents. The Human Resources Director will notify the Director of Nursing of the new hires, and was notified of responsibility on 2/24/23 by the administrator.

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Occurrence reports are completed by the floor license nurse staff when an incident occurs. At that point, the licensed safety nurse will report daily, Monday through Friday during morning meetings. Then it is determined by the Director of Nursing and the Administrator if further investigation is needed. This will be conducted by Nursing Administration and reported to the administrator. During the weekends and off hours, the director of nursing and administrator are contacted by phone and the determination is made for investigation.

All residents and resident representatives are provided information and education on the resident rights that include the right to be free from abuse and neglect by the admissions department on or prior to admission to the facility. All staff members including agency staff are provided information and education on resident rights that include the right to be free from abuse and neglect by the Social Services Department and/or staff development coordinator upon hire and at least yearly thereafter. All staff members including agency staff are responsible for the protection of residents and the immediate removal of any harm to residents. This education is provided by the Social Services Department and/or Staff Development Coordinator upon hire and at least yearly thereafter.

The Administrator and Director of nursing received additional coaching and re-education of F610 by the corporate nurse consultant and the Corporate Social Services Consultant on 2/23/23.

The Administrator and Director of Nursing are responsible for the ongoing compliance of F610.

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F 610	Continued From page 26 IJ Removal Date is 2/25/23. On 2/28/23, the facility's credible allegation for immediate jeopardy removal effective 2/25/23 was validated by the following: Staff interviews revealed they had received education on reporting resident abuse and neglect, ensuring residents are stabilized in their wheelchair prior to transport and to observe residents who are being transported by outside staff to ensure they are being handled appropriately. All staff were educated on notifying Administration if they see any resident in an abuse or neglect situation. Nursing staff received education which included the process of filling out an occurrence report. The facility's action plan was validated to be completed as of 2/25/23.	F 610		
F 686 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	F 686	White Oak - Shelby does	3/24/23

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F 686	Continued From page 27 staff, Nurse Practitioner (NP) and Medical Director (MD), the facility failed to provide wound care to an unstageable sacral pressure ulcer on 3 consecutive days, 12/08/22, 12/09/22, and 12/10/22 for 1 of 3 residents (Resident #154) reviewed for pressure ulcers. The findings included: Resident #154 was admitted to the facility on 09/08/22 and was discharged to the hospital on 12/11/22. Her admitting diagnoses included atrial fibrillation, hypertension, diabetes and end stage renal disease on dialysis. Resident #154's admission Minimum Data Set (MDS) assessment dated 09/14/22 revealed she was cognitively intact with no behaviors and required extensive to total assistance with all activities of daily living except eating in which she required set up only. The assessment also revealed Resident #154 had a pressure reducing device for her bed and chair and was at risk of developing pressure ulcers but had none on admission. The MDS further revealed the resident was currently receiving dialysis. Review of a pressure ulcer report dated 12/07/22 completed by the Treatment Nurse revealed Resident #154 had an unstageable wound to the sacrum that was classified as pressure ulcer with an odor and eschar. It was described as soft with normal surrounding skin and smooth and regular wound edges with no exudate (fluid that leaks out of blood vessels into nearby tissue). According to the report, the treatment plan was to cleanse with Dakin's solution (antiseptic used to cleanse wounds) and apply skin prep (liquid film that shields delicate and vulnerable skin).	F 686	Treatments/Services to Prevent/Heal Pressure Ulcers Resident #154 was found to have an unstageable acquired pressure ulcers on her sacral area on 12/07/22 by the Treatment Nurse. Treatment Nurse did not write the order for wound care until 12/11/22. As a result of the Treatment Nurse not following policy and procedure because she forgot to write the order. Resident #154 did not receive wound care to her sacral wound one 12/08/22, 12/09/22, and 12/10/22. Resident did receive wound care on 12/11/22 as documented by the nurse. Resident was discharged to the hospital on 12/11/22 and is no longer a resident. Skin audits were completed on all residents by the Nursing Administration Team. These audits were completed on 3/07/23. All new residents will have a skin audit on admission. A review of treatment order was conducted by the Nursing Administration Team, to assure that all pressure areas have a timely wound care order on the Treatment Administration Record (TAR), this was completed on 3/16/23. Treatment nurse along with other licensed nursing staff were re-educated on timely writing/transcribing and initiating of treatment order and completion of a skin assessment sheet. The re-education was conducted by the Director of Nursing (DON) and was completed on 3/13/23. Newly hired staff will receive this	

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F 686	Continued From page 28 Review of a physician's order written 12/11/22 revealed an order written by the Treatment Nurse for Resident #154's sacral pressure ulcer to be cleansed with Dakin's solution, apply skin prep around the wound and cover with a foam dressing daily and prn related to pressure ulcer, turn, and reposition every 2 hours, and daily skin audit by the nurse. Review of Resident #154's Treatment Administration Record (TAR) revealed the sacral unstageable pressure ulcer wound dressing had only been done on 12/11/22 and daily wound care to the unstageable pressure wound was not done 12/08/22 through 12/10/22. Interview on 02/22/23 at 12:05 PM with the Treatment Nurse revealed Resident #154 had a decline in the condition of her skin. She stated on 12/07/22 she found the resident had an unstageable facility acquired pressure ulcer on her sacral area with an odor. The Treatment Nurse explained Resident #154's RP had visited the resident on 12/11/22 and observed the wound during her wound care on that date and after seeing the wound the RP requested the resident be sent out to the hospital for evaluation and treatment of the wound. Phone interview on 02/23/23 at 8:26 AM with Nurse #2 who cared for Resident #154 on 12/10/22 and 12/11/22 on 1st shift revealed she was a travel nurse and had worked at the facility for a few weeks but could not recall the resident or her wound. Interview on 02/23/23 at 11:48 AM with the Medical Director (MD) revealed she didn't look at	F 686	education during the orientation period prior to beginning work on the floor. Nursing staff which included Registered Nursing, licensed nurses, and nursing assistants was provided inservice education on pressure ulcers by Director of Nursing. Inservice education was completed on 3/13/23. Education included: risk identifiers/risk factors commonly associated with pressure ulcers; standards of care for promoting healthy skin, including use of support services and pressure reduction/ positioning/ transferring devices; and proper procedure for reporting and documenting noted skin concerns and initiation of appropriate treatments. Newly hired staff will receive this education during the orientation period prior to beginning work on the floor. A pressure ulcer monitoring tool has been created with education provided by Director of Nursing to treatment nurse on proper completion of tool on 3/24/2023. Ongoing monitoring and compliance will be achievable by a Pressure Ulcer monitoring tool. This tool will be completed by the Nursing Administration. Pressure Ulcer Reports will be reviewed by the Nursing Administration which will then follow up to make sure a treatment order has been completed timely. All residents that have pressure areas will be monitored for 90 days. The results from this monitoring tool will be discussed during weekly Quality	

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F 686	Continued From page 29 all the wounds at the facility, but if the Treatment Nurse was monitoring an area that she thought was infected she would contact the MD to see the wound. The MD explained Resident #154 had a venting PEG tube, end stage renal disease, diabetes and atrial fibrillation as well as protein calorie malnutrition and it was possible the resident had a Kennedy ulcer. She further explained she had not seen the wound and could not be certain that was the type of wound the resident had when discharged. Phone interview on 02/24/23 at 11:29 with the Nurse Practitioner (NP) revealed Resident #154 was at the end of her life with multiple comorbidities including what she believed to be the development of a Kennedy ulcer. The NP stated the rapid development and deterioration of the wound was likely due to her gastric outlet obstruction, malnutrition and malabsorption and there was no way to avoid the breakdown of her skin. Follow up phone interview on 02/24/23 at 11:57 AM with the Medical Director (MD) revealed given Resident #154's protein malnutrition and other comorbidities there was nothing that could be done to prevent or avoid skin breakdown and ultimately pressure ulcers. Follow up interview on 02/24/23 at 1:08 PM with the Treatment Nurse revealed she had not written the order for wound care until 12/11/22 and it would not have flagged the nurses on the Treatment Administration Record (TAR) Resident #154 needed wound care. She stated she could not provide any documentation that indicated Resident #154 had wound care to her sacral wound on 12/08/22, 12/09/22, or 12/10/22 but	F 686	Assurance Meetings for its effectiveness. Any identified issues will be corrected per the Quality Assurance Team recommendations. Unresolved issues will be reviewed by the Administrator for follow up re-education. The Director of Nursing is responsible for the ongoing compliance of F686. Completion date of 3/24/23.	

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F 686	Continued From page 30 said she had wound care on 12/11/22 as documented by Nurse #2.	F 686		