STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(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
F 000	INITIAL COMMENTS A complaint survey was conducted from 02/27/23 through 03/08/23. Intake NC00198755 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.15 at tag F624 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F686 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F684, F686 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/31/22 and was removed on 03/04/23. A partial extended survey was conducted. Four of the six complaint allegations resulted in deficiency.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		3/22/23

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

Electronically Signed | 03/25/2023

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F 580	Continued From page 1	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview of the staff, Physician Assistant (PA), Nurse Practitioner (NP), Wound Nurse Practitioner #1, and Physician, the facility failed to notify the medical staff of the Resident #1's sacral pressure ulcer deterioration to the point the wound was 11.5 centimeters (cm) long by 16 cm wide and failed to notify the medical staff when Resident #1 sustained a full-thickness skin tear injury which extended down into the subcutaneous tissue (tissue below the skin) and measured 7 centimeters (cm) long by 3 cm wide on 12/31/22 for 1 of 2 residents reviewed for pressure ulcer(s) and skin tear(s). Immediate jeopardy began on 12/31/22 for Resident #1 when staff failed to notify medical staff of Resident #1's lower right leg injury at the time of hospitalization on 1/14/23 directly after being discharged from the facility. The wound was bleeding and required pressure to control, was open with an approximate/unknown depth, and was unable to approximate (close skin edges). Immediate jeopardy continued on 1/9/23 when staff failed to notify medical staff of Resident #1's sacral pressure ulcer deterioration when the wound increased in size and was discovered to have a foul odor. Immediate jeopardy was removed on 3/4/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.	F 580	*Resident #1 no longer resides in the facility. *On 3/2/2023 the facility completed a 100% skin sweep for all current residents. No issues were identified. On 3/2/2023 the Director of Nursing/Designee reviewed previously completed wound reports for the last 30 days for any wound declines or changes. There were no wound declines or changes. On 3/2/2023 the Director of Nursing/Designee reviewed the previous 30 days of eInteract (electronic assessment tool in the Electronic Health Record) Change in Condition assessments for any missed physician notifications. There were no missed notifications identified. *On 3/2/2023 the Director of Nursing provided 1:1 education with the facility Designated Wound Nurse on notification to Medical Provider (MD/NP/Wound NP) for changes in condition including deterioration of wounds, notification of injuries at the time of injury, and wound protocol to ensure that proper protocol is followed and in place. On 3/2/2023 all Licensed Nursing Staff, including agency staff were educated by the Nursing Administration Team on notification to Medical Provider for changes in condition including deterioration of wounds, facility wound protocol and location of wound protocol, immediate notification of injuries that cannot be treated per facility wound protocol, description of the problem and	

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F 580	Continued From page 3 Findings included: a. On 2/28/23 at 9:50 am an interview was conducted with the Wound Nurse. The Wound Nurse stated she was aware of Resident #1's deterioration in sacral pressure ulcer wound on 1/9/23 and 1/13/23 and had not informed the medical staff (Wound NP, facility NP, PA, or Physician). She further stated she was not informed by Nurse #1 of any wound deterioration over the weekend of 1/7/23 -1/8/23. On 2/28/23 at 10:26 am an interview was conducted with the Director of Nursing (DON). The DON stated she was asked by the Wound Nurse to look at Resident #1's sacral wound on 1/13/22, not medical staff. The DON stated, "if there was a concern with a wound you would ask the staff to reach out to the medical staff." The DON stated she had "not contacted medical staff regarding the resident's sacral wound decline and initiated a nurse judgement of treatment change." On 2/28/23 at 12:20 pm an interview was conducted with the Discharge Nurse. The Discharge Nurse was aware of the reported deterioration to Resident #1's sacral pressure ulcer on 1/14/23 and she had not reported to medical staff. On 2/28/23 at 2:45 pm an interview was conducted with Nurse # 1. Nurse #1 stated she worked every weekend and provided sacral pressure ulcer wound care to Resident #1 on 1/7/23 and 1/8/23 and noted the sacral wound had changed compared to the prior weekend. The wound was "horrible" with black tissue and odor and this change was not reported to medical staff. She stated the change was not reported	F 580	immediate need of the situation. Education of all Licensed Nursing Staff including current agency Licensed Nurses was completed on 3/3/2023. All newly hired Licensed Nursing Staff, including agency staff will be educated by the Director of Nursing/Designee during the facility orientation process on Notification to Medical Provider for changes in condition including changes in wounds, notification of injuries and the wound protocol. *The Director of Nursing/Designee will audit Weekly Wound report for twelve weeks for deterioration and MD/NP notification beginning 3/3/2023. The Director of Nursing/Designee will audit all incident reports to ensure appropriate treatment, MD/NP notification beginning 3/6/2023. This auditing will occur five times/week for twelve weeks. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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because she thought Wound NP #1 was going to see the resident during the week. If the Wound NP was not following, she would call the medical staff member covering the weekend.

On 2/28/23 at 11:03 am an interview was conducted with the facility NP. The NP stated she started her position at the facility on 1/6/23. She stated she first saw Resident #1 on 1/10/23 for a medical visit and had not evaluated the resident's wounds.

On 3/1/23 at 10:30 am an interview was conducted with the Physician Assistant (PA). The PA stated she saw Resident #1 on 1/6/23 and assessed the resident but was not informed by nursing or aware that there was a second skin tear to the right leg and the right leg was not evaluated.

On 3/1/23 at 11:20 am an interview was conducted with Nurse #2. Nurse #2 stated she assisted the Medication Aide with sacral pressure ulcer wound care and observed that the wound had opened, drainage changed to white purulent, and had foul odor on 1/14/23 and had not reported this to medical staff. The resident was discharged to home as planned. Nurse #2 had not stated why this change was not reported.

b. A nursing note written by Nurse #1 dated 12/31/2022 at 7:37 pm documented: "This nurse across the hall in another room when the NA (nurse aide) came to this nurse and stated resident got a skin tear when they (were) transferring resident into her wheelchair. This nurse into room and assess a large skin tear noted to the (right lower leg). Skin and subcutaneous tissue noted to be pushed to the

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right side of the wound and unable to be approximated."

On 3/1/23 at 3:02 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 when staff transferred her without the mechanical lift and the resident hit her right lower leg on the wheelchair footrest, on 12/31/22 and sustained an injury. Nurse #1 stated she completed an incident report and called the weekend medical staff on-call voice mail and left a message on the skin tear line (where to leave a message regarding skin tear). Nurse #1 stated she had not informed medical staff nor considered sending the resident to the Emergency Department at the time of accident because the bleeding had stopped after pressure was applied, and she did not think the wound was "that bad." Nurse #1 had not entered a physician order or notice in the physician follow-up book for the treatment she initiated to the injury.

On 2/28/23 at 11:03 am an interview was conducted with the facility Nurse Practitioner (NP). The NP stated she started her position at the facility on 1/6/23. She stated she first saw Resident #1 on 1/10/23 for a medical visit and had not evaluated the resident's wounds. She stated there was a communication breakdown and missing documentation regarding the wounds. The NP stated when the Wound NP was not available, she wanted to be informed by the Wound Nurse or Wound NP any changes to the resident's wound to follow up. She stated the 1/4/23 wound NP #2 by telehealth note was not in the medical record for her to review. She stated the right lower leg injury should have been evaluated by medicine before discharge on 1/14/23 since it significant.

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On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she was not available on 12/31/22 when Resident #1 suffered the injury to her leg. Wound NP #1 stated she reviewed the resident's record and Wound NP #2 who was covering by telehealth visit had not assessed the right lower leg skin tear (no documentation).

On 3/1/23 at 10:30 am an interview was conducted with the Physician Assistant (PA). The PA stated she saw Resident #1 on 1/6/23 and assessed the resident but was not informed or aware that there was a skin tear injury to the right leg and the right leg was not evaluated. Nor was she made aware of the severity of the injury.

On 3/1/23 at 12:40 pm and interview was conducted with the Physician. The Physician stated she was not informed of Resident #1's right lower leg injury until 1/4/23 when an order was requested. The physician further explained she was not informed of its severity and because of the severity she would have expected to be notified or the resident sent out to the Emergency Department when the injury happened.

The Administrator was advised of immediate jeopardy on 3/1/23 at 6:21 pm.

The facility provided a credible allegation of immediate jeopardy removal.

Credible Allegation of Compliance on 3/4/23.

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

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The facility failed to notify the medical staff Resident #1 sacral wound deterioration and change on 1/9/2023, 1/13/2023 and 1/14/2023 and failed to notify the physician of the severity of the right lower leg injury on 12/31/2022 which resulted in no medical attention being provided. Resident was hospitalized with an infected sacral wound pressure ulcer stage 4 which resulted in sepsis. In addition, Resident #1 sustained a 7 cm by 2cm by 0.1 cm skin tear to the lower right leg. This wound deteriorated to expose bone and subcutaneous tissue and had the high likelihood to become infected.

All residents have the potential to be affected.

On 3/2/2023 the facility completed a 100% skin sweep for all current residents. No issues were identified.

On 3/2/2023 the Director of Nursing/Designee reviewed previously completed wound reports for the last 30 days for any wound declines or changes. There were no wound declines or changes.

On 3/2/2023 the Director of Nursing/Designee reviewed the previous 30 days of eInteract (electronic assessment tool in the Electronic Health Record) Change in Condition assessments for any missed physician notifications. There were no missed notifications identified.

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

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On 3/2/2023 the Director of Nursing provided 1:1 education with the facility Designated Wound Nurse on notification to Medical Provider (Medical Doctor (MD)/Nurse Practitioner (NP)/Wound Nurse Practitioner (NP)) for changes in condition including deterioration of wounds, notification of injuries at the time of injury, and wound protocol to ensure that proper protocol is followed and in place. The facility wound protocol includes a description along with a picture of different types of altered skin integrity and acceptable treatment options to implement for each.

On 3/2/2023 all Licensed Nursing Staff, including agency staff were educated by the Nursing Administration Team on notification to Medical Provider (MD/NP/Wound NP) for changes in condition including deterioration of wounds, facility wound protocol and location of wound protocol (available on each medication cart and at the main nurses station), immediate notification of injuries that cannot be treated per facility wound protocol, description of the problem and immediate need of the situation, per physician triage line as indicated which is available 24 hours a day, 7 days per week. Education of all Licensed Nursing Staff including current agency Licensed Nurses was completed on 3/3/2023.

All newly hired Licensed Nursing Staff, including agency staff will be educated by the Director of Nursing/Designee during the facility orientation process on Notification to Medical Provider (MD/NP) for changes in condition including changes in wounds, notification of injuries and the wound protocol. The Regional Director of Clinical Services notified the Director of Nursing on 3/2/2023 on the implementation for new hires.

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An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Director of Rehab, Director of Life Enrichment, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023. The IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance.

The Director of Nursing/Designee will audit Weekly Wound reports for deterioration and MD/NP notification beginning 3/3/2023.

The Director of Nursing/Designee will audit all incident reports to ensure appropriate treatment, MD/NP notification beginning 3/6/2023.

Alleged date of IJ removal is 3/4/23.

The credible allegation of immediate jeopardy removal was validated on 3/7/23. On 3/7/23 observation and nursing interviews of all shifts were done of nursing education for resident change notification, use of the wound care protocol, and injury notification, for proper assessment/evaluation of wound status and care care, wound changes (including deterioration) and, and medical staff involvement (notification). New nursing hires and contract staff would receive the education before assignment. Current and ongoing wound care planned audits were reviewed. A Quality Assurance meeting was

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F 580	Continued From page 10 held by the Administrator and Corporate and plans for improvement were outlined. The facility's immediate jeopardy removal date of 03/04/23 was validated.	F 580		
F 624 SS=J	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member, home health liaison, and staff interviews, the facility failed to safely discharge 1 of 3 residents to home (Resident #1). The facility failed to submit a signed order for home health services to the home health agency until 3 days after discharge from the facility. Resident #1 had an unstageable pressure wound of the sacrum with purulent malodorous drainage and a large skin tear of the lower right leg that the family described as very deep, and she was able to see "white meat that looked like a bone". Additionally, Resident #1 had an unstageable pressure wound of the left heel and a skin tear of the left lower leg. Resident #1 was sent home with incorrect wound care supplies and incorrect wound care orders. Resident #1 was taken to the emergency room by family members immediately after the facility discharged Resident #1. The family members recognized Resident #1 had serious wounds that needed medical treatment and could not be cared	F 624	*Resident #1 no longer resides in the facility. *On 3/2/2023 the Social Services Director/Designee reviewed all residents that discharged home or to Assisted Living Facilities for the last 30 days to ensure the order for home care services were sent to the agency prior to discharge. One correction needed to be made. *On 3/2/2023 the Vice President of Social Services for Saber Healthcare Group provided education to the facility Social Service Director on Discharge Planning Policy to include timely notification to outside agencies. Social Services Director will confirm with outside agencies that discharge information has been received and confirm start date of services. The	3/22/23

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F 624	Continued From page 11 for at home. Immediate Jeopardy began on 1/14/2023 when Resident #1 was discharged home with an unstageable pressure wound of the sacrum with purulent malodorous drainage, an unstageable pressure wound of the left heel, a skin tear of the lower left leg, and a large skin tear of the lower right leg and without an order for home health services, with incorrect wound care supplies and instructions for wound care. Immediate Jeopardy was removed on 3/4/2023 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident #1 was admitted to the facility on 12/13/2022 with diagnoses to include acute on chronic respiratory failure, (an acute illness affecting a patient with chronic respiratory insufficiency), COVID-19 virus infection, anemia (requiring blood transfusions), kidney disease with acute kidney injury, pain in right knee, 2 Stage 2 pressure ulcers (ulcer extends into the deeper layers of the skin and can look like a shallow crater or blister) of the sacrum, deep tissue injuries (a pressure injury that begins in the muscle closest to the bone and appears as dark, non-blanchable skin) of the right and left heel, congestive heart failure and debility. A hospital admission note dated 1/14/2023 documented Resident #1 had an ejection fraction	F 624	certified medication aides were educated to not send wound supplies home with residents discharging. This was done on 3/3/23 by the Assistant Director of Nursing. *The Social Service Director/Designee will audit all planned discharges in morning clinical meeting to ensure proper notification, communication and documentation is complete with outside agencies as soon as the discharge date is determined 5 times a week for 12 weeks. The Social Service Director/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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(measurement of the percentage of blood leaving the heart with each heartbeat) of 45% (normal 50-70%).

A care plan dated 12/14/2022 addressed Resident #1's plan to discharge to the community after rehabilitation services. The goal for the care plan was to provide Resident #1 with a safe transition back to the community with interventions to involve home health agencies and appropriate community support services (none specified in the care plan).

The admission Minimum Data Set (MDS) assessment dated 12/16/2022 assessed Resident #1 to be moderately cognitively impaired. The MDS documented Resident #1 required extensive assistance with bed mobility, dressing, hygiene, and bathing, and total assistance to transfer and to toilet. The MDS assessment indicated Resident #1 was to be discharged to the community after rehabilitation services.

A physician order dated 12/15/2022 was reviewed. The order was to float heels (elevate off the bed). An order dated 12/27/2022 directed for both heels to have betadine (a topical antiseptic) applied daily.

A wound assessment dated 1/9/2023 documented an unstageable pressure wound on the left heel that measured 7 centimeters (cm) by 6.5 cm, and the depth of the wound was unable to be determined. The note documented that the wound had no drainage and no odor and was improving.

A physician order dated 1/9/2023 directed for left

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lower leg wound care to be completed daily with normal saline to clean the wound, calcium alginate (an absorbent dressing that promotes wound healing) to the wound bed, cover with an absorbent pad and apply gauze to secure.

A wound assessment dated 1/9/2023 documented the skin tear to the left lower leg to measure 7.1 cm by 1.9 cm and 0.1 cm. the wound was described as a trauma that was acquired in-house with a scant (very small) amount of serosanguineous (pink) drainage, a red wound bed, and no odor to the drainage was noted. The wound care documented wound care including applying calcium alginate to the wound, covering the wound with an absorbent pad, and securing the dressing with gauze.

A wound assessment dated 1/9/2023 documented the skin tear on the lower right leg that measured 7.2 cm by 3.5 cm by 0.1 cm. The wound was documented to have a moderate amount of serosanguineous drainage with a pink wound bed.

Wound care orders dated 1/12/2023 for the right lower leg read to clean with normal saline, apply collagen powder (used to promote wound healing), cover with absorbent dressing, and wrap with gauze to secure once daily.

A wound assessment dated 1/9/2023 documented Resident #1 had an unstageable pressure ulcer of the sacrum that measured 11.5 cm by 16 cm. The depth of the wound was unable to be determined due to the presence of slough (dead, moist, stringy tissue). The note documented a moderate amount of serosanguineous drainage with a faint odor and

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noted the wound was deteriorating.

Wound care orders for the sacrum dated 1/12/2023 read to apply an antiseptic solution (sodium hypochlorite and boric acid diluted in water) to clean the wound, then apply an antiseptic soaked gauze to the wound bed, cover with calcium alginate, cover with absorbent dressing, and secure with tape. This dressing change was to be completed daily.

An email dated 1/11/2023 from the Social Worker (SW) to a home health agency liaison read, in part: "Attached is the face sheet for (Resident #1). She is scheduled to be discharged on Saturday, 1/14/2023. She will need home health for nursing (medication management) ...as soon as I have the signed orders, I will send them to you."

An interview was conducted with the SW on 2/28/2023 at 1:41 PM. The SW explained that Resident #1 and her family planned on her returning home after rehabilitation services and a home health agency had been chosen by the family members. The SW reported that she had reached out to home health on 1/11/2023 to alert them to the referral. The SW reported the family was concerned about the discharge home because of Resident #1's high care needs (including transfers, toileting, and bed mobility, as well as wound care) but was relieved to know that home health would be out to assist with Resident #1's care. The family told the SW they had a male family member who was able to lift Resident #1 for transfers.

The Director of Nursing (DON) was interviewed on 3/1/2023 at 9:45 AM. The DON reported she

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was asked by the Wound Nurse to assess Resident #1's sacral wound on 1/13/2023 because the wound was deteriorating. The DON reported that she did not measure the sacral wound and did not remember the status of the wound bed. The DON explained that based on her experience with wounds and her judgement, she decided to change the wound care from medihoney to an antiseptic wound care because she noticed an odor. The DON spoke to the nurse practitioner, who did not observe Resident #1's sacral wound but wrote orders for the antiseptic solution to be used. The DON reported she was not certain if the Wound Nurse had notified the Wound Nurse Practitioner that the sacral wound had deteriorated. The DON reported the facility discharged residents with wounds that home health managed, she felt Resident #1's sacral and right lower leg wound could be managed at home.

A physician discharge order dated 1/13/2023 was reviewed. The order documented Resident #1 was to be discharged on 1/14/2023 and required a home health evaluation for nursing and therapy services.

The facility discharge summary dated 1/13/2023 listed the equipment ordered for Resident #1, which included a wheelchair, walker, bedside commode, shower chair, and oxygen.

A physician order dated 1/13/2023 ordered for Resident #1 to be discharged on 1/14/2023 with home health to evaluate for nursing and therapy services. The follow-up appointment with Resident #1's primary physician was noted, as well as medical equipment for Resident #1's home. No wound care orders or mention of

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wounds were included in the physician order.

A certified medication assistant (CMA) #1 was interviewed on 3/1/2023 at 11:12 AM. CMA #1 reported she had assisted Nurse #2 with Resident #1's discharge from the facility on 1/14/2023. The CMA reported the family members were present during wound care for Resident #1 and observed the pressure ulcer care and asked her for wound care supplies. CMA #1 listed the supplies she had given to Resident #1's family members: absorbent pads, wound cleanser, medihoney and gauze. CMA #1 reported Resident #1's pressure ulcer on the sacrum was large, foul-smelling, and had a pus-like, red-brown drainage. CMA #1 reported she had not sent the wound care supplies for the lower right leg wound care.

Nurse #2 was interviewed on 3/1/2023 at 11:20 AM. Nurse #2 reported she was the weekend supervisor and had discharged Resident #1 from the facility on 1/14/2023. Nurse #2 explained she and CMA #1 performed wound care on Resident #1 before she was discharged, and she had explained wound care to the family members. Nurse #2 reported the family members did not indicate they were going to take Resident #1 to the hospital, nor did they seem to be concerned with the pressure ulcer on the sacrum. Nurse #2 reported she did not think the wound appeared to be infected. Nurse #2 concluded by reporting she had received a call later in her shift from the hospital requesting medication administration records for Resident #1.

The discharge instructions signed by the family dated 1/14/2023 noted follow-up appointments with Resident #1's primary care physician on

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1/20/2023, the name and phone number of the home health agency, scheduled infusion appointments (for treatment of anemia) on 1/17/2023, 1/24/2023, 1/31/2023, and 2/7/2023. The discharge instructions included a note that a list of medications had been provided to the family and written prescriptions were sent to the pharmacy. The discharge instructions did not include a list of wound care supplies or ordered wound care for the sacrum or right lower leg wound.

Discharge instructions dated 1/14/2023 without a signature of the family member for Resident #1 were reviewed. These instructions included wound care to the sacrum (medihoney [an antibacterial wound treatment that removes dead tissue and keeps the wound moist], and dry dressing daily) as well as wound care for the wounds on her right calf (betadine, calcium alginate [anti-microbial absorbent dressing], absorbent pad, wrap with gauze). This summary was faxed to the home health agency on 1/17/2023.

The family member of Resident #1 was interviewed on 3/12023 at 12:09 PM. The family member reported she was with Resident #1 during the discharge process on 1/14/2023. The family member reported Nurse #2 and the CMA performed wound care and gave them instructions before discharge on 1/14/2023. The family member reported she and her sister saw Resident #1's pressure ulcer on her bottom and decided they were going to take Resident #1 directly to the hospital for evaluation because the pressure ulcer was very deep, smelled bad, had a lot of drainage, and it needed to be evaluated by a physician. The family member described the

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wound on the right lower leg to be very deep, and she was able to see "white meat that looked like a bone". The family member concluded by stating she and her sister did not take Resident #1 home but drove directly from the facility to the hospital emergency room.

The Emergency Room (ER) notes dated 1/14/2023 documented Resident #1 had been brought to the ER for evaluation, after discharge from the facility. The notes documented the family reported they were concerned that Resident #1 had an infected pressure ulcer of her sacrum. The diagnoses for Resident #1 included infected decubitus (pressure) ulcer, unstageable (full thickness tissue loss but is covered by extensive necrotic (dead) tissue). The admission note documented 3 different antibiotics were started and surgical consult was needed for pressure ulcer debridement (surgical removal of dead tissue). The right lower leg wound was documented as a chronic wound without further description.

Blood cultures completed at the hospital on 1/14/2023 tested positive for 3 different bacteria. A wound culture of the sacral wound was obtained on 1/14/2023 and showed positive growth of 2 different bacteria.

An email dated 1/17/2023 at 3:24 PM from the home health liaison to the SW was reviewed. The email read, in part: "Just checking on the orders for (Resident #1)."

A reply from the SW to the home health liaison dated 1/17/2023 at 3:30 PM read, in part, "I just sent you the order for (Resident #1)."

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The Home Health Administrator was interviewed by phone on 3/1/2023 at 10:23 AM. The Home Health Administrator reported that the home health agency had not received orders for Resident #1 until 1/17/2023 and home health services would not have been initiated until after the home health agency received those orders.

A follow-up interview was conducted with the SW on 3/1/2023 at 1:42 PM. The SW was not certain why she had not sent the orders to the home health agency until 1/17/2023.

The SW returned at 2:23 PM with a log of discharge residents for January 2023. The log indicated Resident #1's family had been contacted by phone call on 1/16/2023 by the SW. The SW explained the family told her that Resident #1 was hospitalized. The SW reported the orders were signed by the physician on 1/13/2023, but she had left for the day and did not get the signed orders sent to the home health agency. The SW reported she had not worked on 1/14/2023.The SW reported that because Resident #1 was in the hospital, the orders for home health slipped her mind and she did not send the orders until she received the email from the home health liaison on 1/17/2023. The SW reported this was not a safe discharge home for Resident #1 without the home health referral.

The facility Administrator was notified of Immediate Jeopardy on 3/1/2023 at 5:51 PM.

*Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a results of the noncompliance:
The facility failed to prepare for a safe discharge as evidenced by the signed order for home care

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services was not submitted to the home care agency until 3 days after discharge from the facility. Resident #1 would have been at home without skilled home care nursing services for an unstageable pressure ulcer of the sacrum with purulent odorous drainage from 1/14/2023 until 1/17/2023 when the facility sent the signed physician order to the home care agency. The family member recognized this was a serious wound that needed medical treatment and could not be cared for at home.

All residents discharging home have the potential to be affected.

On 3/2/2023 the Social Services Director/Designee reviewed all residents that discharged home or to Assisted Living Facilities for the last 30 days to ensure the order for home care services were sent to the agency prior to discharge. Any issues were immediately corrected.

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

On 3/2/2023 the Vice President of Social Services for Saber Healthcare Group provided education to the facility Social Service Director on Discharge Planning Policy to include timely notification to outside agencies. Social Services Director will confirm with outside agencies that discharge information has been received and confirm start date of services.

Newly hired Social Service employees will receive education as part of the orientation process.

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An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Nurse Managers, Director of Rehab, Director of Life Enrichment, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023. The IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance. Beginning on 3/3/2023 a review of all planned discharges will be reviewed during morning clinical meeting, which is attended by the Administrator, DON, ADON and all department heads, to ensure proper notification, communication, and documentation has been/will be made with any and all outside agencies as indicated to ensure a safe discharge. Notification of outside agencies will occur as soon as discharge date is determined.

Alleged date of IJ removal 3/4/23.

On 3/7/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:
" Review of the education provided to the SW related to timely notification of outside agencies, and confirmation of the information with the outside agency.
" Interview with SW and nursing staff to review education provided and procedure for discharging residents to home with outside agencies.
" Review of the discharges from 3/4/2023: 2

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F 624	Continued From page 22 discharges noted with correct process in place. " Review of audits completed by the facility. The facility's date of the immediate jeopardy removal plan of 3/4/2023 was validated on 3/7/2023.	F 624		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, family member, Physician Assistant (PA), Nurse Practitioner (NP), and Physician interviews, the facility failed to identify the seriousness and complete and document a thorough assessment of an injury to Resident #1's right lower leg sustained during a transfer on 12/31/22. The injury was described as a deep skin tear which measured 7 centimeters (cm) in length, width of 2.5 cm and approximately 0.5 cm deep and required direct pressure with a towel for several minutes to stop the bleeding. The edges of the wound were not able to be approximated (skin was unable to be pulled over the open wound to provide protection to the healing wound). This was reported to the on-call physician via voicemail as a skin tear with no other details provided. There was no treatment order until	F 684	*Resident #1 no longer resides in the facility. *On 3/2/2023 the Wound Nurse, Assistant Director of Nursing, and Clinical Coordinator completed head to toe skin assessments on all residents in the facility to include assessment of current wounds. Appropriate treatment orders are in place. No issues were identified. On 3/2/2023 the Director of Nursing/Designee reviewed all incident reports for the last 30 days to ensure thorough assessment of injury, Medical Provider (MD/NP/Wound NP) notification, treatment orders were obtained timely as indicated, and care plans were up to date. No issues were identified. On 3/2/2023 eInteract	3/22/23

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F 684	Continued From page 23 1/4/23. The family member described the injury as very deep and was able to see "white meat that looked like a bone". This deficient practice occurred for 1 of 2 residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 12/31/22 when the facility failed to identify the seriousness of an injury to Resident #1's right lower leg and the need for medical attention. Immediate jeopardy was removed on 3/4/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. Findings included: Resident #1 was admitted from the hospital to the facility on 12/14/22 acute on chronic respiratory failure, (an acute illness affecting a patient with chronic respiratory insufficiency), COVID-19 virus infection, anemia (requiring blood transfusions), kidney disease with acute kidney injury, pain in right knee, 2 Stage 2 pressure ulcers (ulcer extends into the deeper layers of the skin and can look like a shallow crater or blister) of the sacrum, deep tissue injuries (a pressure injury that begins in the muscle closest to the bone and appears as dark, non-blanchable skin) of the right and left heel, congestive heart failure and debility. A hospital admission note dated 1/14/2023 documented Resident #1 had an ejection fraction (measurement of the percentage of blood leaving the heart with each heartbeat) of 45% recorded on 11/22 (normal 50-70%).	F 684	(electronic assessment tool in the Electronic Health Record) Change in Condition assessment for the last 30 days were reviewed by the Director of Nursing to ensure MD/NP notification and orders were obtained timely as indicated. No issues were noted. *On 3/2/2023 the Director of Nursing provided one on one education with the facility Designated Wound Nurse on notification to Medical Provider for changes in condition including notification of injuries, obtaining orders timely, wound protocol, ensuring the medical provider evaluates and an appropriate treatment order is in place as indicated. The Wound Nurse was educated to follow up with Medical Providers to ensure evaluation of wounds has been completed when they are in the facility. Education for all Licensed Nurses and agency Licensed Nurses was completed on 3/3/2023 regarding following facility wound protocol, notifying Medical Providers of any abnormal assessment findings during routine dressing changes immediately to ensure timely evaluation is completed and any changes to treatments be implemented immediately as indicated, and notification of Medical Providers if a new skin condition cannot be treated with facility wound protocol. Education will be provided to any newly hired Licensed Nurses and agency Licensed Nurses prior to providing direct care. *The Director of Nursing/Designee will randomly audit eInteract Changes in	

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F 684	Continued From page 24 Resident #1's admission Minimum Data Set dated 12/16/23 documented moderately impaired cognition. The resident was dependent with all activities of daily living. The resident required two-person assist for transfer. Resident #1's admission care plan had a focus for actual and potential skin breakdown and assistance with activities of daily living. The transfer intervention was for mechanical lift. An interview was conducted on 2/28/2023 at 4:24 PM with NA #1, and she reported she had worked on 12/31/2022. NA #1 explained she was working on the 100 hall, and the 300 hall NA (NA #4) had asked her to come to Resident #1's room. NA #1 reported she was orienting NA #5 and the two of them went to Resident #1's room on the 300 hall. NA #1 described Resident #1 was in bed with her upper body supported on 3 pillows and NA #4 told her the bed control was not working to elevate the head and she wanted to move Resident #1 to a bed that worked. Resident #1's family member was at the bedside during this time. NA #1 left the room to get the lift to transfer Resident #1 to the other bed. NA #1 shared that when she returned to Resident #1's room, and Resident #1's family member had sat Resident #1 up on the side of the bed. According to NA #1's report, Resident #1 was unable to support herself sitting on the side of the bed and was crying out, "I can't take it." NA#1 described how NA #5 said, "I used to be an EMT (emergency medical technician), I know how to do this (transfer Resident #1)," and proceeded to lift Resident #1 from the bed over to the wheelchair, bumping Resident #1's leg on the wheelchair footrest and causing a skin tear. NA #1 reported she got a towel to hold on the open area of the skin tear to top the bleeding and NA	F 684	Condition assessments 5 times weekly for 12 weeks to ensure Medical Provider (MD/NP/Wound NP) notification, proper medical attention is received and orders are received timely. The Director of Nursing/Designee will audit all incident reports 5 times weekly for 12 weeks to ensure Medical Provider notification, proper medical attention is received and orders are received timely. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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#4 went to get the nurse. NA #1 reported that Nurse #1 arrived in "just a few seconds".

NA #5 was interviewed on 3/7/2023 at 4:18 PM. NA #5 reported her first time working on the floor of the facility was 12/31/2022 and she was assigned to train with NA #1. NA #5 reported she was standing behind the wheelchair and NA #1 and NA #4 lifted Resident #1 from the side of the bed to the wheelchair, and during the transfer, Resident #1's leg scraped against the footrest of the wheelchair. NA #5 reported she had alerted NA #1 and NA #4 that the footrest was jutting out and to push it back, but the other NAs did not correct the position of the footrest. NA #5 reported the wound was bleeding and she took a bedsheet and held pressure on the wound until the nurse arrived almost 20 minutes later.

NA #4 was interviewed on 3/1/2023 at 4:27 PM and she reported she was working 12/31/2022 and assigned to Resident #1 on that date. NA #4 verbalized she was not in the room, when NA #5 transferred Resident #1 and she did not see Resident #1 moved from the bed to the wheelchair but remembered that Resident #1 had sustained a large skin tear on her lower right leg and NA #1 was holding a towel on the leg to stop the bleeding.

A nursing note written by Nurse #1 dated 12/31/2022 at 7:37 PM documented: "This nurse across the hall in another room when the NA came to this nurse and stated resident got a skin tear when they (were) transferring resident into her wheelchair. This nurse into room and assess a large skin tear noted to the (right lower leg). Skin and subcutaneous tissue noted to be pushed to the right side of the wound and unable

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to be approximated. Area cleaned with wound cleanser, (non-stick, antibacterial dressing) applied to wound bed and (absorbent) pad placed on top and wrapped in (gauze). Resident states this area is sore. (Family member) in the facility at this time and was notified of skin tear by this nurse. (On-call physician) was notified via (voicemail) of skin tear." The nurse documented Resident #1 reported pain at a level "5" (1-10 scale, 10 being the most intense pain) of the lower right leg at the skin tear site.

Nurse #1 was interviewed on 2/28/2023 at 2:37 PM. Nurse #1 reported she was assigned to Resident #1 on 12/31/2022 and was notified by the nursing assistant (NA) that Resident #1 had sustained a skin tear to her right lower leg during a transfer. Nurse #1 reported she arrived at Resident #1's room and found 3 NAs at the bedside, 2 fulltime employees and 1 orienting staff member. Nurse #1 reported NA #1 was holding a towel on Resident #1's leg to stop the bleeding from a "heck of a large" skin tear on her lower right leg. Nurse #1 reported she was told by NA #1 that Resident #1 hit her leg on the wheelchair when she was being transferred. Nurse #1 reported she did not think the skin tear was serious and did not require evaluation at the hospital.

On 3/1/23 at 3:02 pm an interview was conducted with Nurse #1. Nurse #1 stated she was assigned to Resident #1 on 12/31/22 when staff transferred her without the mechanical lift and the resident hit her right lower leg on the wheelchair footrest. NA #1 informed her the resident had cut her leg. When she arrived NA #1 was holding a towel and providing pressure on the resident's right lower leg injury due to the bleeding. There

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was blood on the floor and the resident's leg, and it took a couple of minutes of pressure to stop the bleeding. Nurse #1 stated she completed an incident report and documented that subcutaneous tissue could be observed. Nurse #1 indicated the injury was 7 centimeters (cm) long by 2.5 cm wide and depth approximately 0.5 cm. Nurse #1 further stated, "I placed a non-stick dressing into the wound and covered with a large, absorbent cotton pad dry dressing and wrapped as nursing judgement." Nurse #1 stated there was not a wound protocol for placement of the dressing and "I made the decision to place a non-stick dressing to prevent adherence to the wound. The leg wound was approximately 2.5 centimeters open (wide), and I was unable to approximate the edges (place them together), and I had not considered sending the resident to the Emergency Department because the bleeding had stopped. I called the physician on-call and left a message on the skin tear notification voicemail line (on-call physician phone line)." Nurse #1 stated she had not initiated an order for the wound care to the resident's leg and she had not placed the injury in the physician notification book. Nurse #1 stated she completed the resident's right lower leg wound care on 1/1/23 and the following weekend 1/7/23 and 1/8/23. The wound looked the same size (had not measured), was without signs and symptoms of infection, and the drainage was a small amount of serosanguineous. Nurse #1 stated she had not documented the resident's wound observation; she initialed the treatment administration record on 1/7/23 and 1/8/23.

On 1/2/23 there was a multi-disciplinary team meeting documented by the Wound Nurse. It was documented Resident #1 was noted with a

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skin tear to her right lower leg after being transferred from bed to the wheelchair. The area was noted to be treated per standing orders (there was no standing order for use of non-adherent dressing to an injury).

Resident #1's Treatment Administration Record (TAR) revealed no orders for wound care to the residents right lower leg until 1/4/23 when an order was entered to cleanse with normal saline, place a non-stick dressing to the wound bed, and cover with dry dressing each day initiated by the Wound Nurse and signed by the Physician electronically (documented in the order).

Documentation of a telehealth visit by Wound Nurse Practitioner (NP) #2 completed on 1/4/23 did not include an assessment of Resident #1's right lower leg skin tear.

The Wound Nurse note dated 1/4/23 documented Wound NP #2's telehealth visit to evaluate Resident #1's sacral pressure ulcer wound and both heels. There was no evaluation of the resident's skin tear of the right lower leg documented.

On 3/1/23 at 2:00 pm an interview was attempted with Wound NP #2, and she was unavailable.

On 2/28/23 at 9:30 am an interview was conducted with the Wound Nurse. The Wound Nurse stated she assessed Resident #1's right lower leg skin tear on 1/4/23 and informed the physician the resident had a skin tear injury to her right lower leg but had not documented a measurement or condition. A new order was received from the physician to place hydrogel (wound healing ointment) to the wound bed and

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cover with a large dry dressing (change from the non-stick dressing initiated by Nurse #1). The Wound Nurse stated she had not informed nor asked Wound NP #2 to evaluate the resident's right lower leg skin tear during the 1/4/23 telehealth visit. The Wound Nurse dressed the resident's right lower leg injury each day and measured and documented the condition of the injury on 1/9/23 and reported findings to the physician.

An order dated 1/4/23 was initiated by the Wound Nurse to apply hydrogel in the wound bed on the right lower leg and cover with dry dressing every day as prescribed by the Physician and was signed electronically by the Physician (after the telehealth visit).

A review of Resident #1's record revealed the PA saw Resident #1 on 1/6/23 and assessed her sacral wound, both heels, and left leg. The right lower leg was not assessed.

On 3/1/23 at 10:30 am an interview was conducted with the PA. The PA stated she saw Resident #1 on 1/6/23 and assessed the resident sacral pressure ulcer, both heels, and left leg skin tear. The PA stated she was not informed by nursing nor aware that there was a second skin tear to the right leg and the right leg was not evaluated. The PA stated 1/6/23 was her last day at the facility.

A wound assessment dated 1/2/2023 documented a skin tear of the right lower leg that measured 7.6 centimeters (cm) by 3.5 cm by 0.1 cm and had a pink wound bed and a moderate amount of serosanguinous (pink) drainage. The note documented the wound was cleaned with

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normal saline, and an antimicrobial non-stick dressing was applied to the open wound, it was covered with an absorbent pad, and wrapped with gauze. The nursing note that correlated with wound assessment dated 1/2/2023 documented Resident #1 was reporting "3" pain to her right lower leg.

The Wound Nurse's note dated 1/9/23 documentated the resident's right lower leg skin tear by the Wound Nurse. The entry documented Resident #1's skin tear to the right lower leg measured 7 cm length by 3.5 cm wide by 0.1 cm deep. There was moderate serosanguineous drainage, wound bed was pink, there was pain level 3, and the wound was improving. The physician was notified of the wound status and a new order was obtained electronically.

The Wound Nurse was interviewed on 3/1/23 at 9:20 am. The Wound Nurse stated she informed the physician by phone of the resident's right leg skin tear status on 1/9/23 and was provided a new treatment order but did not remember why. She had not asked the physician or any other medical staff member to assess the resident's skin tear. Nursing assessed the wounds during daily dressing changes on the weekends and the Wound Nurse assessed the wound during daily dressing changes Monday through Friday and measured and documented the wound status once a week.

Resident #1's new order documented by the Wound Nurse for the right lower leg skin tear dated 1/9/23 was to place calcium alginate in the wound and cover with a dry dressing and wrap with rolled gauze. The order was initiated by the Wound Nurse as prescribed by the Physician and

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signed electronically.

Wound care orders dated 1/12/2023 for the right lower leg read to clean with normal saline, apply collagen powder (used to promote wound healing), cover with absorbent dressing, and wrap with gauze to secure once daily was initiated by the Wound Nurse and signed by the physician.

There was no further documentation about Resident #1's right lower leg wound after 1/9/23.

On 2/27/23 at 1:40 pm an interview was conducted with the family member. She stated the family visited on Monday (1/2/23) and that the resident had a large wound to the right lower leg. The dressing was soiled and falling off. The nurse was informed, and the Wound Nurse changed the dressing. The family member stated they asked nursing about the dressing to the right leg, and it was changed. The resident complained of pain in the right leg wound.

The family member was interviewed on 3/1/2023 at 12:09 PM. The family member recalled she and other family members were in the facility on 12/31/2023 and the nursing staff had asked the family to step out of the room so they could transfer Resident #1 to a different bed and apply the air mattress to the bed. The family member reported that when she and the other family members returned to the room, they were told that Resident #1 had sustained a skin tear from the wheelchair. The family member explained that they asked for the wound dressing on the right lower leg to be removed and when they saw the skin tear, they told the nurse that the wound needed to be evaluated at the hospital. The family member described the wound on the right lower

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leg to be very deep, and she was able to see "white meat that looked like a bone". The family member reported the skin was pushed back away from the wound and the nurse said she had not been unable to pull it back over the open wound and Resident #1 reported pain at the wound site. The family member said that Nurse #1 told them the physician had been notified of the skin tear and didn't feel that the wound needed to be assessed at the hospital.

On 2/28/23 at 10:26 an interview was conducted with the Director of Nursing (DON). The DON stated, "if there was a concern with a wound you would ask the staff to reach out to the medical staff. I would use nursing judgement for standing orders only. Resident #1's skin tear to the right lower leg was not assigned to Wound NP #1 to follow, nursing was taking care of the skin tear by initiating the wound treatment and obtained an order from the Physician." The DON stated she was not sure if the wound treatment initiated by Nurse #1 for Resident #1's skin tear was part of the standing orders. The DON had no comment about the lack of the Wound Nurses' documentation of the right lower leg skin tear. She stated that all wounds were to be assessed and measured each week by the Wound Nurse and the Wound NP if following. The Wound Nurse completed all resident wound care Monday through Friday and assigned nursing staff were to complete wound care on the weekends. The DON stated that the resident's skin tear was treated each day and the physician provided an order and the Wound Nurse was responsible to report any decline in the wound. The DON stated she had not assessed the resident's right lower leg injury herself and was aware that the Wound Nurse was following and had provided updates to

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the Physician.

On 2/28/23 at 11:03 am an interview was conducted with the NP for the facility. The NP stated she started her position here on 1/6/23 and took the place of the PA. She stated she first saw Resident #1 on 1/10/23 for a medical visit and had not evaluated the resident's wounds on 1/10/23. She was of the understanding the Wound NP was following all the residents' wounds and was to be notified of concerns and changes. She stated that the skin tear to the lower right leg should have been followed by medical staff and wanted to be informed by the Wound Nurse or Wound NP of the changes to the resident's wound. All the resident's wounds should have been evaluated by medicine before discharge on 1/14/23 since it was significant and there was a change.

On 3/1/23 at 12:40 pm an interview was conducted with the Physician. The Physician stated she was not informed of the severity of Resident #1's right lower leg skin tear. The Wound Nurse communicated her assessments she provided the wound care order. The physician stated the resident should have been sent to the Emergency Department on 12/31/22 or at least followed by the medical staff in the facility from when the injury occurred on 12/31/22. The Physician was not aware that the NP or PA had not assessed/observed the right lower leg wound.
Resident #1's hospital record dated 1/14/23 documented the right lower leg wound was a chronic wound without further description.

The Administrator was notified of IJ on 3/1/23 at 6:21 pm.

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The facility provided a credible allegation of immediate jeopardy removal.

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

The facility failed to ensure that Resident #1 accidental injury on 12/31/22 to her right calf which resulted in a 7 cm by 2cm by 0.1 cm skin tear to the lower right leg was evaluated by a medical provider (MD/NP/Wound NP). There was no physician order for treatment for 4 days. Notification of the accidental injury to Resident #1 lower right leg was reported on the physician triage line voicemail per protocol as a skin tear. The resident's hospital record dated 1/14/2023 documented that the resident's injury to her right lower leg was trauma with tissue injury depth to the bone.

All residents have the potential to be affected.

On 3/2/2023 the Wound Nurse, Assistant Director of Nursing, and Clinical Coordinator completed head to toe skin assessments on all residents in the facility to include assessment of current wounds. Appropriate treatment orders are in place. No issues were identified.

On 3/2/2023 the Director of Nursing/Designee reviewed all incident reports for the last 30 days to ensure thorough assessment of injury, Medical Provider (MD/NP/Wound NP) notification, treatment orders were obtained timely as indicated, and care plans were up to date. No issues were identified.

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F 684	Continued From page 35 On 3/2/2023 eInteract (electronic assessment tool in the Electronic Health Record) Change in Condition assessment for the last 30 days were reviewed by the Director of Nursing to ensure MD/NP notification and orders were obtained timely as indicated. No issues were noted. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 3/2/2023 the Director of Nursing provided 1:1 education with the facility Designated Wound Nurse on notification to Medical Provider (Medical Director (MD)/Nurse Practitioner (NP)/Wound Nurse Practitioner (NP)) for changes in condition including notification of injuries, obtaining orders timely, wound protocol, ensuring the medical provider (MD/NP/Wound NP) evaluates and an appropriate treatment order is in place as indicated. The Wound Nurse was educated to follow up with Medical Providers to ensure evaluation of wounds has been completed when they are in the facility. The Wound Nurse will continue to complete weekly wound assessments and assigned Licensed Nurses complete treatments and dressing changes per physician orders. The facility wound protocol includes a description along with a picture of different types of altered skin integrity and acceptable treatment options to implement for each. The NP will be educated by the respective physician group manager regarding proper assessment and evaluation of all residents to include assessment of wounds/skin integrity concerns by 3/3/2023 in order to prevent deterioration of wounds and to ensure	F 684		

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appropriate orders are in place to prevent worsening of wounds/skin conditions and follow up with facility Wound Nurse/Designee to ensure no evaluation needs have been missed.

Education for all Licensed Nurses and agency Licensed Nurses was completed on 3/3/2023 regarding following facility wound protocol, notifying Medical Providers of any abnormal assessment findings during routine dressing changes immediately to ensure timely evaluation is completed and any changes to treatments be implemented immediately as indicated, and notification of Medical Providers if a new skin condition cannot be treated with facility wound protocol. Education will be provided to any newly hired Licensed Nurses and agency Licensed Nurses prior to providing direct care.

Education was completed on 3/3/2023 with all Licensed Nursing Staff, including Licensed agency nursing staff of wound protocol and location of wound protocol (in binder on medication carts and at main nurses station), documentation of any skin integrity concerns, notification of medical provider (MD/NP/Wound NP) regardless of day or time, notification of new skin concerns for the Wound Nurse to ensure proper follow up and assessment is completed.

An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Director of Rehab, Director of Life Enrichment, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on

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F 684	Continued From page 37 3/2/2023. The IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance. Alleged date of IJ removal 3/4/23. The credible allegation of immediate jeopardy removal was validated on 3/7/23. On 3/7/23 observation and nursing interviews of all shifts were done of nursing education and the in-service signed roster was reviewed regarding proper assessment/evaluation of wound care, notification of changes, use of the wound care protocol, and medical staff involvement. A documented resident audit was completed of all residents for injuries. New nursing hires and contract staff would receive the education before assignment. A Quality Assurance meeting was held by the Administrator and Corporate and plans for improvement were outlined. The facility's immediate jeopardy removal date of 03/04/23 was validated.	F 684		
F 686 SS=J	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	F 686		3/22/23

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F 686	Continued From page 38 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, Wound Nurse Practitioner (NP) #1, Physician Assistant, Facility Nurse Practitioner, Physician, and Family Member, the facility failed to provide treatment and services, consistent with the facility's wound protocol, to promote healing and identify infection of the pressure areas Resident #1 had on admission. Resident #1's Stage 2 pressure ulcers deteriorated, increased in size and developed odor, drainage, and eschar (dead tissue) during her one month stay. Staff did not consult with medical staff when there was drainage and deterioration of the wound. On the day of discharge, the Family Member took Resident #1 directly to the hospital where she was diagnosed with a stage 4, open and infected decubitus ulcer of the sacrum. The infection was not identified at the facility. This deficient practice affected 1 of 2 residents reviewed for pressure sores (Resident #1). Immediate jeopardy began on 1/9/23 for Resident #1 when staff failed to address the resident's continued sacral pressure ulcer deterioration. Immediate jeopardy was removed on 3/4/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. Findings included:	F 686	*Resident #1 no longer resides in the facility. *On 3/2/2023 the facility completed a 100% skin sweep for all current residents. No issues were identified. On 3/2/2023 the Director of Nursing/Designee reviewed previously completed wound reports for the last 30 days for any wound declines or changes. No issues were identified. On 3/2/2023 all wound physician orders for the last 30 days were reviewed by Director of Nursing/Designee for appropriateness of treatment orders. No issues were identified. On 3/2/2023 Braden Scale Skin Risk assessment were reviewed by the Director of Nursing/Designee and updated if indicated. On 3/2/2023 Care Plans for identified skin risk were reviewed and updated as indicated by the Director of Nursing/Designee. *On 3/2/2023 the Director of Nursing provided one on one education with the facility Designated Wound Nurse on notification to Medical Provider (MD/NP/Wound NP) for changes in condition including wounds/skin tears/pressure injuries, obtaining orders timely, following facility wound protocol, ensuring the medical provider is notified timely of new or deteriorating wounds, evaluates and that an appropriate treatment order is in place as indicated.	

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F 686	Continued From page 39 The facility standing order revised 3/2021 documented "Wound Care Protocol, 1. Document wound assessments to include measurements and description of the wound. 2. Only wound nurse to stage wounds. 3. Place in problem book for follow up with PEC (on-call physician). The unstageable pressure ulcer wounds that are completely covered with nonviable necrotic (dead) tissue cannot be staged. Ulcers should be carefully evaluated for the presence of undermining, sinus tracts or tunning. A physician or wound care specialist should evaluate wounds that show signs and symptoms of infection. Debridement of ulcers with unstable devitalized tissue is necessary. Notify the medical doctor or wound consultant for debridement options (i.e., enzymatics, referral for sharp debridement)." Debridement is the removal of non-viable material, foreign bodies, and poorly healing tissue. Resident #1 was admitted from the hospital to the facility on 12/14/22 acute on chronic respiratory failure, (an acute illness affecting a patient with chronic respiratory insufficiency), COVID-19 virus infection, anemia (requiring blood transfusions), kidney disease with acute kidney injury, pain in right knee, 2 Stage 2 pressure ulcers (ulcer extends into the deeper layers of the skin and can look like a shallow crater or blister) of the sacrum, deep tissue injuries (a pressure injury that begins in the muscle closest to the bone and appears as dark, non-blanchable skin) of the right and left heel, congestive heart failure and debility. A hospital admission note dated 1/14/2023 documented Resident #1 had an ejection fraction (measurement of the percentage of blood leaving the heart with each heartbeat) of 45% recorded	F 686	The facility wound protocol includes a description along with a picture of different types of altered skin integrity and acceptable treatment options to implement for each. On 3/2/2023 all Licensed Nursing Staff, including Licensed Nursing agency staff were educated by the Nursing Administration Team on notification to Medical Provider for changes in skin condition including deterioration of wounds regardless of day or time, wound protocol location, and entering orders into the electronic health record (EHR). All education completed on 3/3/2023. All Certified Nurse Aides (C.N.A.s) including agency C.N.A.s were educated to report any identified skin integrity concerns to Licensed Nursing Staff immediately. All education completed on 3/3/2023. All newly hired Licensed Nursing Staff and Certified Nurse Aides, including Licensed Nursing and Certified Nurse Aide agency staff will be educated by the Director of Nursing/Designee during the facility orientation process. *The Director of Nursing/Designee will audit Weekly Wound reports for 12 weeks beginning on 3/3/2023. The Director of Nursing/Designee will audit all new treatment orders to ensure wound protocol is followed and assessment by medical provider beginning on 3/3/2023. The Interdisciplinary Team will review all residents with current wounds including pressure injuries during the facility weekly Resident Review Meeting. This auditing	

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F 686	Continued From page 40 on 11/22 (normal 50-70%). An admission nurses' note dated 12/14/22 documented pressure ulcer assessment as follows: The right buttock had a stage two ulcer 3.0 centimeters (cm) x 3.9 cm x 0.1 cm. The wound bed was red. The left buttock had a stage two ulcer 4.9 cm x 3.5 cm x 0.1 cm. The wound bed was red. The right gluteal fold had a stage two ulcer 0.4 cm x 0.6 cm x 0.1 cm (newly identified on admission). Resident #1's physician order dated 12/14/22 was to cleanse the buttocks with normal saline and cover with foam dressing. Resident #1's admission Minimum Data Set dated 12/16/22 documented a moderately impaired cognition. The resident was dependent with all activities of daily living. The resident had 4 stage 2 pressure ulcers. The resident was always incontinent of urine and stool. The resident required 1 staff member assistance for bed mobility. A pressure ulcer risk assessment scale completed on admission documented high risk for pressure ulcer development. Resident #1's admission care plan dated 12/20/22 had a focus for actual and potential skin breakdown. The interventions were to provide treatment as ordered, assess, and document the status, monitor, document and report changes to the physician, turn and reposition as indicated, and use pressure relieving devices.	F 686	will be weekly for twelve weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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The Wound Nurse note dated 12/20/22 indicated the pressure ulcer assessment to the buttocks was as follows:
The right buttock had a stage two ulcer 3.0 x 3.9 x 0.1 cm. The wound bed was red with no odor and drainage was a small amount of sanguineous (watery red). The wound was unchanged and pain level was none.
The right inferior buttock had a stage two ulcer 1.0 x 0.8 x 0.1. The wound and dressing order were unchanged and there was no pain.
The left buttock had a stage two ulcer 4.9 x 3.5 x 0.1. There was scant sanguineous drainage. Wound bed was pink with no odor.
The right gluteal fold had a stage 2 ulcer 0.4 x 0.6 x 0.1. The wound was unchanged.

A white blood cell count result was 6.6 on 12/21/23 (range 6 - 10).

Resident #1 had a multidisciplinary note written by the Wound Nurse dated 12/22/22 documented the stage 2 pressure ulcers to the buttocks, a protein drink was added to promote healing, and staff were to turn and position. The Wound NP was supposed to follow up on 12/27/22.

The Wound Nurse note dated 12/27/22 documented that all the buttock areas were measured together and described as a sacral pressure ulcer stage 2. The wound bed was pink and yellow with no odor. The wound was assessed by the Wound NP #1. The measurement was 4.8 x 5.6 x 0.3 with no drainage. The Wound NP #1 ordered honey-based wound gel and dry dressing daily.

On 12/27/22 Wound NP #1 documented her initial

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assessment of Resident #1's sacral pressure ulcer wound. The chief complaint was necrotic tissue in the wound and services were requested. The wound was present on admission and unstageable. Tissue depth was subcutaneous with mild serous drainage. The measurement was 4.8 x 5.6 x 0.3. The wound was documented as unavoidable.

On 2/28/23 at 2:00 pm an interview was conducted with Wound NP #1. She stated she saw Resident #1 for her first visit on 12/27/22 for sacral pressure ulcer. The ulcer was stable and the same size as when admitted. She stated she went on leave after the 12/27/22 visit and was not available for resident care until 1/17/23. Arrangements were made for telehealth wound care on 1/4/23.

A multidisciplinary meeting on 12/29/22 documented by the Wound Nurse the resident had an air mattress in place.

The Wound Nurse note dated 1/4/23 documented the Wound NP #2 telehealth visit evaluated the resident's sacral pressure ulcer wound. The Wound Nurse measured the sacral wound during the evaluation. Measurements were, 11.5 x 15 and depth was undetermined. It had a small amount of sanguineous drainage. The wound bed had pink and yellow tissue with a necrotic appearance and slough (dead skin tissue) with no odor. The wound had gotten significantly larger, deteriorated with necrotic tissue and was close to the sacral bone. New orders were received to apply hydrogel to the wound, imaging to assess the sacral bone for involvement, and labs. Autolytic debridement (medication added to stimulate the body to naturally eliminate dead

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tissue) was being utilized and Wound NP #1 will continue to follow.

On 2/28/23 at 9:50 am an interview was conducted with the Wound Nurse. The Wound Nurse stated on 1/4/23 there was a noted change in Resident #1's sacral pressure ulcer wound. A wound NP telehealth visit was done with Wound NP #2 by video. The wound had new necrosis (dead tissue in the wound bed). The order was changed to use hydrogel with silver to the wound bed. Wound NP #2 ordered labs and a sacral x-ray.

Wound NP #2's note dated 1/4/23 for documented the sacral wound length 11.5 cm by width 15 cm and depth was 0.5 cm down to the subcutaneous (tissue below the skin) layer. The wound bed had 80% yellow/black tissue with mild serous drainage. The wound was unstageable and deteriorating. The deterioration was significant with an increase in wound volume and percentage of necrotic tissue. Labs were ordered to rule out osteomyelitis. A new order to cleanse with normal saline, apply skin prep around the wound, place hydrogel with silver to the wound bed, and dry protective dressing each day was written.

On 3/1/22 at 2:00 pm an attempt was made to interview Wound NP #2 and she was not available.

A Physician Assistant (PA) note, dated 1/6/23, documented that Resident #1's sacral pressure ulcer wound was assessed and had small drainage with no odor and pink with yellow wound bed. The wound order was changed to honey-based wound gel with dressing each day.

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No measurement was documented.

On 3/1/23 at 10:30 am an interview was conducted with the PA. The PA stated she saw Resident #1 on 1/6/23 and assessed the resident's sacral pressure ulcer. The PA stated the sacral wound had minimal drainage with no odor and the wound was unstageable with pink tissue and yellow slough. She stated the sacral wound order was changed to honey-based wound gel with calcium alginate instead of the hydrogel ordered two days earlier. She was not aware that Wound NP #2 documented the sacral wound was deteriorating and to the bone and had ordered an x-ray to assess for osteomyelitis and a complete blood count to assess for infection. The PA stated she had not read Wound NP #2's note prior to changing the dressing order. The PA stated 1/6/23 was her last day at the facility.

On 2/28/23 at 2:45 pm an interview was conducted with Nurse #1. Nurse #1 stated she provided wound care to Resident #1 on the weekends. Nurse #1 stated on the weekend of 1/7/23 and 1/8/23 she noted the sacral wound had deteriorated from the prior weekend. There was black necrosis and red around the black part with drainage and odor. Nurse #1 stated she had to use a larger dressing to cover the wound that had gotten larger. Nurse #1 stated she was aware there was a telehealth visit by Wound NP #2 who was following the resident and thought the Wound NP #2 was following. Nurse #1 had not contacted medical staff about her concerns and had not documented her findings.

The Wound Nurse note dated 1/9/23 documented the Wound Nurse assessed and measured Resident #1's sacral pressure ulcer wound as

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follows: the length 11.5 cm by width 16 cm and depth was 0.5 cm. There was a moderate amount of serosanguineous drainage, and the wound bed appeared yellow with slough and faint odor. The wound was deteriorating, and the resident had a pain level score of 3 (0 to 10 scale with 0 being no pain). The family was notified. No medical staff communication was documented.

Lab results were collected on 1/9/23 for a complete blood count. The 1/9/23 result revealed an elevated white blood cell count of 13.2 (range 6 - 10). An elevated white blood cell count can be an indicator of infection.

The radiograph taken on 1/6/23 of the sacrum showed a result dated 1/6/23 that reported no osteomyelitis (bone infection).

On 2/28/23 at 11:25 am an interview was conducted with the Facility Nurse Practitioner. She stated she started her position on 1/6/23 and took the place of the Physician Assistant. She saw Resident #1 on 1/10/23 for a medical visit and had not evaluated the resident's wounds. She stated the Wound NPs were seeing the resident and she did not evaluate the wounds, unless there was a need. She stated there was a mildly elevated white blood cell count lab, but that there was no concern for wound infection and the x-ray did not show osteomyelitis of the sacrum. She stated staff had not informed her Wound NP #1 was not available to consult from 12/31/22 to 1/17/23.

A review of the resident's record did not document a nursing assessment of the sacral pressure ulcer wound condition or measurements

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for 1/13/23. A new order for antiseptic solution cleanse and wet to dry dressing with the solution each day was written by the Director of Nursing and signed by the Physician without observation of the wound.

On 2/28/23 at 9:50 am an interview was conducted with the Wound Nurse. The Wound Nurse stated she was not aware that the resident's white blood cell count was elevated. She said the physician was responsible for labs. She added the Nurse Supervisor would provide lab reports to whoever need the labs. She said if wounds changed and developed odor, then you would change the course of treatment. She stated she asked the DON to look at the sacral wound because the wound had deteriorated further. She stated, usually, an antiseptic solution was initiated when there was a concern for infection. The Director of Nursing (DON) and she decided on 1/13/23 there was an odor to the resident's sacral wound and started using antiseptic solution to clean and pack. There was no physician order.

On 2/28/23 at 10:26 an interview was conducted with the Director of Nursing (DON). The DON stated she was asked by the Wound Nurse to look at Resident #1's sacral wound on 1/13/22 for a second opinion for treatment change. On 1/13/22 the Wound Nurse asked me to evaluate Resident #1's sacral wound and the DON said she was not familiar with the status of the wound. She stated that she could not recall if using an antiseptic for a deteriorating pressure ulcer was part of the standing order.

The record had no further documentation of the sacral wound's status.

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On 2/28/23 at 11:25 am, the Facility Nurse Practitioner (NP) stated staff had not informed her that the resident's wound had deteriorated and had odor and increased drainage until 1/13/23. The DON informed her that the nurses changed the wound treatment to antiseptic cleanse and packed it with gauze wet to dry and she wanted to be informed of the wound deterioration. The Facility Nurse Practitioner evaluated the resident for discharge on 1/13/23 and had not evaluated her wounds. The DON gave report of the wounds' condition but not of the amount of deterioration. She observed a photo of the sacral wound taken on 1/14/23 from the resident's hospital record. She stated there was a breakdown in communication and missing documentation when Wound NP #1 was not available and wanted to be informed by the nurse of the changes to the resident's wound.

On 2/28/23 at 12:20 pm an interview was conducted with the Discharge Nurse. She stated the Wound Nurse completed the dressing changes and she was informed that the sacral wound was getting worse. She stated there was an odor coming from the resident's wound during the 1/4/23 dressing change reported by the nurse assigned (was not reported to medical staff). She stated the odor and drainage was a concern by the nursing staff. The family would visit and complain that there was an odor and drainage coming from the sacral wound. She stated when she saw the sacral wound during the week of 1/9/23, it was pink, getting larger with yellow slough. The resident was noted to have declined the last week of her admission.

On 3/1/23 at 9:45 am an interview was conducted

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with the DON. She stated that on 1/13/23 she accompanied the Wound Nurse as requested and observed Resident #1's sacral pressure ulcer wound because of wound changes. The DON stated the Wound Nurse was new to her role and the DON was asked to look at the wound. The DON stated she had not measured the wound or evaluated the depth nor remembered if the pressure ulcer had black eschar. The DON stated she made the decision to change the wound care order from honey-based gel treatment with calcium alginate to antiseptic solution cleanse and wet to dry with the solution. The DON stated she gave her assessment of what she saw to the Facility NP later. The Facility NP had not assessed the resident's wound. The DON stated she was not aware that Wound NP #1 instructed the Wound Nurse to contact the Wound NP consultant's office if there were changes to the wound so that an assessment could be done by telehealth. The DON stated she was not aware that the Wound Nurse had not contacted medical staff that the resident's sacral wound had continued to deteriorate, and the plan was to notify the Wound NP consultant's office if there were changes. The DON stated that the physician signed off on orders electronically from her computer and had not assessed the resident's sacral wound. The DON stated she had not documented her observation on 1/13/23 of the resident's sacral wound.

On 3/1/23 at 11:12 am an interview was conducted with the Medication Aide (MA). The MA stated she was assigned to Resident #1 on the day of discharge 1/14/23. She changed the dressing to the resident's sacral pressure ulcer wound and found that it had a bad odor and was open. The wound had a reddish, brown purulent

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drainage. Nurse #2 was present for the wound care. She had not reported her findings to medical staff.

On 3/1/23 at 11:20 am an interview was conducted with Nurse #2. Nurse #2 stated she was present when the MA changed Resident #1's sacral wound dressing and provided assistance. She was not concerned about the wound and provided the supplies for wound care to take home. Nurse #2 stated that the sacral wound had opened, had black tissue, and had white drainage.

On 3/1/23 at 12:50 pm an interview was conducted with the Physician. The physician stated she was not aware of Resident #1's sacral pressure ulcer wound deterioration. The physician stated she would have wanted the nursing staff to report changes and continued deterioration of a wound to the medical staff. The medical staff was required to evaluate all wounds at least 5 days before discharge. The physician stated she was not aware Resident #1 had no medical staff assessment within this timeframe. The physician stated she was not sure the pressure ulcer was avoidable, but the lack of medical staff attention was avoidable. She further stated the resident outcome was hard to predict because of the many other diagnoses.

On 2/27/23 at 1:40 pm an interview was conducted with Resident #1's family member. She stated the resident had a sacral wound that had a strong odor and pain. "I reported my concerns to the nurse several times and the wound was not treated by a physician. On the day of discharge (1/14/23) the resident's smell and pain to the sacrum was so bad we went

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straight to the hospital." The family member commented that before hospitalization for COVID the resident had never had a pressure ulcer.

Resident #1's hospital record documented the resident was brought to the hospital by the family on 1/14/23 instead of being taken home as discharge planned by the facility. The resident was seen for complaint about wound to the buttock. The family felt the wound was not addressed (at the facility). The family reported foul smell coming from the buttock wound. The hospital physician assessment documented the resident had two lower extremity wounds that were prior and a new wound from trauma in wheelchair. The buttock wound was a large, open stage 4 pressure ulcer that was malodorous, had a large amount of purulent (containing pus) drainage, and had pitting edema surrounding. The diagnosis was unstageable infected decubitus ulcer of the sacrum.

The Administrator was notified of immediate jeopardy on 3/1/23 at 6:22 PM.

The facility provided a credible allegation of immediate jeopardy removal.

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

The facility failed to seek medical attention for Resident #1's sacral pressure ulcer that had deteriorated and had become larger and developed sour odor, increased pain, increased drainage, black eschar tissue, and purulent drainage to determine the appropriate wound changes (1/9/2023, 1/13/2023 and 1/14/2023).

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Nursing had not followed their wound protocol and discontinued a physician order for sacral wound care and initiated antiseptic solution treatment without medical evaluation/observation (last completed 1/6/2023) of deteriorating wound on 1/13/2023. The resident was hospitalized with an infected sacral wound pressure ulcer stage 4 (as staged by the hospital) which resulted in sepsis. A review of the residents' hospital record admission dated 1/14/2023 documented blood cultures and wound culture to be positive of the same organism for infection and sepsis.

All residents have the potential to be affected.

On 3/2/2023 the facility completed a 100% skin sweep for all current residents. No issues were identified.

On 3/2/2023 the Director of Nursing/Designee reviewed previously completed wound reports for the last 30 days for any wound declines or changes. No issues were identified.

On 3/2/2023 all wound physician orders for the last 30 days were reviewed by Director of Nursing/Designee for appropriateness of treatment orders. No issues were identified.

On 3/2/2023 Braden Scale Skin Risk assessment were reviewed by the Director of Nursing/Designee and updated if indicated.

On 3/2/2023 Care Plans for identified skin risk were reviewed and updated as indicated by the Director of Nursing/Designee.

Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete.

On 3/2/2023 the Director of Nursing provided 1:1 education with the facility Designated Wound Nurse on notification to Medical Provider (Medical Director (MD)/Nurse Practitioner (NP)/Wound Nurse Practitioner (NP)) for changes in condition including wounds/skin tears/pressure injuries (PIs), obtaining orders timely, following facility wound protocol, ensuring the medical provider (MD/NP/Wound NP) is notified timely of new or deteriorating wounds, evaluates and that an appropriate treatment order is in place as indicated. The facility wound protocol includes a description along with a picture of different types of altered skin integrity and acceptable treatment options to implement for each.

On 3/2/2023 all Licensed Nursing Staff, including Licensed Nursing agency staff were educated by the Nursing Administration Team on notification to Medical Provider (MD/NP/Wound NP) for changes in skin condition including deterioration of wounds regardless of day or time, wound protocol location (in binder on medication carts and at main nurses station) and entering orders into the electronic health record (EHR). All education completed on 3/3/2023.

All Certified Nurse Aides (C.N.A.s) including agency C.N.A.s were educated to report any identified skin integrity concerns (redness, open areas, saturated dressings, odors from wounds) to Licensed Nursing Staff immediately. All education completed on 3/3/2023.

All newly hired Licensed Nursing Staff and Certified Nurse Aides, including Licensed Nursing

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and Certified Nurse Aide agency staff will be educated by the Director of Nursing/Designee during the facility orientation process on Notification to Medical Provider (MD/NP/Wound NP) for changes in condition including deterioration of wounds and wound protocol. The Regional Director of Clinical Services notified the Director of Nursing on 3/2/2023 on the implementation for new hires.

The Director of Nursing/Designee will audit Weekly Wound reports for deterioration beginning on 3/3/2023.

The Director of Nursing/Designee will audit all new treatment orders to ensure wound protocol is followed and assessment by medical provider (MD/NP/Wound NP) beginning on 3/3/2023.

Residents with current wounds including pressure injuries (PI) will continue to be reviewed by the Interdisciplinary Team during weekly Resident Review Meeting.

An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Director of Rehab, Director of Life Enrichment, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023. The IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance.

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F 686	Continued From page 54 Alleged date of IJ removal 3/4/23. The credible allegation of immediate jeopardy was validated on 3/7/23. On 3/7/23 observation and nursing interviews of all shifts were done of nursing education and the in-service signed roster was reviewed regarding proper assessment/evaluation of wound care and changes, timely entering of orders, use of the wound care standing order, and medical staff involvement notification. New nursing hires and contract staff would receive the education before assignment. Current and ongoing wound care planned audits were reviewed. A Quality Assurance meeting was held by the Administrator and Corporate and plans for improvement were outlined. The facility's immediate jeopardy removal date of 03/04/23 was validated.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member, physician, Nurse Practitioner, and staff interviews, the facility failed to ensure 1 of 3 residents were transferred safely (Resident #1). Resident #1 was transferred to the wheelchair by one NA without the use of a mechanical lift which resulted in a 7 centimeter (cm) long by 2 cm wide by 0.1 cm	F 689	*Resident #1 no longer resides at the facility *On 3/2/2023 each Electronic Health Record (EHR) was reviewed by the Director of Nursing/Designee to ensure the Kardex and Care plans reflected the	3/22/23

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F 689	Continued From page 55 deep skin tear of her right lower leg that the family described as very deep, and the family member was able to see "white meat that looked like a bone". This wound required pressure to control the bleeding and the edges of the wound were not able to be approximated (skin was unable to be pulled over the open wound to provide protection to the healing wound). Immediate Jeopardy began on 12/31/2022 when Resident #1 was transferred unsafely by one NA without the use of a mechanical lift, resulting in a 7 cm by 2 cm by 0.1 cm skin tear of the lower right leg that required pressure to stop the bleeding and could not be approximated. Immediate Jeopardy was removed on 3/4/2023 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident #1 was admitted to the facility on 12/13/2022 with diagnoses to include acute on chronic respiratory failure, (an acute illness affecting a patient with chronic respiratory insufficiency), COVID-19 virus infection, anemia (requiring blood transfusions), kidney disease with acute kidney injury, pain in right knee, 2 Stage 2 pressure ulcers (ulcer extends into the deeper layers of the skin and can look like a shallow crater or blister) of the sacrum, deep tissue injuries (a pressure injury that begins in the muscle closest to the bone and appears as dark,	F 689	correct transfer status. On 3/2/2023 the Director of Nursing reviewed all incident reports for the last 30 days to ensure resident were transferred as specified in their plan of care. No issues were identified. *On 3/2/2023 all Licensed Nursing Staff and Certified Nurse Aides, to include agency Licensed Nursing staff and Certified Nurse Aides were educated with return demonstration by the Nursing Administration Team and/or Rehab staff on transferring according to the resident's individualized plan of care according to the facility Mechanical Lift Policy and accessing transfer status from the Kardex or Care Plan. Education was completed on 3/3/2023. All newly hired Licensed Nursing Staff and Certified Nurse Aides, including agency nursing staff will receive this education with return demonstration during the facility orientation process on total lift transfers according to the facility Mechanical Lift Policy and accessing transfer status from Kardex or Care Plan. *The Director of Nursing/Designee will randomly audit 3 staff members weekly for 12 weeks to ensure proper lift/transfer techniques. The Director of Nursing/Designee will randomly question 5 staff nursing staff members weekly for 12 weeks on location and utilization of resident transfer care plan and Kardex. The Director of Nursing/Designee will randomly question 5 interviewable residents weekly for 12 weeks to ensure proper/safe transfers.	

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F 689	Continued From page 56 non-blanchable skin) of the right and left heel, congestive heart failure and debility. A hospital admission note dated 1/14/2023 documented Resident #1 had an ejection fraction (measurement of the percentage of blood leaving the heart with each heartbeat) of 45% (normal 50-70%). The admission Minimum Data Set (MDS) assessment dated 12/16/2022 assessed Resident #1 to be moderately cognitively impaired. The MDS assessed Resident #1 to require total assistance of 2 people to transfer. The MDS documented Resident #1 had limited range of motion of both lower legs and she required a wheelchair for mobility. Resident #1 was unable to perform surface to surface transfers without staff assistance. A care plan dated 12/14/2022 identified Resident #1 was at risk of falling, with an intervention to transfer total lift with 2+ assistance. A review of the physician orders revealed Resident #1 was not prescribed blood thinners. The Kardex (a brief summary of resident care needs available for review within the electronic documentation system) for Resident #1 was reviewed, and it was noted that transfer instructions included the extensive assistance of 2 people with the use of a mechanical lift. A physical therapy evaluation note written by physical therapist (PT) #1 dated 12/14/2022 assessed Resident #1 to require maximum assistance of 2 people to transfer. The evaluation noted that Resident #1 was unable to assist with transfers.	F 689	These audits will be conducted weekly for twelve weeks. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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PT #1 was interviewed on 3/6/2023 at 2:21 PM. PT #1 reported she was the primary therapist for Resident #1 during her stay at the facility. PT #1 reported Resident #1 able to stand and bear weight for brief periods of time but required 2-person extensive assistance to transfer safely. PT #1 explained NA staff used the mechanical lift to transfer Resident #1. PT #1 clarified transferring a resident with 2-person extensive assistance without a mechanical lift involved one person standing behind the resident and using the gait belt to lift, with another person in front of the resident to stabilize them and guide the resident to the chair. PT #1 reported Resident #1 had limited range of motion of both of her knees and required one person to move her legs to transfer from the bed to the chair. PT #1 concluded that a transfer with one person would not be a safe transfer.

The Director of Rehabilitation was interviewed on 3/6/2023 at 2:09 PM. The Director of Rehabilitation reported she had provided treatment to Resident #1 once prior to 12/31/2022. The Director of Rehabilitation reported Resident #1 was very weak and she declined getting out of bed for therapy treatment.

An interview was conducted with the Certified Occupational Therapist Assistant (COTA) on 2/28/2023 at 12:54 PM The COTA reported that Resident #1 was very weak, and she required 2-person assistance to transfer with a mechanical lift. The COTA reported that Resident #1 was able to bear weight on her legs to stand, but she was unable to pivot to transfer from the bed to the wheelchair, and she was unable to lift her legs to take steps to transfer without extensive

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assistance of 2 people. The COTA reported that one person transferring Resident #1 by lifting her under her arms was very unsafe and could result in serious injury.
An incident report dated written by Nurse #1 on 12/31/2022 documented Resident #1 sustained a skin tear to her lower right leg after transfer to the wheelchair. The note documented Resident #1's family members were at the facility and notified of the incident, and the on-call physician services were notified by a voice mail that Resident #1 had a skin tear.

A nursing note written by Nurse #1 dated 12/31/2022 at 7:37 PM documented: "This nurse across the hall in another room when the NA came to this nurse and stated resident got a skin tear when they (were) transferring resident into her wheelchair. This nurse into room and assess a large skin tear noted to the (right lower leg). Skin and subcutaneous tissue noted to be pushed to the right side of the wound and unable to be approximated. Area cleaned with wound cleanser, (non-stick, antibacterial dressing) applied to wound bed and (absorbent) pad placed on top and wrapped in (gauze). Resident states this area is sore. (Family member) in the facility at this time and was notified of skin tear by this nurse. (On-call physician) was notified via (voicemail) of skin tear." The nurse documented Resident #1 reported pain at a level "5" (1-10 scale, 10 being the most intense pain) of the lower right leg at the skin tear site.

Nurse #1 was interviewed on 2/28/2023 at 2:37 PM. Nurse #1 reported she was assigned to Resident #1 on 12/31/2022 and was notified by the nursing assistant (NA) that Resident #1 had sustained a skin tear to her right lower leg during

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a transfer. Nurse #1 reported she arrived at Resident #1's room and found 3 NAs at the bedside, 2 fulltime employees and 1 orienting staff member. Nurse #1 reported NA #1 was holding a towel on Resident #1's leg to stop the bleeding from a "heck of a large" skin tear on her lower right leg. Nurse #1 reported she was told by NA #1 that Resident #1 hit her leg on the wheelchair when she was being transferred. Nurse #1 went on to explain that NA#1 and NA #4 were in the room, as well as NA #5 who was orienting. Nurse #1 reported Resident #1 was transferred to the wheelchair by the NA #5 and they had not used a mechanical lift. Nurse #1 reported she did not think the skin tear was serious and did not require evaluation at the hospital.

A follow-up interview was conducted with Nurse #1 on 3/1/2023 at 3:02 PM. Nurse #1 reported she had called the Director of Nursing (DON) right after the incident to report it and had been instructed by the DON to talk to NA #1, NA #4, and NA #5 to instruct them on proper transfer techniques. Nurse #1 reported that when she arrived to assess the wound and apply a dressing, the skin that had been torn was dry and curled away from the wound. Nurse #1 reported she was unable to pull the skin back over the wound because it was so dry. Nurse #1 estimated that it took her about 1 minute to get to the resident's room after being notified of the injury.

An interview was conducted on 2/28/2023 at 4:24 PM with NA #1, and she reported she had worked on 12/31/2022. NA #1 explained she was working on the 100 hall, and the 300 hall NA (NA #4) had asked her to come to Resident #1's room. NA #1 reported she was orienting NA #5 and the two of

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them went to Resident #1's room on the 300 hall. NA #1 described Resident #1 was in bed with her upper body supported on 3 pillows and NA #4 told her the bed control was not working to elevate the head and she wanted to move Resident #1 to a bed that worked. Resident #1's family member was at the bedside during this time. NA #1 left the room to get the lift to transfer Resident #1 to the other bed. NA #1 shared that when she returned to Resident #1's room, and Resident #1's family member had sat Resident #1 up on the side of the bed. According to NA #1's report, Resident #1 was unable to support herself sitting on the side of the bed and was crying out, "I can't take it." NA#1 described how NA #5 said, "I used to be an EMT (emergency medical technician), I know how to do this (transfer Resident #1)," and proceeded to lift Resident #1 from the bed over to the wheelchair, bumping Resident #1's leg on the wheelchair footrest and causing a skin tear. NA #1 reported she got a towel to hold on the open area of the skin tear to top the bleeding and NA #4 went to get the nurse. NA #1 reported that Nurse #1 arrived in "just a few seconds".

NA #4 was interviewed on 3/1/2023 at 4:27 PM and she reported she was working 12/31/2022 and assigned to Resident #1 on that date. NA #4 explained NA #1 was training NA #5. NA #4 said that Resident #1's bed would not work to elevate the head of the bed, and they were planning to transfer her to another bed using the mechanical lift. NA #4 verbalized she was not in the room, when NA #5 transferred Resident #1 and she did not see Resident #1 moved from the bed to the wheelchair but remembered that Resident #1 had sustained a large skin tear on her lower right leg and NA #1 was holding a towel on the leg to stop the bleeding.

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NA #5 was interviewed on 3/7/2023 at 4:18 PM. NA #5 reported her first time working on the floor of the facility was 12/31/2022 and she was assigned to train with NA #1. NA #5 explained that they were called to Resident #1's room because the bed did not work, and they were going to transfer her to a new bed. NA #5 reported she was standing behind the wheelchair and NA #1 and NA #4 lifted Resident #1 from the side of the bed to the wheelchair, and during the transfer, Resident #1's leg scraped against the footrest of the wheelchair. NA #5 reported she had alerted NA #1 and NA #4 that the footrest was jutting out and to push it back, but the other NAs did not correct the position of the footrest. NA #5 reported the wound was bleeding and she took a bedsheet and held pressure on the wound until the nurse arrived almost 20 minutes later. NA #5 reported that after the incident, they were instructed to correctly transfer residents by Nurse #1. NA #5 concluded by stating she didn't return to work at the facility after that night.

The family member was interviewed on 3/1/2023 at 12:09 PM. The family member recalled she and other family members were in the facility on 12/31/2023 and the nursing staff had asked the family to step out of the room so they could transfer Resident #1 to a different bed and apply the air mattress to the bed. The family member reported that when she and the other family members returned to the room, they were told that Resident #1 had sustained a skin tear from the wheelchair. The family member explained that they asked for the wound dressing on the right lower leg to be removed and when they saw the skin tear, they told the nurse that the wound needed to be evaluated at the hospital. The family

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member described the wound on the right lower leg to be very deep, and she was able to see "white meat that looked like a bone". The family member reported the skin was pushed back away from the wound and the nurse said she had not been unable to pull it back over the open wound and Resident #1 reported pain at the wound site. The family member said that Nurse #1 told them the physician had been notified of the skin tear and didn't feel that the wound needed to be assessed at the hospital.

A wound assessment dated 1/2/2023 documented a skin tear of the right lower leg that measured 7.6 centimeters (cm) by 3.5 cm by 0.1 cm and had a pink wound bed and a moderate amount of serosanguinous (pink) drainage. The note documented the wound was cleaned with normal saline, and an antimicrobial non-stick dressing was applied to the open wound, it was covered with an absorbent pad, and wrapped with gauze. The nursing note that correlated with wound assessment dated 1/2/2023 documented Resident #1 was reporting "3" pain to her right lower leg.

Wound care orders dated 1/4/2023 for the right lower leg read to clean with normal saline, apply antimicrobial non-stick dressing, cover with absorbent dressing, and wrap with gauze to secure once daily.

The Wound Nurse was interviewed on 3/1/2023 at 11:48 AM. The Wound Nurse reported she was also the staff development coordinator and she had provided orientation to the NA #5 before the NA went out onto the floor for hands-on training. The Wound Nurse reported that during orientation, new staff are shown videos with

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proper transfer techniques, and they are shown where to find the information related resident care for each resident in the kardex. The Wound Nurse explained she was unable to do further training with the NA #5 because she had quit without notice the next day and did not return to the facility. The Wound Nurse reported she had assessed the right lower leg wound on 1/2/2023. The Wound Nurse reported that she had not considered sending Resident #1 out for further treatment of the wound to the right lower leg.

The facility nurse practitioner (NP) was interviewed on 2/28/23 at 11:03 AM. The NP stated that the skin tear to the lower right leg should have been followed by medical staff. She stated that the trauma wound was a full-thickness skin tear to the right lower leg.

The Physician (MD) was interviewed on 3/1/23 at 12:40 pm. The MD reported she was not informed of Resident #1's right lower leg skin tear with its severity. The MD reported the resident should have been sent to the Emergency Department on 12/31/22 or at least followed by the medical staff in the facility due to the size of the skin tear.

The Administrator was notified of Immediate Jeopardy on 3/1/2023 at 5:51 PM.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of noncompliance.
The facility failed to ensure Resident #1 was transferred safely from her bed to the wheelchair by the use of the total lift. Resident #1 was transferred to the wheelchair by one NA which resulted in a 7 centimeter (cm) long by 2 cm wide

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by 0.1 cm deep skin tear of her right lower leg. This wound deteriorated to expose bone and subcutaneous tissue and had the high likelihood to become infected. In addition, there was the high likelihood of a serious adverse outcome when the resident was not transferred using the total lift.

All residents not transferred as determined by their assessment or plan of care could be affected.

On 3/2/2023 each Electronic Health Record (EHR) was reviewed by the Director of Nursing/Designee to ensure the Kardex and Care plans reflected the correct transfer status.

On 3/2/2023 the Director of Nursing reviewed all incident reports for the last 30 days to ensure resident were transferred as specified in their plan of care.

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

On 3/2/2023 all Licensed Nursing Staff and Certified Nurse Aides, to include agency Licensed Nursing staff and Certified Nurse Aides were educated with return demonstration by the Nursing Administration Team and/or Rehab staff on transferring according to the resident's individualized plan of care according to the facility Mechanical Lift Policy and accessing transfer status from the Kardex or Care Plan. The Director of Nursing/Designee will supply a list of all nursing department individuals that have not completed return demonstration of transfers on

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3/3/2023 to the Nursing Administration Team (RN Weekend Supervisor notified of this responsibility on 3/3/2023) to ensure no Nursing Staff work before the return demonstration has been validated. All verbal education was completed on 3/3/2023.

All newly hired Licensed Nursing Staff and Certified Nurse Aides, including agency nursing staff will be educated with return demonstration during the facility orientation process on total lift transfers according to the facility Mechanical Lift Policy and accessing transfer status from Kardex or Care Plan. The Regional Director of Clinical Services notified the Director of Nursing on 3/2/2023 on the implementation for new hires.

An Ad Hoc QAPI was completed with the Interdisciplinary Team (IDT) which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Managers, Director of Rehab, Director of Life Enrichment, Director of Social Services, Environmental Services Director, Admissions Director, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Clinical Coordinator, and the Medical Director on 3/2/2023. The IDT was updated regarding Immediate Jeopardy (IJ) citations the facility received on 3/1/2023 along with regulation, policy, and necessary education that is needed in order to be in compliance.

Alleged IJ removal date 3/4/23.

On 3/7/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:
" Review of the education provided to the nursing staff and NA staff related to safe transfer

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F 689	Continued From page 66 techniques. " Interview with nursing staff to review education provided and procedure for transfers, with transfer competencies for each staff member included. " Observation of transfer of a resident with mechanical lift. " Review of audits completed by the facility. The facility's date of the immediate jeopardy removal plan of 3/4/2023 was validated on 3/7/2023.	F 689		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, family, and staff interviews, the facility failed to provide a resident with pain relief for 1 of 3 residents reviewed for pain control (Resident #1). Resident #1's family members reported Resident #1 was having pain and the facility failed to initiate their standing admission orders to provide pain relief. This resulted in Resident #1's family administering over the counter (OTC) pain medication to her during her stay at the facility. The findings included: Standing orders for the facility, revised 3/2021 were reviewed. Included in the standing orders	F 697	*Resident #1 no longer resides in the facility *3/22/23 the Director of Nursing completed a thirty day lookback of pain evaluations for all residents to identify any other residents potentially being untreated for pain. There were no issues noted. *The Assistant Director of Nursing completed education with all licensed nursing staff, including agency Licensed Staff and therapists regarding reporting pain to the nurse in timely manner. Licensed nursing staff received education	3/22/23

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F 697	Continued From page 67 was an order for acetaminophen 1000 milligrams three times per day as needed for pain, with instructions to place resident on the problem list for follow-up by the clinician. Resident #1 was admitted to the facility on 12/13/2022 with diagnoses to include right knee pain and unstageable sacral pressure wound. A physician order dated 12/13/2022 ordered diclofenac sodium gel 1% (non-steroidal anti-inflammatory medication) to be applied topically to the right knee, every 8 hours as needed. Review of the medication administration records for 12/2022 and 1/2023 revealed Resident #1 did not have the diclofenac sodium gel applied. The admission Minimum Data Set (MDS) assessment dated 12/16/2022 assessed Resident #1 to be moderately cognitively impaired. The MDS documented Resident #1 had limited range of motion of both lower legs. The MDS documented Resident #1 did not have pain. A care plan dated 12/14/2022 identified Resident #1 had the potential to experience pain. Interventions for the care plan included to implement positioning for pain relief, administer medications as ordered, assess for verbal and non-verbal signs of pain, and provide education to resident and family members about pain management. The pain level summary (record of pain assessments for the stay of a resident) for Resident #1 was reviewed. On 12/27/2022 it was noted that Resident #1 reported pain level "3"	F 697	regarding assessing for pain, standing orders for pain and notifying medical providers of any pain that may be ineffectively managed. This education was completed on 3/11/2023 All newly hired Licensed Nursing Staff and Therapy staff including Licensed Nursing and Therapy agency staff will be educated by the Director of Nursing/Designee during the facility orientation process. *The Director of Nursing/designee will conduct pain interviews of five random alert and oriented residents weekly for twelve weeks to identify any unreported/unmanaged pain. The Director of Nursing/designee will assess for signs and symptoms of pain for five residents that are not able to communicate pain weekly for twelve weeks and address any identified signs or symptoms of pain immediately. The 24 hour report will be reviewed in clinical morning meeting five times a week for twelve weeks to identify potential issues with pain management. The Director of Nursing/Designee will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator is responsible for compliance.	

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(1-10 scale, with 10 being the most intense pain) documented by the wound care nurse, on 12/31/2022 she reported pain level "5" documented by Nurse #1, and on 1/1/2023 she reported pain level "3" documented by Nurse #1.

A review of the physician orders revealed no PRN acetaminophen had been initiated for Resident #1.

Resident #1 was discharged from the facility on 1/14/2023.

An interview was conducted with Resident #1's family member on 3/1/2023 at 12:09 PM. The family member reported that Resident #1 told her and other family members that she was having pain in her buttocks from a wound, and that she had pain in her right calf from a skin tear that happened on 12/31/2023. The family member reported she had asked a nurse for pain medications for Resident #1, but the nurse did not bring the pain medications in for Resident #1. The family member was not able to name the nurse or remember specific dates. The family member explained that because the facility did not give Resident #1 pain medications, she and other family members brought in acetaminophen to give to her. The family member said that the acetaminophen helped Resident #1's pain level and allowed her to rest comfortably. The family member reported that Resident #1 was unable to describe her pain but said that it was the new skin tear and the pressure wound on her sacrum. The family member reported that Resident #1 was unable to sit because of the sacrum wound pain.

The Wound Nurse was interviewed on 3/6/2023 at 2:46 PM. The Wound Nurse reported that

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Resident #1 had not reported pain to her. The Wound Nurse reported she did not recall documenting that Resident #1 had a level "3" pain on 12/27/2022.

An interview was conducted with Nurse #1 on 3/1/2023 at 3:02 PM. Nurse #1 reported she was providing care to Resident #1 on the night she sustained the skin tear to her lower right leg. Nurse #1 reported Resident #1 had reported that her right leg was "a little sore". Nurse #1 reported she had not told the physician that Resident #1 was experiencing pain, and she did not recall documenting a pain level of "5" on 12/31/2023 or a level "3" on 1/1/2023. Nurse #1 did not recall the family asking for pain medications for Resident #1.

Nursing assistant (NA) #4 was interviewed on 3/1/2023 at 4:27 PM. NA #4 reported that Resident #1 complained of pain, and she had reported to a nurse. NA #4 reported that that she did not know if Resident #1 received pain medications. NA #4 reported that Resident #1's pain was primarily in her sacrum when she was laying on her back.

The facility physician was interviewed 3/3/2023 at 2:52 PM. The MD reported that she expected residents who experienced pain would have that pain addressed by nursing staff with either the standing orders or by calling for orders.

A physical therapist (PT) was interviewed on 3/6/2023 at 2:21 PM. The PT reported that Resident #1 reported pain "in her bottom" from the pressure ulcer. The PT explained that after a therapy session, she would position Resident #1 on her side to relieve pressure off the pressure

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ulcer and reported the pain to a nurse. The PT was not certain which nurse had been given report.

The Director of Nursing (DON) was interviewed on 3/6/2023 at 2:53 PM. The DON reported she was not aware of Resident #1's family members medicating her with acetaminophen. The DON explained the facility had standing orders that were signed by the MD on admission and a nurse could initiate those standing orders at any time. The DON expressed she was not certain why Resident #1 did not ask for pain medication, or why the resident did not receive pain control because there were standing orders to provide pain control to the resident.