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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 5/11/23 through 5/18/23. Immediate Jeopardy was identifed on 05/26/23 after a management review of findings. The survey team returned to the facility on 5/31/23 to validate the immediate jeopardy removal plan. Therefore, the exit date was changed to 5/31/23. Event ID# IB7T11. The following intake was investigated: NC00201962. Intake NC00201962 resulted in immediate jeopardy. Two (2) of the 3 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/5/23 and was removed on 5/28/23. A partial extended survey was conducted.	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;	F 580		6/12/23

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

Electronically Signed | 06/12/2023

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(B) A significant change in the resident's physical, 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

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to notify the physician when Resident #1 developed an opened area the size of a nickel on his scrotum with significant amounts of pus or drainage. Resident #1 had a history of Fournier's gangrene (a rare, life-threatening bacterial infection of the scrotum, penis or perineum), abscess of corpus cavernosum (tissue forming the bulk of the penis), and sepsis. Resident #1 was assessed for abscesses at the emergency department of Hospital #1 and transferred to Hospital #2 for urology care. Hospital #2 operated on the scrotal abscess and debrided the Fournier's gangrene. Resident #1's post operative stay was complicated by continuing sepsis and end organ dysfunction (damage occurring in major organs fed by the circulatory system). This deficient practice occurred for 1 of 3 residents reviewed for notification of change (Resident #1). Immediate jeopardy began on 5/5/23 when the physician was not notified of a new open area Resident #1's scrotum. Immediate jeopardy was removed on 5/28/23 when the facility provided and implemented an acceptable allegation of Immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective and the completion of staff education. Findings included: Resident #1 was admitted to the facility on 8/9/18.	F 580	1. Resident #1 expired after transferring from the center to an acute setting. 2. All residents have the potential to be affected. Change in condition assessments completed between 4/15/2023 and 5/15/2023 were reviewed by nursing leadership to ensure that proper notifications were made to the Physician, Advanced Practice Provider(s), or on-call Physician/Advanced Practice Provider. No other residents were affected. 3. Education provided by the Director of Nursing and Nurse Practice Educator on Assessing residents, notifying the Physician, Advanced Practice Provider(s), or on-call Physician/Advanced Practice Provider of changes in resident□s condition; adequately documenting changes and notification; and how to respond to resident refusals of care/assessment. Education completed by May 17, 2023. 4. The Director of Nursing and/or designee will audit all resident change in conditions to ensure that the Physician, Advanced Practice Provider(s), or on-call Physician/Advanced Practice Provider is notified of the change for 30 days from 5/15/2023 then once weekly X 2 weeks then once monthly X 2 months.	

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His medical history in the facility medical record included paraplegia, presence of urogenital implants, necrotizing fasciitis (a rare bacterial infection that spreads quickly in the body and can cause death), Fournier's gangrene (a rare, life-threatening bacterial infection of the scrotum, penis or perineum), abscess of corpus cavernosum (tissue forming the bulk of the penis), and sepsis.

Resident #1's Minimum Data Set (MDS) assessment dated 2/16/23 revealed he was assessed as moderately cognitively impaired. His active diagnoses included wound infection, anemia, hypertension, heart failure, neurogenic bladder, diabetes mellitus, paraplegia and multiple sclerosis. He was documented to have an indwelling catheter and colostomy.

During an interview on 5/11/23 at 10:21 AM Nurse #4 stated she provided wound care for Resident #1 on 5/4/23 and noted no skin breakdown areas to his scrotum. The nurse did not indicate there was any swelling or raised areas.

During an interview on 5/11/23 at 11:28 AM Nurse #2 stated on 5/5/23 during the morning around 6:00 AM she went to administer a medication injection to Resident #1's stomach and when she pulled the sheets back, she thought they were wet with urine. She noted his indwelling catheter was kinked under his thigh. She unkinked the tubing, got urine flow, and she was able to give him his medicine. She indicated she informed him the nurse aides were going to clean him up. A short time later the nurse aides (Nurse Aides #1 and #2) told her Resident #1 had an open area to his scrotum that needed to be assessed. She stated she then went down to assess him and

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said, "I heard you have something on your scrotum I need to look at," and he responded, "no." She told him she needed to see it to make sure he was okay, and he told her "You can look at it but don't touch it." She stated she visualized his scrotum, and there was an open area the size of a nickel with no bleeding or drainage. Resident #1 then covered it up, so she only had a brief look at it, and she told him they needed to take care of it. He indicated they could take care of it later. Nurse #2 reported she told Resident #1 she would let the oncoming nurse know about the area as the day shift provided wound care. She stated this was around 6:00 - 6:15 AM and the next shift started at 7:00 AM. She stated she then told Nurse #1 about the area at change of shift report. She concluded since she could not examine the wound, she did not have anything to report to the physician so she did not notify the physician as the day shift would do that when they completed wound care.

During an interview on 5/11/23 at 10:55 AM Nurse Aide (NA) #1 stated Resident #1 needed to be cleaned up on 5/5/23 in the early morning and he often would refuse care. Both she and Nurse Aide #2 entered Resident #1's room. She stated they thought it was urine that had leaked everywhere when they first entered and assumed something had happened to his catheter. Resident #1 had a suprapubic catheter and when they removed a towel, which was on top of his scrotum, they noted it was not urine but fluid leaking from what appeared to be an open area to his scrotum. The right side of his scrotum appeared to have ruptured open leaving black tissue and yellow drainage to the area. The area covered the right side of his scrotum and was very alarming which they indicated to the nurse. She stated they

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ensured his comfort and then notified Nurse #2 to assess the area. NA #1 stated about 5 minutes later Nurse #2 came to her and indicated Resident #1 had refused to let her assess the area. NA #1 then told Nurse #2 that she was very concerned about that area and that he needed to be assessed as soon as possible as it was a very pressing issue. Nurse #2 then walked away, and NA #1 thought she was going back to Resident #1, so she did not report the concern to the oncoming nurse aide. This all happened around 6:00 AM and her shift ended at 7:00 AM.

During an interview on 5/11/23 at 11:50 AM Nurse Aide #2 stated she cared for Resident #1 on night shift (7:00 PM to 7:00 AM) on 5/3/23 and 5/4/23. On the night shift of 5/3/23 no concerns were noted with Resident #1 and his scrotum during her activities of daily living care that shift. The morning of 5/5/23 Nurse #2 came to her and requested she clean the resident as he had gotten urine all over himself. She stated this was unusual as he had a suprapubic catheter as well as a colostomy. She stated she went and got Nurse Aide #1 and went to the room to clean him up. They took his gown off and began cleaning him up and when they removed his brief to clean his groin area, they noted from his waist down to his knees the fluid did not have the appearance of urine but instead had the appearance of pus or drainage. She stated they continued to clean him up and on the right side of his scrotum there was area about the size of a dime that appeared slightly swollen but was not black but flesh colored and as they cleaned it, they noted that the drainage was coming from that open area and there was so much drainage that they had to use a brief like pad on the front part of his scrotum to keep him from becoming soaked again in

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drainage. She stated she then went and let Nurse #2 know that Resident #1 was cleaned up but had a new open area to his scrotum and they had cleaned up pus and drainage but no urine. The nurse indicated she was passing medications but then would go in and check on the resident after, so NA #2 did not report the concern to the oncoming nurse aide. She concluded her shift ended and she had no further involvement with Resident #1 and did not know if the nurse assessed the resident or not.

During an interview on 5/11/23 at 10:13 AM Nurse Aide #3 stated she took report that morning, on 5/5/23, from Nurse Aide #2 and the nurse aide indicated Resident #1 had a bath and she had emptied his catheter and colostomy bags. Nurse Aide #2 did not mention anything which indicated Resident #1 had a change to his scrotum, so Nurse Aide #3 did not have a reason to visualize Resident #1's scrotum or request the nurse assess it.

During an interview on 5/11/23 at 9:06 AM Nurse #1 stated she was his regular nurse. She further stated it was important to know Resident #1 had no feeling to his groin and scrotum so he could not tell if something was hurting him there. She stated on 5/5/23 she worked a 12-hour shift beginning at 7:00 AM. She was not notified of any concerns from Nurse #2 with Resident #1 during change of shift report, so she had no reason to assess or contact the physician regarding Resident #1. She worked her shift as normal and completed her medication passes and then was doing wound care around 6:00 PM that day when she was going in to provide wound care for Resident #1. She set up her equipment and pulled back his sheet and removed his brief.

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Nurse #1 stated Resident #1's scrotum had the appearance of an abscess that had ruptured and the best way she could describe it was to imagine boiling an egg and when the egg cracks, the white of the egg comes out. But in this case what came out was black and not normal looking tissue. She stated Resident #1 had Fournier's gangrene before and the tissue observed on 5/5/23 had a similar appearance. She reported she got the Director of Nursing (DON) to observe the area and they agreed Resident #1 needed to be sent out to the hospital. Nurse #1 stated she notified the on-call provider and the on-call provider ordered for the resident to be sent out to the hospital. Resident #1 was discharged from the facility at 6:50 PM. Nurse #1 denied that Nurse #2 reported the area to her at change of shift that morning. She indicated Nurse #2 should have called the physician when she was informed of the area from the nurse aides. She added that the physician should have been informed of the resident's refusal for treatment so that a decision could be made to send the resident out to be assessed. Nurse #1 concluded Resident #1 was discharged from the facility at 6:50 PM, and at no time did he ever have a temperature, other abnormal vital signs, or indicators of distress during her shift including as he discharged.

Review of Hospital #1's records dated 5/5/23 revealed Resident #1 presented to the emergency department with an abscess to the groin and scrotum. General surgery was consulted for plan of care or transfer. The Consulting Surgeon wrote, they were consulted for scrotal and penile abscess and Resident #1 had a history of drainage of penile abscess, scrotal abscess, and debridement of Fournier's

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gangrene by urology at a different hospital a few years ago. The physical exam revealed the scrotum was swollen and had signs and symptoms of an infection. The wound had spread to the left side of the scrotum and penis and there was an abscess on the left side of the penis draining pus. The assessment noted dead tissue as well. The Consulting Surgeon documented the treatment was beyond the scope of his practice and recommended transfer to urology at Hospital #2.

Review of Hospital #2's records revealed a history and physical dated 5/6/23 that noted Resident #1 had a history of multiple sclerosis, paraplegia, and prior debridement for Fournier's gangrene in April of 2022. The Physician noted Resident #1 was transferred from an outside hospital with hypotension and purulent drainage from his scrotum, penis and perineum concerning for Fournier's gangrene. Resident #1 was taken to the operating room on 5/6/23 for debridement (surgical procedure to remove dead or infected tissue) of scrotal abscess and Fournier's gangrene. The discharge summary dated 5/7/23 revealed Resident #1's post operative stay was complicated by continuing sepsis and end-organ dysfunction, and he was transferred to hospice and expired on 5/7/23.

Attempts to contact physician at the hospital #1 were made on 5/11/23 at 2:20 PM, 2:44 PM, and 3:45 PM, and further attempts made on 5/12/23 at 9:52 AM and again on 5/17/23 at 5:18 PM. These attempts were unsuccessful.

During an interview on 5/11/23 at 12:58 PM Physician #1 stated he was Resident #1's primary physician at the facility. He further stated he was

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not made aware of the open area on Resident #1's scrotum until after he had been hospitalized, and to his knowledge it was not reported to any on call provider until later that day, 5/5/23. Even though Nurse #2 was unable to assess the area as the resident did sometimes refuse, she should have notified him or the on-call physician of the open area and the extent of the drainage. He concluded it was hard to say if Resident #1's outcome would have been different had the physician been notified earlier that day about the drainage and abscess, but he would have sent the resident out immediately upon being made aware of an open area on his scrotum with drainage even if the resident did not allow a full assessment.

During an interview on 5/11/23 at 12:53 PM the Administrator stated the nurse should have notified the physician as soon as she was made aware of a new skin opening and drainage from Resident #1's scrotum by the nurse aide. He concluded the nurse and nurse aides should have reported the new open area to the oncoming shift.

During an interview on 5/31/23 at 9:52 AM the Director of Nursing stated Nurse #2 should have attempted to assess the area or notify someone that Resident #1 was not allowing an assessment of the area. Nurse #2 should have notified the oncoming shift of the area, lack of assessment, and not having notified the doctor. Nurse #2 should have notified the doctor of the lack of assessment and of the new area when it was brought to her attention by the nurse aides.

The Administrator was notified of the immediate jeopardy on 5/26/23 at 2:01 PM.

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The facility provided the following 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 the noncompliance

The facility failed to notify the Physician of a change of condition for Resident #1 in a timely manner and failed to have effective systems in place for Nursing staff to know what changes need to be reported and what needs to be reported immediately.

" The Director of Nurses and/or designee conducted a 30 look back to review other residents identified with a change in condition to verify Physician and/or Provider was notified in a timely manner. This review was completed by May 17, 2023 and consisted of a thorough review of 24-hour reports, progress notes, and change of condition assessments. No additional concerns were 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

" The Nurse Practice Educator and/or designee re-educated Licensed Nurses on Notification of Changes in Condition with emphasis on changes that require immediate physician notification and documentation by May 27, 2023. Changes requiring prompt notification include a significant change in resident physical, mental, or psychosocial status, an accident

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F 580	Continued From page 11 involving the resident that results in injury or the potential for requiring physician intervention, a need to alter treatment significantly, and a decision to transfer or discharge the resident. Additionally, re-education was completed with Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by May 17, 2023. The EInteract Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, or PRN staff will be re-educated prior to returning to duty. New hires will be educated by the Nurse Practice Educator during the orientation process. " Effective May 15, 2023, the Director of Nurses and/or designee will review changes in condition by reviewing the 24-hour report, progress notes, change in condition assessments, and stop and watch alerts in the morning Clinical Meeting to verify prompt and/or immediate notification is communicated to the Physician and/or Provider. " Removal of Immediate Jeopardy is May 28, 2023 The credible allegation for immediate jeopardy removal with a compliance date of 5/28/23 was validated on 5/31/23, as evidenced by staff interviews and in-service record reviews. The in-services included information on notification of the physician or on call provider of changes in residents, communication of change of conditions in residents between staff, and documenting the	F 580		

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F 580	Continued From page 12 change in condition as well as who was notified. The facility's immediate jeopardy removal date of 5/28/23 was validated.	F 580		
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 and physician interviews, the facility failed to identify the seriousness of an open area on the scrotum that nurse aides reported had significant amounts of pus or drainage and failed to seek urgent medical attention once the resident refused an assessment. Resident #1 had paraplegia, had no feeling in his groin/scrotum area, and had a history of prior debridement for Fournier's gangrene. Fournier's gangrene is a type of flesh-eating disease (necrotizing fasciitis) that destroys the soft tissue of the scrotum, penis and perineum and is associated with a high mortality rate and requires immediate medical attention. Resident #1 was sent to Hospital #1's emergency department (ED) for evaluation. The ED Physician noted a scrotal abscess and drainage which were concerning for necrotizing infection as well. It was determined Resident #1 needed to be transferred to urology at Hospital #2 for	F 684	1. Resident #1 expired after transferring from the center to an acute setting. 2. All residents have the potential to be affected. All resident□s skin assessments from 5/18/23 □ 5/28/23 were reviewed for new skin issues and to ensure that treatment orders are in place for existing skin injuries by nursing leadership. No other residents were affected. 3. Education was completed with Certified Nursing Assistants on utilization of the STOP - & - WATCH form for reporting new changes in resident□s conditions to the primary nurse. Education was completed with the Licensed Nurses on Necrotizing Fasciitis, Fournier□s Gangrene, and Gangrene; as well as, assessing residents and what action to	6/12/23

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continued care and surgical intervention. Resident #1 had surgery on 5/6/23 and his post operative stay was complicated by continuing sepsis and end-organ dysfunction (damage occurring in major organs fed by the circulatory system). He was transferred to hospice and expired on 5/7/23. This occurred for 1 of 3 residents reviewed for notification of change (Resident #1).

Immediate Jeopardy began on 5/5/23 when a high risk resident did not receive urgent medical attention. Immediate Jeopardy was removed on 5/28/23 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective and the completion of staff education.

Findings included:

Resident #1 was admitted to the facility on 8/9/18. His medical history in the facility medical record included paraplegia, presence of urogenital implants, necrotizing fasciitis (a rare bacterial infection that spreads quickly in the body and can cause death), Fournier's gangrene (a rare, life-threatening bacterial infection of the scrotum, penis or perineum), abscess of corpus cavernosum (tissue forming the bulk of the penis), and sepsis.

Resident #1's Minimum Data Set (MDS) assessment dated 2/16/23 revealed he was assessed as moderately cognitively impaired. His

take when a resident refuses care. Education initiated by the Director of Nursing and Nurse Practice Educator. All education completed by May 17, 2023. Any new Certified Nursing Assistants and Licensed Nurses will be educated on the above topics prior to starting patient care (staff and agency).

4. STOP - &- WATCH forms submitted to DON and/or designee will be reviewed in the daily clinical meeting to ensure any changes in resident condition are addressed. All documented change in conditions will be monitored to ensure that treatment orders are in place and that follow-up is complete. This will be monitored daily for 30 days then once weekly X 2 weeks then once monthly X 2 months. All skin checks will be monitored daily X 30 days then weekly X 2 weeks, then monthly X 2 months. All findings are to be presented to the QAPI team.

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active diagnoses included wound infection, anemia, heart failure, hypertension, neurogenic bladder, diabetes mellitus, paraplegia and multiple sclerosis. The MDS indicated Resident #1 had a suprapubic catheter and colostomy.

Resident #1's care plan dated 2/14/23 revealed he was care planned to be at risk for skin breakdown and has actual skin breakdown which included being sent to the emergency room for a ruptured abscess to groin. The interventions included providing preventative treatments as ordered, observe for verbal and nonverbal signs of pain related to wound or wound treatment, wound treatment and medication as ordered, and weekly skin assessments by licensed nurse.

Review of a progress note completed by Nurse #1 dated 5/1/23 revealed a head-to-toe skin check was completed. Resident #1 had previously identified skin issues noted, and no concerns were identified with Resident #1's scrotum at that time.

During an interview on 5/11/23 at 9:06 AM Nurse #1 stated she did a skin check on Resident #1 on 5/1/23 and found no new areas to his skin, just the already identified wounds to his sacrum, right foot, and left calf.

During an interview on 5/11/23 at 10:21 AM Nurse #4 stated she provided wound care for Resident #1 on 5/4/23 and noted no skin changes to his scrotum.

Record review for 5/5/23 revealed Nurse #2 did not document any concerns for Resident #1.

During an interview on 5/11/23 at 11:28 AM Nurse

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#2 stated on 5/5/23 around 6:00 AM she went to administer a medication injection to Resident #1's stomach and when she pulled the sheets back, she thought they were wet with urine. She noted his indwelling catheter was kinked under his thigh. She unkinked the tubing, got urine flow, and she was able to give him his medicine. She indicated she informed him the nurse aides were going to clean him up. In the middle of her medication pass a short time later the nurse aides (Nurse Aides #1 and #2) told her Resident #1 had an open area to his scrotum that needed to be assessed. She stated she went down to assess him and said, "I heard you have something on your scrotum I need to look at," and he responded, "no." She told him she needed to see it to make sure he was okay, and he told her "You can look at it but don't touch it." She stated she visualized his scrotum, and there was an open area the size of a nickel with no bleeding or drainage. Resident #1 then covered it up, so she only had a brief look at it, and she told him they needed to take care of it. He indicated they could take care of it later. Nurse #2 reported she told Resident #1 she would let the oncoming nurse know about the area as the day shift provided wound care. She stated this was around 6:00 - 6:15 AM and the next shift started at 7:00 AM. She stated she continued to complete her medication pass and then told Nurse #1 about the area at change of shift report. She concluded since she could not examine the wound, she did not have anything to report to the physician so she did not notify the physician as the day shift would do that when they completed wound care.

During an interview on 5/11/23 at 10:55 AM Nurse Aide (NA) #1 stated Resident #1 needed to be cleaned up on 5/5/23 in the early morning and he

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often would refuse care. Both herself and Nurse Aide #2 entered Resident #1's room and she thought it was urine that had leaked everywhere when they first entered and assumed something had happened to his catheter. Resident #1 had a suprapubic catheter and when they removed a towel, which was on top of his scrotum, they noted it was not urine but fluid leaking from what appeared to be an open area to his scrotum. The right side of his scrotum appeared to have ruptured open leaving black tissue and yellow drainage to the area. The area covered the right side of his scrotum and was very alarming, which they indicated to the nurse. She stated they ensured his comfort and then notified Nurse #2 to assess the area. NA #1 stated about 5 minutes later Nurse #2 came to her and indicated Resident #1 had refused to let her assess the area. NA #1 then told Nurse #2 that she was very concerned about that area and that he needed to be assessed as soon as possible as it was a very pressing and acute issue. Nurse #2 then walked away, and NA #1 thought she was going back to Resident #1, so she did not report the concern to the oncoming nurse aide. This all happened around 6:00 AM and her shift ended at 7:00 AM.

During an interview on 5/11/23 at 11:50 AM Nurse Aide #2 stated she cared for Resident #1 on night shift (7:00 PM to 7:00 AM) on 5/3/23 and 5/4/23. On the night shift of 5/3/23 no concerns were noted with Resident #1's scrotum during her activities of daily living care that shift. The morning of 5/5/23 Nurse #2 came to her and requested she clean the resident as he had gotten urine all over himself. She stated this was unusual as he had a suprapubic catheter as well as a colostomy. She stated she went and got Nurse Aide #1 and went to the room to clean him

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up. They took his gown off and began cleaning him up and removed his brief to clean his groin area. NA#2 stated there was fluid from his waist to his knees and it did not have the appearance of urine but instead had the appearance of pus or drainage. She stated they continued to clean him up and on the right side of his scrotum there was an area about the size of a dime that appeared slightly swollen but was not black but flesh colored. As they cleaned it, they noted that the drainage was coming from that open area and there was so much drainage that they had to use a brief like pad on the front part of his scrotum to keep him from becoming soaked in drainage again. She stated she let Nurse #2 know that Resident #1 was cleaned up but had a new open area to his scrotum and they had cleaned up pus and drainage but no urine. Nurse #2 indicated she was passing medications but would go in and check on the resident after, so she did not report the concern to the oncoming nurse aide. She concluded her shift ended and she had no further involvement with Resident #1 and did not know if Nurse #2 assessed the resident or not.

During an interview on 5/11/23 at 10:13 AM Nurse Aide #3 stated she took report that morning, on 5/5/23, from Nurse Aide #2 and the nurse aide indicated Resident #1 had a bath and she had emptied his catheter and colostomy bags. Nurse Aide #2 did not mention anything which indicated Resident #1 had a change of his scrotum, so Nurse Aide #3 did not have a reason to visualize Resident #1's scrotum or request the nurse assess it.

Review of a progress note dated 5/5/23 at 7:05 PM revealed Nurse #1 went to Resident #1's room to provide wound care to resident and while

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attempting to turn the resident onto his left side, the nurse observed that Resident #1's scrotum was swollen and appeared to have an abscess that was ruptured. The on-call provider was contacted at 6:22 PM and made aware of the situation and an order was given to send to the emergency department for evaluation and treatment. The nurse contacted 911 at 6:24 PM.

During an interview on 5/11/23 at 9:06 AM Nurse #1 stated she remembered Resident #1 and was his regular nurse. She further stated it was important to know Resident #1 had no feeling to his groin and scrotum so he could not tell if something was hurting him there. She stated on 5/5/23 she worked a 12-hour shift beginning at 7:00 AM. She was not notified of any concerns from Nurse #2 with Resident #1 during change of shift report, so she had no reason to assess or contact the physician regarding Resident #1. She worked her shift as normal and completed her medication passes. Around 6:00 PM it was time to provide wound care for Resident #1. She set up her equipment and pulled back his sheet and removed his brief. Nurse #1 stated Resident #1's scrotum had the appearance of an abscess that had ruptured and the best way she could describe it was to imagine boiling an egg and when the egg cracks, the white of the egg comes out. But in this case what came out was black and not normal looking tissue. She stated Resident #1 had Fournier's gangrene before and the tissue observed on 5/5/23 had a similar appearance. She reported she got the Director of Nursing (DON) to observe the area and they agreed Resident #1 needed to be sent out to the hospital. She added that the physician should have been informed of the resident's refusal for treatment so that a decision could be made to send the

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resident out to be assessed. Nurse #1 stated she notified the on-call provider and the on-call provider ordered for the resident to be sent out to the hospital. Resident #1 was discharged from the facility at 6:50 PM.

Review of Hospital #1's records dated 5/5/23 revealed an emergency department (ED) Provider note that indicated Resident #1 had a history of necrotizing fasciitis and presented with a severe scrotal abscess with purulent foul-smelling drainage which were concerning for necrotizing infection as well. The Provider noted Resident #1 had no sensation to this area. A sepsis work up was ordered in addition to IV (intravenous) antibiotics and fluid resuscitation (due to hypotension). General surgery was consulted for plan of care or transfer. The Consulting Surgeon documented the entire scrotum was red and swollen and there was a large area, approximately 7 centimeters (cm) by 5 cm, on the right side of the scrotum that was necrotic (dead tissue) and draining foul smelling pus. The underlying testicle was exposed and appeared to be draining pus as well. It was also noted the left side of the penis had an abscess that was draining pus. The Consulting Surgeon documented Resident #1 had a history of drainage of penile abscess, scrotal abscess, and debridement of Fournier's gangrene by urology at a different hospital a few years ago. The assessment noted dead tissue as well. The Consulting Surgeon documented the treatment was beyond the scope of his practice and recommended transfer to urology at Hospital #2.

Review of Hospital #2's records revealed a history and physical dated 5/6/23 that noted Resident #1 had a history of multiple sclerosis,

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paraplegia, and prior debridement for Fournier's gangrene in April of 2022. The Physician noted Resident #1 was transferred from an outside hospital with hypotension and purulent drainage from his scrotum, penis and perineum concerning for Fournier's gangrene. Resident #1 was taken to the operating room on 5/6/23 for debridement (surgical procedure to remove dead or infected tissue) of scrotal abscess and Fournier's gangrene. The discharge summary dated 5/7/23 revealed Resident #1's post operative stay was complicated by continuing sepsis and end-organ dysfunction, and he was transferred to hospice and expired on 5/7/23.

Attempts to contact physician at Hospital #1 were made on 5/11/23 at 2:20 PM, 2:44 PM, and 3:45 PM, and further attempts made on 5/12/23 at 9:52 AM and again on 5/17/23 at 5:18 PM. These attempts were unsuccessful.

During an interview on 5/11/23 at 12:58 PM Physician #1 stated he was Resident #1's primary physician at the facility. He further stated he was not made aware of the open area with drainage on Resident #1's scrotum until after he had been hospitalized, and to his knowledge it was not reported to any on call provider until later that day, 5/5/23. Even though Nurse #2 was unable to assess the area as the resident did sometimes refuse, she should have notified him or the on-call physician of the open area and the extent of the drainage. He concluded it was hard to say if Resident #1's outcome would have been different had the physician been notified earlier that day about the drainage and abscess, but he would have sent the resident out immediately upon being made aware of an open area on his scrotum with drainage even if the resident did not

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allow a full assessment.

During an interview on 5/11/23 at 12:53 PM the Administrator stated Nurse #2 should have notified the physician as soon as she was made aware of a new skin opening and drainage from Resident #1's scrotum by the nurse aides and was unable to assess the area. He concluded the nurse and nurse aides should have reported the new open area to the oncoming shift.

During an interview on 5/31/23 at 9:52 AM the Director of Nursing stated Nurse #2 should have attempted to assess the area or notify someone that Resident #1 was not allowing an assessment of the area on his scrotum. Nurse #2 should have notified the oncoming shift of the area, lack of assessment, and not having notified the doctor. Nurse #2 should have notified the doctor of the lack of assessment and of the new area when it was brought to her attention by the nurse aides.

The Administrator was notified of the immediate jeopardy on 5/26/23 at 2:01 PM.

The facility provided the following 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 the noncompliance.

The facility failed to conduct an assessment of Resident #1 and take appropriate actions when Resident #1 refused an assessment.

" The Director of Nurses and/or designee conducted a 30 look back to review other

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residents identified with a change in condition to verify a thorough assessment was completed by a Licensed Nurse. This review was completed by May 17, 2023, and consisted of a thorough review of 24-hour reports, progress notes, and change of condition assessments. No additional concerns were identified.

" The Licensed Nurses and/or designee completed a skin assessment on all residents to identify skin changes in condition and verify the Physician and/or Provider was notified of changes by May 27, 2023. No additional residents were identified with necrotizing fasciitis and Fournier's gangrene.

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.

" The Nurse Practice Educator and/or designee will provide education to Licensed Nurses on necrotizing fasciitis and Fournier's gangrene with specific emphasis on how rapidly it can progress, how detrimental it can be, and the seriousness/urgency of seeking immediate medical attention by May 27, 2023. A post-test has been created and is in progress to validate knowledge and/or comprehension of education. The Director of Nurses and/or Nurse Practice Educator will track and verify no Licensed Nurse (s) will be allowed to return to work with scheduled time off, on leave of absence (FMLA), vacation, or PRN until they have successful completed the education/training and post-test. New hires will be educated by the Nurse Practice Educator during the orientation process.

" The Nurse Practice Educator and/or

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designee will educate Licensed Nurses on the importance of conducting a thorough assessment, documenting the assessment, and on specific measures to take if a patient refuses an assessment to include notifying the Responsible Party, and Physician/Provider, and educating the resident on the importance of allowing an assessment to be completed, and re-approach by May 27, 2023. The Director of Nursing and/or Nurse Practice Educator will track and verify Licensed Nurses with scheduled time off, on leave of absence (FMLA), vacation, or PRN staff will be re-educated prior to returning to duty. New hires will be educated by the Nurse Practice Educator during the orientation process.

" The Nurse Practice Educator and/or designee re-educated Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by May 17, 2023. The EInteract Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, or PRN staff will be re-educated prior to returning to duty. New hires will be educated by the Nurse Practice Educator during the orientation process.

" Effective May 15, 2023, the Director of Nurses and/or designee will review changes in condition by reviewing the 24-hour report, progress notes, change in condition assessments, in the morning Clinical Meeting to verify a thorough assessment has been completed.

" Removal of Immediate Jeopardy is May 28,

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F 684	Continued From page 24 2023 The credible allegation for Immediate Jeopardy removal with a compliance date of 5/28/23 was validated on 5/31/23, as evidenced by staff interviews and in-service record reviews. The in-services included information on identification of changes in residents, importance of assessments, documenting assessments, and measures to take if a resident refused an assessment. The education further included information on necrotizing fasciitis and Fournier gangrene with a focus on the speed at which it can cause a decline and requires emergent medical attention. The facility's Immediate Jeopardy removal date of 5/28/23 was validated.	F 684		