STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF FAYETTEVILLE	2461 LEGION ROAD FAYETTEVILLE, NC 28306

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F 000	INITIAL COMMENTS The survey team entered the facility on 02/17/24 to conduct a complaint survey and exited on 02/19/24. The survey team returned to the facility on 02/28/24 to obtain additional information and exited on 02/29/24. Therefore, the exit date was changed to 02/29/24. Event ID# H2ZW11 The following intakes were investigated: NC00213509, NC00213247 and NC00213889. 2 of the 9 complaint allegations resulted in deficiency.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		3/28/24

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

Electronically Signed | 03/21/2024

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F 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to complete a	F 636	1. Immediate action(s) taken for the resident(s) found to have been affected	

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F 636	Continued From page 2 comprehensive assessment including Minimum Data Set (MDS) within 14 days of admission for 1 of 3 residents (Resident #2). The Findings included: Resident #2 was admitted into the facility on 12/26/23 with diagnoses of chronic peripheral venous insufficiency, vascular dementia and chronic kidney disease stage 3. A review of Resident #2's medical record on 2/28/24 revealed an admission Minimum Data Set (MDS) had not been started or completed, An interview was conducted on 2/28/24 11:39 AM with the Minimum Data Set (MDS) Coordinator and she revealed that she was behind on MDS's due to an influx of residents and the prior MDS Coordinator not putting information into the system. She further revealed when she started in January 2024 she had to input some of the current residents information into the system before she was able to start completing the residents MDS's. An interview with the Chief Clinical Officer on 2/28/24 at 11:39 AM indicated that she was not aware of the comprehensive assessments not being completed until the current MDS Coordinator informed her. The facility is currently recruiting MDS Coordinators from sister buildings to get the comprehensive assessments and comprehensive care plans up to date.	F 636	include: On 3/13/24 the MDS team completed a accurate, comprehensive assessment to include all previous missing elements for resident #2. 2. Identification of other residents having the potential to be affected was accomplished by: MDS Coordinator completed a 100% facility audit to determine outstanding and inaccurate assessments. The baseline audit was completed on 3/12/24. MDS consultant performed a detailed audit to identify trends and opportunities for improvement. All residents of this facility have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 3/13/24, the Nursing Home Administrator re-educated MDS Coordinator, Admission Nurse, and Director of Nursing on timely completion of comprehensive assessments completed. MDS Consultant conducted a meeting with the MDS team, Administrator, Nurse Consultant, and Senior Leadership Team. Two MDS Nurses have been added to the team. Three additional, experienced MDS	

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F 636	Continued From page 3	F 636	Coordinators from sister facilities and a MDS Consultant were utilized to complete all outstanding assessments. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Corporate Clinical Team will audit for timely completion of comprehensive assessments weekly for 4 weeks and then monthly for 2 months or until QAPI team deems compliance. Corrective action completion date: 3/28/24.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		3/28/24

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F 655	Continued From page 4 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and medical record review the facility failed to develop a baseline care plan within 48 hours after admission for 1 of 1 resident reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted into the facility on 1/2/24 with diagnoses of protein malnutrition, muscle wasting and atrophy, peripheral vascular disease, and anxiety. He was discharged to the hospital on 2/7/24.	F 655	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 2/20/24, the MDS Coordinator completed the baseline care plan and comprehensive care plan for Resident #1. 2. Identification of other residents having the potential to be affected was accomplished by: MDS Coordinator completed a 100% facility audit to determine outstanding and	

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F 655	Continued From page 5 A review of the medical records indicated there was no baseline care plan developed. A review of Resident #1's admission Minimum Data Set dated 1/9/24 noted he was sometimes understood, usually understands, was severely cognitively impaired, rejected care 1-3 days, was dependent on staff for his activities of daily living, had a urinary catheter, was incontinent of bowel and had a pressure area. A telephone interview was conducted on 2/18/24 at 2:00 PM with the former Social Service Designee who indicated she had overseen the completion of the baseline care plans however, she got behind on them, resulting in some of the baseline care plans not getting completed. She further indicated that she did not remember setting up a care plan meeting with Resident #1 or his family. An interview was conducted with the Director of Nursing on 2/19/24 at 9:27 AM revealed that a base line care plan should have been developed and an initial family care plan meeting scheduled. An interview was conducted with the Administrator on 2/19/24 at 9:00 AM indicated that a base line care plan should have been developed and an initial family care plan meeting scheduled.	F 655	inaccurate care plans. The baseline audit was completed on 3/18/24. All residents of this facility have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Prior to the survey completion, the Nursing Home Administrator re-educated the MDS Coordinator, Admission Nurse, and Director of Nursing on timely completion of baseline and comprehensive care plans. A new system was implemented that the admission nurse will initial the baseline care plan within 48 hours of admission. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Corporate Clinical Team will audit new admissions at random weekly for 4 weeks to ensure that a base line care plan is completed within 48 hours of admission and then monthly for 2 months or until QAPI team deems compliance. Corrective action completion date: 3/28/24.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		3/28/24

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F 657	Continued From page 6 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and medical record review the facility failed to develop a person-centered comprehensive care plan for 2 of 3 residents reviewed for care plans (Resident #1 and #2). The findings included: 1) Resident #1 was admitted into the facility on 1/2/24 with diagnoses of protein malnutrition, muscle wasting, and atrophy, and peripheral vascular disease. He was discharged to the	F 657	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 2/20/24, the MDS Coordinator completed the comprehensive care plan for Resident #1. 2. Identification of other residents having the potential to be affected was accomplished by:	

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F 657	Continued From page 7 hospital on 2-7-24. An admission skin assessment was completed on 1/2/24 indicating a pressure area to the right hip. A review of Resident #1's admission Minimum Data Set dated 1/9/24 noted 1 stage 4 pressure area present on admission and noted no pressure ulcer/injury care, applications of nonsurgical dressings, or applications of ointments or medications. The Care Area Assessment (CAA) dated 1/15/24 indicated pressure ulcers were triggered and required a care plan. A review of Resident #1's care plan revealed there a comprehensive care plan had not been developed within 7 days after the completion of the comprehensive assessment and did not have a care plan related to pressure ulcers. An interview was conducted on 2/17/24 at 1:00 PM with the MDS Coordinator who revealed that she was behind on care plans due to an influx of residents. She agreed there was not a care plan developed regarding pressure ulcers for Resident #1 and there should have been one. An interview was conducted with the Director of Nursing on 2/19/24 at 9:27 AM revealed that a care plan regarding pressure ulcers should have been developed. An interview was conducted with the Administrator on 2/19/24 at 9:00 AM indicated that a care plan regarding pressure ulcers should have been developed.	F 657	MDS Coordinator completed a 100% facility audit to ensure all facility residents had a current care plan. The baseline audit was completed on 3/18/24. All residents of this facility have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Prior to the survey completion, the Nursing Home Administrator re-educated the MDS Coordinator, Admission Nurse, and Director of Nursing on timely completion of comprehensive care plans. A new system was implemented that the admission nurse will initial the baseline care plan within 48 hours of admission. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Corporate Clinical Team will audit 2 new admissions weekly for 4 weeks to ensure that a comprehensive care plan is completed timely and then monthly for 2 months or until QAPI team deems compliance. Corrective action completion date: 3/28/24.	

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F 657	Continued From page 8 2) Resident #2 was admitted into the facility on 12/26/23 with diagnoses of chronic peripheral venous insufficiency, vascular dementia with moderate anxiety and psychotic disturbance, insomnia due to other mental disorders and chronic kidney disease stage 3. A review of Resident #2's medical record revealed a comprehensive assessment nor comprehensive care plan had been formulated. An interview was conducted on 2/28/24 11:39 AM with the Minimum Data Set (MDS) Coordinator and she revealed that she was behind on MDS's due to an influx of residents and the prior MDS Coordinator not putting information into the system. She further revealed when she started in January 2024 she had to input some of the current residents information into the system before she was able to start completing the residents MDS's. An interview with the Chief Clinical Officer on 2/28/24 at 11:39 AM indicated that she was not aware of the comprehensive assessments and care plans not being completed until after the current MDS Coordinator informed her. The facility was currently recruiting MDS Coordinators from sister buildings to get the comprehensive assessments and comprehensive care plans up to date.	F 657		
F 686 SS=E	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.	F 686		3/28/24

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F 686	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Medical Director interviews, the facility failed to complete and document comprehensive weekly skins assessments and nursing notes related to treatment or prevention of pressure ulcers, provide treatments as ordered, and initiate an air mattress and protective heel boots when recommended for a resident with and at risk for pressure ulcers. Resident #1 developed new pressure ulcers and existing pressure ulcers deteriorated. This deficient practice occurred for 1 of 3 residents reviewed for pressure ulcers (Resident #1). The findings included: Resident #1 was admitted into to the facility on 1/2/24 with diagnoses of dementia, protein malnutrition, muscle wasting/atrophy, paranoid schizophrenia, anxiety, and peripheral vascular disease, protein calorie malnutrition, and muscle weakness. A review of Resident #1's admission skin assessment dated 1/2/24 noted a pressure	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected include: A review of all current residents with pressure ulcers, including resident # 1 was completed by the Chief Clinical Officer and Treatment Nurse to assure appropriate orders were in place. 2. Identification of other residents having the potential to be affected was accomplished by: The facility nurse(s) conducted skin assessments on all residents. Identified concerns were addressed. A medical records review was completed on all residents by Nursing Supervisors to ensure weekly skin assessments were completed and treatment recommendations/orders were in place. A care plan audit was conducted by the facility Administrator to ensure that treatment recommendations/orders were	

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F 686	Continued From page 10	F 686		

wound to his right hip.

A review of Resident #1's Braden Scale (a scale composed of six subscales, mobility, activity, sensory perception, skin moisture, nutritional status and friction. Each subscale has its own operational definitions and rate from 1 (least favorable) to 3 or 4 (most favorable) completed on 1/2/24 revealed Resident #1's score was a 13 which meant Resident #1 was at moderate risk for developing pressure areas.

A review of Resident #1's admission Minimum Data Set dated 1/9/24 noted he was severely cognitively impaired, had one stage 4 pressure area present on admission and noted no pressure ulcer/injury care, applications of nonsurgical dressings, or applications of ointments or medications. It further noted that he had no behaviors, rejected care 1-3 days, had received both antipsychotic and antianxiety medications, had limited range of motion in his bilateral lower extremities.

A review of Resident #1's undated care plan revealed there was no care plan regarding pressure ulcers.

A review of Resident #1's Physician orders revealed an order dated 1/2/24 for Resident #1was to been seen, evaluated, and treated by Wound Care.

a. Resident #1 was seen by the Wound Care Nurse Practitioner (NP) on 1/3/24 who noted a stage 4 right hip posterior wound (Wound A) measured 0.9 cm (centimeters) x 1cm x 1cm (estimated depth) and ordered Calcium Alginate with silver dressing to be applied daily. She also

on the care plan that the care plan was being followed.

The facility has determined that 100% residents with pressure ulcers have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:

All facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed and revised as needed.

Facility standing orders for wound treatments were reviewed and revised by the Chief Clinical Officer, Wound Consultants and the facility Medical Director.
Nursing personnel (RNs, LPNs, including the Treatment Nurse) were in-serviced on the week of March 11, 2024 by the Chief Clinical Officer. This in-service included:
Facility Wound Protocols.
Initiating new treatment recommendations by wound specialist and orders as written by the physician,
Performing pressure ulcer and any other treatments as ordered by the physician and documentation on the TAR.
Completing weekly skin and wound assessments and documenting them timely in the electronic medical record.

A weekly wound and weight meeting was initiated.
In addition, the facility Wound Consultant

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F 686	Continued From page 11 recommended a low air loss mattress and heel suspension boots be utilized. A review of Resident #1's January 2024 Treatment Administration Record (TAR) did not indicate an order for Calcium Alginate with silver dressing to be applied daily. The Medical Director saw Resident #1 on 1/8/24 and noted that Resident #1 had transferred from another nursing home, had been noncompliant quite often, refused medication often, and had a stage 4 pressure injury to the right hip. Resident #1 was seen by the Wound Care NP on 1/10/24. She also noted Wound A had not improved measurements remained the same and ordered Wound A packed with silver hydro-fiber or alginate (rope or sheet cut into strand) and covered with an absorbent dressing. She noted there was no low air loss mattress on the bed and Resident #1's heels were not suspended, she again recommended both be utilized. A culture and bone biopsy were obtained during this visit of Wound A. She noted laboratory blood work completed on 1/9/24 included Albumin level of 2.9 (normal range 3.4-5.4), Total Protein 6, (6.0-8.3) White blood cell count 10.7 (normal range 4.5-11), Hemoglobin 10.3 (normal range 12-16), Hematocrit 32.4 % (normal range 36-48%), and Creatinine 1.4 (normal range 0.7-1.3). She also recommended a low air loss mattress and heel suspension boots be utilized. A review of Resident#1's medical record indicated one weekly skin assessment was completed by the licensed nursing staff on 1/16/24 which noted an area to the left buttock measuring 4.5 cm x 3.0 cm with a red fleshy peri wound. This was the	F 686	educated certified nursing aides on preventative skin care on March 20, 2024. Topics included: Preventative skin care, turning and repositioning, air mattress use, offloading measures and Reporting new skin issues to the nurse immediately 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Chief Nursing Officer or designee will audit weekly for 4 weeks and monthly for 2 months. Audits will include the following: Weekly skin assessments Weekly wound assessments Treatment recommendations and orders are being added and processed into the EHR and TAR and documentation on the TAR. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 28, 2024.	

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only weekly skin assessment documented in the medical record.

A review of Resident #1's medical record revealed bone biopsy results reported on 1/16/24 that indicated medullary space tissue with granulation response comprised predominantly of plasma cells, lymphocytes, and a few scattered neutrophils with adjacent trabeculae compatible with chronic non-specific osteomyelitis (bone infection).

On 1/17/24 the Physician wrote an order for the for Levofloxacin (antibiotic) 500 mg given once a day by mouth for 22 days (1/18/24 through 2/9/24) for the diagnosis of osteomyelitis.

A review of Resident #1's January 2024 Medication Administration Record (MAR) revealed he refused to take this medication on January 24th through the 28th, his February MAR indicated he took the medication as scheduled.

Resident #1 was seen by the Wound Care NP on 1/17/24. She noted Wound A had not improved measurements were 0.9 cm x 1 cm x 1 cm with undermining at 12 o'clock of 3 cm, undermining at 6 o'clock of 1 cm, undermining at 3 o'clock of 2 cm and undermining at 9 o'clock 3.5 cm. She continued with the order of calcium alginate with silver and a dry protective dressing.

A review of Resident #1's January 2024 (TAR) noted the order to pack Wound A with silver hydro-fiber or alginate (rope or sheet cut into strand) and cover with an absorbent dressing daily was not documented as completed on January 15th, 18th, 20th, 23rd, or 24th.

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A review of the Registered Dietician noted dated 1/16/24 included Resident #1 was on a regular dysphasia advanced diet with thin liquids noted a 50-100% intake at majority of meals with maximum assistance. Increased nutrient needs to aid in wound healing and recommended 30 milliliters of an advanced wound care ready to drink concentrated liquid protein providing 17 grams of hydrolyzed collagen protein and 100 calories per fluid ounce twice a day, obtain Resident#1's weight, monitor appetite percentage, and labs as ordered.

A review of the Wound Care NP note dated 1/24/24 indicated Wound A was not improving and measured 1 cm x 1 cm x 1.5 (estimated depth). The Wound Care NP ordered to cleanse Wound A with normal saline or a wound cleanser, pack with gauze moistened with a mixture of sodium hypochlorite (0.4% to 0.5%), and boric acid (4%) diluted in water and fill all the dead space then cover with an absorbent dressing. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's medical record indicated the Medical Director saw him on 1/24/24 and noted that he was seeing Resident #1 because of a decline in the past several days. He also noted that Resident #1 was currently on antibiotics for a presumed osteomyelitis of the left hip wound and that Resident #1 had been refusing quite a bit of medications and was not eating. It was also noted that Resident #1 had developed six new wounds in the last few days with deep tissue injuries as well. The Medical Director further indicated that he had spoken with Resident #1's sister and updated regarding the new wounds and that he had developed and that

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he may be in the dying process and suggested Resident #1 be placed on hospice which the sister refused, the sister also declined Resident #1 to have a feeding tube and wanted the facility staff to feed him. The Medical Director advised Resident #1's sister that the facility could not force feed him and if he declined more that he would be sent to the hospital for evaluation.

A review of Resident #1's January 2024 Physician orders revealed the order from the Wound Care NP 1/25/24 to cleanse Wound A with normal saline or a wound cleanser, pack with gauze moistened with a mixture of sodium hypochlorite (0.4% to 0.5%) and boric acid (4%) diluted in water and fill all the dead space then cover with an absorbent dressing daily.

A review of Resident #1's January TAR revealed the order to cleanse Wound A with normal saline or a wound cleanser, pack with gauze moistened with a mixture of sodium hypochlorite (0.4% to 0.5%) and boric acid (4%) diluted in water and fill all the dead space then cover with an absorbent dressing daily was documented as completed from 1/25/24 through 1/29/24. Further review revealed the treatment was not documented as completed on 1/30/24.

A review of the February 2024 TAR indicated the treatment was documented as completed 2/1/24 through 2/7/24.

Attempts to interview the Treatment Nurse employed by the facility for the month of January 2024 were unsuccessful.

An interview on 2/28/23 at 2:00 PM with the Chief Clinical Officer indicated that the low air loss

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mattresses and heel suspension boots were in the building on 1/31/24, however if she was notified of a resident requiring one before 1/31/24 one would have been made available. She further revealed that weekly skin assessments on all the residents should be completed by the nursing staff. She indicated Resident #1 had the low air loss mattress placed on his bed on 2/1/24 and that heel suspension boots were placed on Resident #1 the same day.
A review of Resident #1's Wound Care NP notes dated 2/7/24 indicated the wound had not improved measured 2.5 cm x 2.5 cm x 1.8 cm and noted that he had had rapid health decline and malnutrition, healing may not be feasible and skin failure was highly suspected. It further noted that his primary care physician had recommended Resident #1 be sent to the Emergency Room.

b. A review of Resident #1's Wound Care NP notes dated 1/17/24 noted a new stage 2 pressure area on Resident #1's left buttock (Wound B) measured 4.5 cm x 3.5 cm x 0.1 cm with serosanguinous drainage and ordered hydrophile paste dressing covered with a dry dressing daily.

A further review of Resident #1's Physician orders indicated an order from the Wound Care NP dated 1/17/24 to cleanse Wound B with wound cleanser or normal saline, apply hydrophilic paste and cover with a dry dressing daily and prn. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's January 2024 TAR indicated the treatment to cleanse Wound B with wound cleanser or normal saline, apply

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hydrophilic paste and cover with a dry dressing was not documented as completed on January 18th, 20th, and 23rd.

A review of the Wound Care NP notes dated 1/24/24 the area was healed.

c. A review of Resident #1's Wound Care NP notes dated 1/17/24 noted a new deep tissue pressure injury area (DTPI) had developed on the left foot 1st digit distal (Wound C) measured 0.5 cm x 0.7 cm x 0.2 cm (estimated depth) and ordered skin prep applied daily to the area. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's January physician orders revealed an order dated 1/17/24 for skin prep daily to the left foot 1st digit distal.

A review for Resident #1's Wound Care NP notes dated 1/24/24 noted the DTPI (Wound C) was improved, was smaller by volume without fluctuance or open ulceration. She also recommended a low air loss mattress and heel suspension boots be utilized and to continue the order of skin prep to Wound C.

A review of Resident #1's January 2024 TAR revealed the skin prep to the left foot 1st digit distal ordered daily was not documented as completed on January 18th, 20th,23rd, and 30th.

A review of Resident #1's Wound Care NP notes dated 1/31/24 noted Wound C had not improved but was stable. She also recommended a low air loss mattress and heel suspension boots be utilized. She continued with the order for skin prep Wound C.

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A review of Resident #1's Wound Care NP notes dated 2/7/24 noted Wound C was stable in appearance and volume with intact purple discolored skin. She also noted that a low air loss mattress and heel suspension boots were being utilized.

d. A review of Resident #1's Wound Care NP notes dated 1/17/24 noted a new deep tissue pressure injury area had developed on the left foot 1st digit medial (Wound D) and measured 1 cm x 1.4 cm x 0.2 cm (estimated depth), she ordered skin prep applied daily to area. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's physician orders indicated an order dated 1/17/24 to apply skin prep to the left foot 1st digit medial daily.

A review of Resident #1's Wound Care NP notes dated 1/24/24 noted Wound D had not improved and measured 1.4 cm x 1 cm x 1.4 cm (estimated depth) was stable by volume and appearance and continued the treatment of skin prep to the area.

A review of Resident #1's January TAR revealed the skin prep to the left foot 1st digit medial ordered daily was not documented as completed on January 18th, 20th, 23rd, and 30th.

A review of Resident #1's Wound Care NP notes dated 1/31/24 noted Wound D measured 1cm x 1.4 cm x 0.2 cm (estimated depth) and was not improved but was stable and continued the treatment of skin prep. She also recommended a low air loss mattress and heel suspension boots be utilized.

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A review of Resident #1's February TAR included the order for skin prep to the left foot 1st digit was not documented as completed on February 1st, 2nd, 6th, or 7th.

A review of Resident #1's Wound Care NP notes dated 2/7/24 noted Area D measured 0.5 cm x 0.3 cm x 0.2 cm (estimated depth) and the deep tissue area had evolved, was now with full thickness depth, exposed smooth bone. Pale pink subcutaneous tissue with scant serous exudate. The wound stage had been changed from deep tissue pressure injury to stage 4 and treatment changed to betadine moist gauze and dry dressing daily for microbial management and osteomyelitis was suspected at the site. She noted that a low air loss mattress and heel suspension boots were being utilized. Resident #1 was sent to the hospital on this day.

e. A review of Resident #1's Wound Care NP notes dated 1/24/24 noted a new area to the coccyx and bilateral buttocks (Wound E) was 10% unstageable, was 50% intact and 40% a deep tissue pressure injury. Wound E measured 6 cm x 6 cm with an estimated depth of 0.5 cm, had 10% granulation tissue which was soft and dusky. Wound E presented with purplish non blanching discoloration on both sides of the coccyx with dusky appearing subcutaneous tissue on the left buttock. There was mild serous exudate and the periwound had blanching erythema. She ordered hydrophilic paste with a dry protective dressing done daily. She recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's January 2024 TAR

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revealed no treatment order for Wound E.

A review of Resident #1's Wound Care NP notes dated 1/31/24 indicated wound E was not improving and measured 8.5 cm x 6 cm x 0.5 cm (estimated depth) she further noted the area was slightly larger by length, had non blanching intact skin and intact tissue extending to both buttocks. There was noted a small area of exposed subcutaneous tissue with scant exudate and dusky/pale base. She recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's February TAR revealed an order to cleanse wound on coccyx/buttocks with wound cleanser or normal saline, apply hydrophilic paste and a dressing daily was completed on 2/7/24 through 2/x/24.

A review of Resident #1's Wound Care NP notes dated 2/7/24 indicated Wound E had not improved, measured 11.5 cm x 12 cm x 0.8 cm (estimated depth) was now larger by volume with primarily deep maroon discolored skin extending from the sacrum to the bilateral buttocks. She noted that a low air loss mattress and heel suspension boots were both being utilized.

f. A further review of Resident #1's Wound Care NP notes dated 1/24/24 noted a new area to the left medial heel (Wound F) which measured 4 cm x 3 cmx 0.3 cm (estimated depth) stage 4 deep tissue pressure injury and ordered skin prep to the area daily. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's Wound Care NP notes

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dated 1/31/24 noted Wound F was not improved and measured 4 cm x 4.5 cm x 0.3 cm (estimated depth). She noted the area was slightly larger volume with an irregularly shaped deep tissue pressure injury of the posterior/medial heel with bogginess over posterior aspect. She continued with the treatment of skin prep daily to the area.

A review of Resident #1's January TAR revealed no treatment order for Wound F.

A review of Resident #1's February 2024 physician orders revealed a treatment for skin prep to the left medial heel daily.

A review of Resident #1's February 2024 TAR revealed treatment skin prep daily to the left medial heel was not documented as complete on February 1st, 2nd, or 6th.

A review of Resident #1's Wound Care NP notes dated 2/7/24 noted measured 4 cm x 4.5 cm x 0.3 cm (estimated depth) was stable.

g. A continued review of Resident #1's Wound Care NP notes dated 1/24/24 noted a new area to the right medial ankle (Wound G) which measured 3 cm x1 cm x 0.3 cm (estimated depth) deep tissue pressure injury and ordered skin prep to the area daily. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's January 2024 TAR revealed no treatment order for Wound G.

A review of Resident #1's Wound Care NP notes dated 1/31/24 noted Wound G measured 3 cm x 3 cm x 1 cm (estimated depth) and was improved

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and there was no change to the treatment.

A review of Resident #1's Wound Care NP notes dated 2/7/24 noted Wound G measured 1.5 cm x 1.5 cm x 1cm (estimated depth) and the deep tissue pressure injury had evolved and had smaller volume, but primarily black/yellow nonviable tissue curette debridement was preformed to remove the nonviable tissue. The wound base remained obscured due to dusky/purple discoloration and treatment changed to betadine moist gauze with dry gauze dressing.

A review of Resident #1's February 2024 TAR revealed no treatment to the area.

h. A continued review of Resident #1's Wound Care NP notes dated 1/24/24 noted a new area to the right lower lateral leg (Wound H) measured 1.5 cm x 2 cm x 0.3 cm (estimated depth) was deep tissue pressure injury and ordered skin prep to the area daily. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's Wound Care NP notes dated 1/31/24 noted Wound H had not improved, measured 10.5 cm x 2 cm x 0.3 cm (estimated depth) and was now 70% deep tissue pressure injury and 10% was now open with soft dusky granulation tissue and order was changed to fine gauze mesh cover with gauze dressing every other day.

A review of Resident #1's January 2024 TAR revealed no treatment order for Wound H.

A review of Resident #1's February 2024 TAR

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revealed the order for fine gauze mesh and cover with a gauze dressing every other day was documented as completed on the scheduled days.

A continued review of Resident #1's Wound Care NP notes dated 2/7/24 noted area not improved, measured 10 cm x 1 cm x 0.3 cm (estimated depth), and noted smaller overall volume, deep tissue pressure injury continues to evolve with dry black/yellow tissue, intact tissue and scant serous exudate. The wound stage had been changed from a deep tissue pressure injury to unstageable. Treatment remained unchanged. Resident #1 was discharged to the hospital 2/7/24.

j. A continued review of Resident #1 Wound Care NP notes dated 1/24/24 noted a new area to the left lower medial leg (Wound J) which was 10% unstageable with a soft dusky granulation tissue and 90% intact deep tissue pressure injury measured and 5.5 cm x 1 cm x 0.4 cm (estimated depth) and ordered autolytic foam dressing changed every 3 days. She also recommended a low air loss mattress and heel suspension boots be utilized.

A review of Resident #1's January 2024 TAR did not reflect the treatment order for Wound J.

A continued review of Resident #1's Wound Care NP notes dated 1/31/24 noted Wound J had not improved and measured 6.5 cm x 2 cm x 0.2 cm (estimated depth). She further noted that Wound J presented with larger volume mostly yellow nonviable adherent tissue with moderate serous exudate. The periwound with mild edema and

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blanching erythema. Scalpel debridement was performed as medically indicated to viable muscle tissue. Treatment was changed to calcium alginate with silver and covered with dry gauze.

A review of the February TAR indicated this treatment was documented completed from 2/2/24 through 2/7/24.

A review of Resident #1's Wound Care NP noted dated 2/7/24 noted Wound J was improving with measurements of 5 cm x 2 cm x 0.5 cm (estimated depth) and was smaller with increased soft, pale pink granular tissue. The treatment was changed to betadine moist gauze with a gauze dressing. She also noted a low air loss mattress and heel suspension boots were being utilized.

k. The Wound Care NP noted Wound K on 1/31/24 which was a deep tissue pressure injury to the right lateral heel and measured 2 cm x 3 cm x 0.2 cm (estimated depth) and skin prep to the area daily was ordered.

A review of Resident #1's Wound Care NP notes dated 2/7/24 was not improved and measured 2 cm x 3 cm x 0.2 cm (estimated depth) and was noted as stable and the treatment remained unchanged.

A review of Resident #1's February 2024 TAR revealed the daily skin prep was documented as completed on 2/2/24 through 2/7/24.

l. The Wound Care NP noted a deep tissue pressure injury to the right ischium (Wound L) on 1/31/24 measured 2 cm x 1.5 cm x 0.4 cm (estimated depth) and skin prep to the area daily was ordered.

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A review of Resident #1's Wound Care NP notes dated 2/7/24 noted Wound L was not improved measured 2 cm x 1.5 cm x 0.4 cm (estimated depth) and was noted as stable with intact purple discoloration.

A review of Resident #1's February 2024 TAR revealed the daily skin prep was not documented as complete on 2/2/24 through 2/7/24.

m. The Wound Care NP noted Wound M on 1/31/24 which was a deep tissue pressure area to the left lower lateral leg measured 3 cm x 1.7 cm x 0.2 cm (estimated depth) and fine mesh gauze and dry dressing to the area every other day was ordered.

A review of Resident #1's February 2024 TAR from 2/1/24 through 2/7/24 revealed the order for fine mesh gauze and a dry dressing every other day was documented as completed on 2/3/24 and 2/5/24.

A review of Resident #1's Wound Care NP notes dated 2/7/24 indicated the area was improving and measured 1.5 cm x 1 cm x 0.2 cm (estimated depth) and had a smaller volume and increased intact tissue. The treatment remained unchanged to the area.

n. A further review of Resident #1's Wound Care NP notes dated 2/7/24 indicated a new area to right upper/mid back (Wound N) which measured 5 cm x 11 cm x0.5 cm (estimate) and an order for skin prep daily was ordered.

The Wound Care NP also noted on her notes dated 2/7/24 laboratory blood work completed for

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Resident #1 on 2/5/24 included an Albumin of 2.7, Total Protein 6, Creatinine 1.0, White blood count 14.5, hemoglobin 10.1 and Hematocrit 32.4.The Wound Care NP further noted that she discussed her concerns regarding Resident #1's progressive physical/cognitive decline as well as multiple new wounds with rapid onset and lab results with Resident #1's Primary Care Physician and Director of Nursing. In consideration of his rapid health decline and malnutrition, healing may not be feasible and skin failure is highly suspected. The Primary Care Physician ordered Resident #1 to be sent to the Emergency Room.

The Director of Nursing noted on the transfer sheet dated 2/7/24 Resident #1 was sent to the Emergency Department (ED) related to possible wound infection.

Review of the ED Provider Note dated 2/7/24 revealed Resident #1 was transferred there for an evaluation of a sacral wound of unknown duration. It was noted Resident #1 was unable to provide significant history but denied chest pain or abdominal pain. When asked if he was in pain he stated yes and indicated the pain was in his bottom. Resident #1 was tachycardic (rapid heart rate) with a heart rate of 119 and was hypotensive (low blood pressure) with a blood pressure (BP) of 88/52 (hypotension). Laboratory blood work included White Blood Cell Count was 14.3 (4.5-11.0), Erythrocyte Sedimentation Rate (measures inflammation in the body) was 96 (0-15), C-Reactive Protein (sign of inflammation due to infection or chronic disease) was 132 (0.8-1.0), Blood Urea Nitrogen (test kidney function) was 44 (7-25), Thyroid Stimulating Hormone 15.95 (0.4-4.0) and blood cultures were obtained. A computed tomography scan was

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completed and showed posteriorly and lateral right hip fluid collection with some gas in the posterior soft tissues, consistent with an inflammatory infectious process and gas forming organism. Lower extremities with scattered wounds, the sacrum had an unstageable wound with slough (yellow/white material in the wound bed that can be wet or dry, thick, thin, or patchy) and a right hip with ulceration and surrounding erythema with eschar (dead dark tissue) present. General surgery was consulted for surgical debridement of the sacral and right hip pressure ulcers. The ED Provider's impression was mixed cardiogenic and septic shock. Resident #1 received a bolus of 1.5 liters intravenous (IV) fluids due to symptoms of dehydration including very concentrated urine, dry mucosa and poor skin turgor. Initially Resident #1's BP improved but a short time later his BP started to trend down. X-ray results indicated a right-sided pleural effusion with suspected mild infiltrate. A right femoral central line (venous catheter in the femoral artery) was placed for the administration of medications to treat low BP (vasopressor) and two broad spectrum IV antibiotics. Resident #1 was transferred to the Intensive Care Unit for continued vasopressor support.

A review of Resident #1's nursing progress notes indicated there were no notes related to his pressure areas, deep tissue pressure injuries, or nursing interventions related to skin integrity.

An interview with the Wound Care NP on 2/18/24 at 1:39 PM indicated that skin breakdown interventions, such as orders, should have been put into place for Resident #1. She further revealed that in her opinion some of the wounds may have been avoidable if the measures that

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she had recommended had been put into place.

An interview with the Medical Director on 2/17/24 at 10:30 AM revealed that pressure areas were unavoidable for Resident #1, and he did not expect them to heal due to the resident's poor appetite, refusal of medication, low albumin, and comorbidities.

An interview with Nurse #1 on 2/18/24 at 11:26 AM revealed she had worked with Resident #1 in the month of January, and she could not recall if there were treatments ordered when Resident #1 entered the facility. She also revealed she could not recall if there were any skin breakdown precautions in place.

An interview with Medication Aide on 2/18/24 at 10:27 AM revealed that she needed to coax Resident #1 to take his medications and she remembered he had an open area on his hip but did not remember if there were treatments being completed on it or if there were skin breakdown precautions put into place.

An interview on 2/18/24 at 10:10 AM with Nurse Aide (NA) #1 indicated that Resident #1 required assistance with eating but ate good for him, he was turned and repositioned every two hours but would refuse at times and he assisted with putting an air mattress on Resident #1's bed on 2/1/24, he stated there were no heel boots to put on the resident available that he was aware of.

An interview on 2/18/24 at 10:37 AM with NA #2 stated that Resident #1 was very nice, and she had to either help him start eating or at times feed him but would drink sweet tea any time it was offered. She stated he was turned and

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repositioned every two hours but would try and refuse at times. She further stated that a week or two before he was sent to the hospital he started refusing to eat or turn more.

An interview with NA #3 on 2/18/24 at 10:48 AM revealed that Resident #1 was total care and would initially refuse care but after she talked to him for a bit would usually allow care to be given. She further revealed that he needed assistance to eat and was turned every 2 hours, she did not remember heel boots being on.

An interview with the Director of Nursing on 2/19/24 at 9:27 AM indicated after the Wound Care NP saw a resident her recommendations and orders should be entered into the physician orders by the treatment nurse, and she expected for treatments to be done as ordered. She further indicated that residents were discussed in the morning meetings held Monday through Friday.

On 2/28/24 at a telephone interview with the Medical Director indicated that while Resident #1 was in overall decline but if interventions such as a low air loss mattress and heel suspension boots were put into place it would have probably delayed or prevented the formation of additional pressure areas and injuries. He was not aware of the recommendations from Wound Care NP but regardless any recommendations that are given by Wound Care NP should be implemented and followed. He further indicated that he was concerned about facility treatment nurse(s) prior to the current one because he felt wound care was not being done as ordered or at times not at all. He stated that the facility does not need to ask him about any recommendations from Wound Care NP as he felt they are there to assist in

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F 686	Continued From page 29 healing or preventing skin issues with the residents, unless there was a concern that the recommendation was harmful in some way to the resident.	F 686		