STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345204	A. BUILDING _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK HEALTH AND REHABILITATION	455 VICTORIA ROAD ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/6/25 through 4/09/25. The credible allegation was validated on 04/14/25, therefore the exit date was changed to 04/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KYYV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/6/25 through 4/9/25. On 4/14/25 the survey team went back to the facility to validate the facility's credible allegations. Therefore the exit date was changed to 4/14/25. The following intakes were investigated: NC00218382, NC00225831, NC00220618 and NC00220596. 1 of the 5 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.65 at tag F825 at a scope and severity (J) Tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/26/24 and was removed on 4/11/25. An extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		4/15/25

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

Electronically Signed | 05/07/2025

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F 684	Continued From page 1 § 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, Medical Director, and Orthopedic Surgeon interviews, the facility failed to complete and document assessments of a surgical site. Resident #63 had an unwitnessed fall on 11/28/24 and suffered a fracture in the epicondyle region (bony prominence on the humerus bone in the arm) of the elbow. Resident #63's on 12/13/24 the resident underwent an open reduction internal fixation (ORIF) surgical procedure (involves making an incision to realign the bone and then holding the pieces together with hardware like plates, screws, or rods). At Resident #63's follow-up appointment with the Orthopedic Surgeon on 12/26/24 Occupational Therapy (OT) for range of motion (ROM), pain and edema (swelling caused by a buildup of fluid) control, home exercise program (HEP), and splint wear with removal for hygiene purposes and active ROM exercises was ordered. This order was not processed or communicated to OT. The 1/23/25 follow-up appointment with the Orthopedic Surgeon was cancelled due to Resident #63 being ill. The Transportation Aide rescheduled the appointment for 2/20/25. The facility did not seek guidance for care from the Orthopedic Surgeon in consideration of the delay with the follow-up appointment. There were no documented	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 11/28/24 Resident #63 had an unwitnessed fall and was sent to the Emergency Room (ER) where she was diagnosed with a closed fracture of right olecranon (proximal end of elbow) process of ulna. Resident # 63 returned to the facility with a splint in place and had surgery (open reduction with internal fixation) on 12/13/24. On 12/26/24 Resident #63 returned to the orthopedic office for a follow up and returned to the facility with instructions for an Occupational Therapist Referral, long arm posterior slap splint. Instructions included: Needs to wear splint at all times except for hygiene purposes and gentle active range of motion purposes. The facility failed to follow the orthopedic recommendations for Resident #63 by not implementing removing Resident #63's splint for hygiene purposes and gently range of motion. Resident #63 was supposed to see the orthopedic doctor on	

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F 684	Continued From page 2 nursing assessments of Resident #63's surgical site from 12/13/24 through 2/20/25. The Orthopedic Surgeon removed the splint on 2/20/25 and observed a pressure wound over the medial aspect (area closest to the body) of the elbow with limited elbow range of motion and ordered wound care for the pressure wound. The Wound Nurse first observation of the surgical site was on 2/20/25. The Wound Care Provider saw the Resident weekly beginning on 2/25/25 and noted the wound was consistent with a medical device related stage 4 pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). The pressure wound continued to deteriorate and on 3/26/25 Resident #63 was brought to the hospital for emergent surgery for irrigation and debridement of her right elbow with hardware removal. Resident #63 was admitted postoperatively and given intravenous (IV) antibiotics for MRSA (Methicillin-Resistant Staphylococcus aureus) which were continued after her discharge on 4/1/25. This deficient practice affected 1 of 3 residents reviewed for quality of care. Immediate jeopardy began on 12/26/24 when the facility failed to implement and complete routine assessments of Resident #63's surgical site. Immediate jeopardy was removed on 04/11/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.	F 684	01/23/25 but was sick and the appointment was rescheduled. On 02/20/25 Resident #63 returned to the orthopedic doctor's office. At the visit the splint was removed and a pressure ulcer over the medial aspect of the elbow with some limited range of motion was noted. On 2/20/25 wound nurse received orders from wound provider for wound care orders for resident #63. On 02/25/25 the Wound Provider evaluated the wound and determined that it was a Stage 3 and 4 pressure ulcer and the orthopedic hardware was exposed. The Wound Provider provided wound care orders and instructed the staff to notify the Orthopedic doctor. The Orthopedic doctor was notified and placed Resident #63 on antibiotic and continue daily wound care on 02/28/25. On 03/26/25 Resident #63 required surgery to remove the exposed hardware and returned to the facility on 04/01/25 on intravenous (IV) antibiotic for Methicillin resistant staphylococcus aureus (MRSA) of the wound. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with new orders and splints are risk when a physician order is not followed. On 4/9/25 the Administrator and the Director of Clinical Services reviewed all resident orders with outside appointments in the past 90 days to ensure they were in place and correct. No new issues were	

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F 684	Continued From page 3 The findings included: Resident #63 was admitted on 11/29/23 with diagnoses that included non-traumatic brain dysfunction, hypertension, and Alzheimer's disease. Resident #63's quarterly Minimum Data Set (MDS) dated 09/07/24 indicated she had severe cognitive impairment and required maximal assistance with upper body dressing and personal hygiene. Resident #63 did not have any pressure wounds and was not receiving any therapy. On 11/28/24 at 4:15 PM Nurse #1 wrote Resident #63 was found lying on her right side, face down on the floor on the left side of the bed. The resident was noted to have right arm in flexed position and was unable to move her arm independently. The right arm was immediately immobilized to prevent further injury, and the resident was instructed not to move arm. Resident #63 was carefully placed onto her bed with multiple staff members. The Medical Director (MD) was notified and new orders received to obtain STAT (without delay) right humerus (long bone of the upper arm), elbow, radius (forearm), and ulna (one of two long bones in the forearm) x-ray due to the fall. Nurse #1 wrote on 11/28/24 at 4:35 PM the X-Ray technician performed an x-ray at bedside and confirmed a fracture in the epicondyle region of elbow. The x-ray technician was unable to perform other exams (radial/ulna/humerus) secondary to the resident's condition. A verbal order was received from the on-call provider to	F 684	identified. On 4/9/25 the Wound Nurse completed a head-to-toe skin assessment on Resident #63 with no new skin issues noted. On 4/9/25 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Wound Nurse completed an audit of all current facility residents with all pressure and non-pressure wound care and splint orders to ensure the correct physician ordered treatment was in place. All resident treatments and dressings were correct and matched the physician's order. On 4/9/25 the Therapy Director completed an audit of all new admits in the past 30 days and current facility residents with therapy orders to ensure the correct physician ordered treatment was in place. All resident treatments were correct and matched the physician's order. On 4/9/25 the Director of Clinical Services audited all new admits in the past 30 days and current residents with splints to ensure the order states to check skin integrity before and after applying splint. All residents had orders. On 4/9/25 Regional Operator, Director of Clinical Services, the Director of Nursing, Assistant Director of Nursing, Unit Manager's, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review and determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the referral form was returned with Resident #63 on 12/26/24 but was not given to the	

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F 684	Continued From page 4 send to the emergency department (ED) for fracture of right elbow after the residents fall and the residents responsible party was aware of new orders. The Director of Nursing (DON) was contacted, and the [local county] emergency medical services (EMS) was in route to the facility. Resident #63's emergency department (ED) summary dated 11/28/24 revealed Resident #63 was brought to the ED after a fall and had a fractured right olecranon (bony prominence that forms the tip of the elbow). The discharge instructions indicated Resident #63 needed to see an orthopedic specialist within 10 days. Nurse #2 progress note written on 11/29/24 at 8:46 AM read Resident #63 returned from the hospital on a stretcher with maximum assistance x 2 transfer from the stretcher to bed. The resident is resting comfortably and responds to verbal and tactile stimulation. The resident's sling is intact to her right arm with good "CNS" to fingertips noted. Review of a physician order dated 11/29/24 read for non-weight bearing to right arm and sling to be worn at all times and for oxycodone 5 mg (milligrams) every 4 hours as needed for pain management were continued. The Orthopedic Surgeon's progress note dated 12/5/24 noted Resident #63 to clinic today with a transfer aide from her skilled nursing facility for evaluation of a right olecranon fracture. The resident reported that her pain has been 4/10 in severity. Resident #63 has been in a posterior slab splint but the transfer aide from her facility reports that she is taking it off. The Orthopedic Surgeon took Resident #63's splint down to	F 684	nurse to review. Instead, it was placed in the Medical Record folder to be uploaded to the medical record. The recommendations for an Occupational Therapist referral and to take the splint off for hygiene and active range of motion were not implemented. To address the root cause the facility implemented education on who will be responsible for ensuring the referral form is brought back to the facility when a resident has an outside appointment so new recommendations or orders can be implemented. The Unit Manager will be responsible for ensuring the referral form returns with the resident. If it is the weekend or after the Unit Manager has left, the hall nurse will be responsible. The transporter will notify the Unit Manager the resident is back from the appointment and will give her any paperwork at that time. If there is no referral form the Unit Manager will call the physician office to obtain a copy of the form. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/9/25, the Director of Clinical Services provided education to the Administrator, DON and ADON, and Transportation driver that included the following: A) The transportation driver will notify the Unit Manager or hall nurse the resident has returned from the outside appointment, the Unit Manager will be	

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F 684	Continued From page 5	F 684		

evaluate her skin and found no open wounds or abrasions and there was no threatened skin. There was ecchymosis and swelling along the posterior aspect of her elbow and gentle range of motion of the shoulder did not seem to cause significant pain. All of the resident's fingers were pink and warm and well-perfused with brisk capillary refill.

A nurse's note dated 12/6/24 at 11:08 AM written by the Director of Nursing (DON) indicated Resident #63's responsible party had consented with the orthopedic group for the resident to have surgery on her right upper extremity (RUE) to repair her fracture on 12/13/24. Outpatient surgery had been scheduled with the surgery center and pre-operation orders were received.

The hospital discharge instructions dated 12/13/24 indicated Resident #63 had surgery for open reduction internal fixation (hardware placed on bone for stabilization). The discharge instructions were to follow up with the Orthopedic Surgeon on 12/26/24, take pain medications as instructed, non-weight bearing for operated limb. Incision care instructions were to wear a plastic bag over the effective extremity when taking a shower and to notify the provider if the splint gets wet to have it replaced. Other incision care instructions were to not use lotions or creams near the affected area and call the provider if the incision has drainage.
The hospital discharge instructions dated 12/13/24 included physician orders for doxycycline hyclate (antibiotic) one (1) tab 100 mg twice daily for 14 days to treat or prevent infections. Also included was an order for acetaminophen-hydrocodone 325/5 mg oral tablet one (1) every 6 hours times 4 days for pain and

responsible for obtaining a completed referral form or encounter notes from the appointment visit. For appointments/ER visits occurring on weekends the hall nurse will be responsible for obtaining and reviewing the referral.
B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy.
C.) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed with any new orders entered into the medical record.
D.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse.
E.) On 4/9/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review.
F.) On 4/10/25 an all call was sent to facility residents Responsible Party's to notify the Unit Manager or Hall Nurse when signing the resident out for an

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F 684	Continued From page 6 non-weightbearing for operated limb. There were no assessments of the surgical documented by nursing staff from 12/13/24 through 12/26/24. An orthopedic progress note dated 12/26/24 indicated Resident #63 was seen by the Orthopedic Surgeon for a two-week follow-up post open reduction internal fixation of a right olecranon fracture. The resident was fitted with a custom fitted long arm posterior orthosis (an external device like a brace or a splint) for her right upper extremity by the orthopedic office occupational therapist. The progress note instructed to contact the occupational therapy department if needed. The progress note included the goal for Resident #63 was to be independent with wearing the orthosis and with its care and to follow surgical precautions with the orthosis. It was noted that the surgical incision was healing well along the posterior aspect of Resident #63's elbow. In addition, gentle range of motion of the elbow did not cause any significant pain and she had stable alignment of her elbow status post open reduction internal fixation with olecranon plate. The occupational therapist educated Resident #63 and her caregiver (Transportation Aide) on how to wear and provide care for the orthosis (an external medical device such as a brace or splint). The Transportation Aide was unavailable for interview. A signed paper Orthopedic Surgeon referral order dated 12/26/24 for Resident #63 to receive occupational therapy had been scanned into Resident #63's health record on 1/2/25 under the	F 684	outside physician appointment and to return any paperwork/referrals from the appointment to the Unit Manager or Hall Nurse. On 4/9/25 DON and ADON provided education to all facility Licensed Nurses and Nurse Aides that included the following: A) Unit Manager, or designee, will be responsible for obtaining a completed referral form or encounter note from the appointment visit. For appointments/ER visits on occurring on weekends hall nurse will be responsible for obtaining and reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse. D) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record. E.) Any new admissions that admit with splints or current residents with new	

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F 684	Continued From page 7 tab "medications and treatments" when all other orthopedic information was found under the "consults" tab. The occupational therapy referral order was for the resident to be evaluated and to treat the right olecranon ORIF with ROM (range of motion), pain and edema control, modalities, and HEP (home exercise program). It was noted Resident #63 needed to wear the splint at all times except for hygiene purposes and gentle AROM (active range of motion) exercises 1 to 2 times weekly for 8 weeks. Nurse #7 was identified as the nurse assigned to Resident #63 on 12/26/24. Attempts to contact Nurse #7 for a phone interview were not successful. Resident #63's physician's orders for December 2024 were reviewed and found no order entered on 12/26/24. The DON stated in an interview on 4/7/25 at 3:50 PM that Resident #63 had a follow up appointment scheduled with the Orthopedic MD on 01/23/25 but Resident #63 was sick, and the appointment was rescheduled for 02/20/25 by the Transportation Aide. Nurse #2 wrote on 1/27/25 at 5:41 PM the resident's splint is intact to right arm with good "CNS" to fingertips. There were no documented nursing assessments of Resident #63's surgical site or Occupational Therapy notes entered in the medical record from 12/26/24 through 2/20/25. An Orthopedic Surgeon progress note dated 02/20/25 indicated Resident #63 was seen today	F 684	splints; the Unit Manager, or designee, will be responsible for ensuring residents have orders for splints. If no orders are present, the Unit Manager, or designee, will be responsible for obtaining splint orders from the provider. Unit manager, or designee, will be responsible for entering orders and ensuring all residents with splints have an order to check skin integrity underneath the splints. DON, or designee, will follow up in clinical meetings to ensure the process has been completed. The current facility Licensed Nurses and newly hired nurses not receiving education on 4/9/25 will not be allowed to work until the education has been completed. The DON will utilize an active employee list to track completion of education and validate the post education written test was completed and passed. This responsibility was communicated to the DON by the Administrator on 4/9/25. Education will also be included during orientation for newly hired facility Licensed Nurses, to be completed by Director of Nursing or Nurse Manager. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The DON/Designee will complete quality assurance monitoring of outside resident appointments/new admissions to ensure accuracy and all referral forms followed up on. Monitoring will be completed 5x per week during clinical meeting x 8 weeks, 3x per week x 6 weeks, then weekly x 4 weeks and as necessary thereafter.	

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F 684	Continued From page 8 for a follow-up of her right olecranon fracture. The Orthopedic Surgeon wrote that he last saw the resident on 12/26/24, the resident was supposed to come back 4 weeks after that appointment, and it had been almost 2 months since he last saw her. The progress note included the resident had been wearing the splint at night and the nursing aide with her said the resident had been taking it off during the day. Upon removing the splint, the Orthopedic Surgeon indicated he noticed a pressure wound over the medial aspect (area closest to the body) of the elbow with limited elbow range of motion. Resident #63 still had steri-strips on her elbow from the last visit with the Orthopedic Surgeon and he wrote that it concerned him as to the hygiene of this area and whether she had been spending time out of the splint to work with therapy. The Orthopedic Surgeon indicated he was discontinuing her splint device and ordered wound care for the medial elbow wound. Additionally, he wrote the medial elbow wound was far away from her surgical incision and did not appear infected. He indicated there was no concern for exposed hardware in her elbow and wanted to be called by the facility right away if it became infected. The Orthopedic Surgeon wanted to see the resident for an appointment on 3/26/25 at 10:30 AM. Medication Aide #1 was interviewed on 4/9/25 at 1:33 PM. She stated that she had been assigned to Resident #63 regularly in December 2024, January and February 2025. She stated she remembered Resident #63 had a splint on her right arm in December, January and February and she had never removed that splint and had never seen any other nurses or NA's remove the splint. The Medication Aide said the splint was black and went from the back of the resident's	F 684	The Director of Nursing will report the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance. Date of compliance is 4/15/25	

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F 684	Continued From page 9	F 684		

upper arm to her forearm and it had Velcro straps that held it in place. She stated she never noticed a smell and did not recall Resident #63 complaining of pain in her right arm.

Nurse #4 was interviewed on 4/09/25 at 1:50 PM. Nurse #4 worked was usually assigned to Resident #63 on night shift and had been assigned to the resident in December 2024 through April 2025. She stated she had never taken the splint off the resident and had not noticed the wound on her right arm smell. Nurse #4 stated she did check the capillary refill and circulation for the resident and that the resident never complained of pain. Nurse #4 stated her understanding was the splint was supposed to stay on Resident #63 because she did not see any orders for taking it off.

NA #5 was interviewed on 4/9/25 at 1:32 PM and stated she remembered Resident #63 having 2 different types of splints and that the resident was able to take off both. NA #3 stated she was instructed that the splint was to stay on at all times. NA #5 stated she had never noticed a smell from the residents wound and the resident was able to communicate if she was in any pain. NA #5 said Resident #5 would sometimes complain of pain and NA #5 would tell her nurse.

The Wound Nurse documented a progress note on 2/20/25 at 5:54 PM. The wound Nurse wrote Resident #63 had arrived back from her orthopedic office appointment. The resident had an elastic bandage wrap and cast padding on her right upper extremity after removing her splint. When splint was removed, the resident was noted to have a small open area to her right elbow measuring approximately 0.8 cm

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(centimeters) x 0.9 cm x 0.1 cm depth with rusty discoloration located around wound edges. There was mild serous drainage (wound discharge, clear to yellow in color) noted and the resident had complained of mild pain when palpation was performed that resolved once the stimulus was removed. Resident #63 was observed to also have hypergranulation tissue (overgrowth of healing tissue) above the ulcer as well. The Wound Provider was notified, and new orders were received from the Wound Provider.

The Wound Nurse stated during an interview on 4/9/25 at 10:11 AM that Resident #63 came back from the orthopedic appointment on 2/20/25 and the resident was not wearing her splint for the first time since it was placed on her. The Wound Nurse stated it was his first observation of the resident's surgical site. He stated he did call the Orthopedic Surgeon to get treatment orders for the wound and he also called the Wound Provider for treatment orders. The Wound Nurse said the Wound Provider ordered the wound to be treated with Dakin's solution (diluted bleach used to kill germs) to pat dry, cover the wound with a pad and cover with tape. The Wound Nurse said it was a daily treatment and as needed.

The Wound Provider's order written by the Wound Nurse on 02/20/25 read once daily, clean right elbow wound with quarter strength Dakin's and pat dry. Apply xeroform to wound bed and cover with a non-sticky pad. Wrap with kerlix (gauze bandage rolls) and secure with soft cloth surgical tape. Change daily and as needed.

The Wound Nurse progress note dated 2/25/25 at 5:24 PM read that he had reached out to the resident's Orthopedic Surgeon regarding the

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Wound Providers treatment recommendations and to schedule the residents 6-week follow-up appointment. The appointment was rescheduled for Thursday 02/27/2025 at 8:00 AM. The orthopedic office was updated regarding the Wound Providers current treatment recommendations and the current treatment regimen that was in place. The Wound Nurse wrote he had spoken to the triage nurse for the Orthopedic Surgeon who said a message would be transcribed to the Orthopedic Surgeon. The progress note read the Wound Nurse had attempted to reach out to the orthopedic office to get further clarification and a second message was sent to the Orthopedic Surgeon.

Resident #63 was first seen by the Wound Provider on 2/25/25. The Wound Provider noted the right elbow wound had full-thickness tissue loss overlying the olecranon. On examination, the surgical hardware was noted in the wound bed base and the wound site was reported to have developed secondary to a brace status post ORIF right olecranon. The Wound Provider indicated the wound was consistent with a medical device related stage 4 pressure injury (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) measuring 0.5 cm x 0.6 cm x 0.3 cm depth. The Wound Provider wrote the right medial elbow wound had full thickness tissue loss overlying the right medial epicondyle (bony prominence at the end of a long bone) with hypergranulation tissue present. The right medial elbow wound was reported to have developed secondary to a brace status post ORIF right olecranon and consistent with medical devise related stage 3 pressure injury measuring 0.8 cm x 0.8 cm x 0.2 cm depth.

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There were no signs of acute infection for any wounds. The treatment orders for the right medial elbow wound were from the Orthopedic Surgeon to cleanse the wound with normal saline, pat dry and apply xeroform to the wound bed. Then cover it with non-adherent pad and secure with rolled gauze wrap daily. The wound treatment orders for the right elbow wound with exposed surgical hardware were to loosely pack the wound with quarter strength Dakin's moistened gauze to provide topical antimicrobial control per Orthopedic Surgeons approval. The Wound Provider added she requested staff notify Orthopedic Surgeon of the hardware exposed in base of right elbow wound with the treatment recommendation above and requested for further evaluation per the Orthopedic Surgeon.

On 2/26/25, the Wound Provider wrote an order that read to cleanse right elbow wound with quarter strength Dakin's solution and pat dry. Loosely pack with a quarter strength Dakin's moistened gauze and cover with a non-adherent pad, wrap with kerlix. Secure with soft cloth surgical tape. Change daily and as need for soiling or dislodgement.

A physician order from the Orthopedic Surgeon on 2/26/25 indicated doxycycline hyclate (antibiotic) 100 mg twice daily by mouth for 21 days for medial elbow pressure wound.

A review of the treatment administration record (TAR) dated 02/20/25 to 02/28/25 found the wound treatment order for right elbow wound was initialed completed once daily on 2/21/25 through 2/26/25.

The right elbow wound treatment order written on

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02/26/25 were initialed as completed 02/26/25, 02/27/25 and 02/28/25 on the TAR.

A progress note dated 02/27/25 from the Orthopedic Surgeon indicated Resident #63 was seen for follow-up of her fractured right olecranon. Resident #63 was treated with open reduction and internal fixation on 12/13/24. The Orthopedic Surgeon wrote Resident #63 had seen him the previous week and was able to take her splint off and get her moving. The Orthopedic Surgeon noted he did not think Resident #63 had been moving much at the skilled nursing facility and her splint was still in place. Resident #63 returned to the clinic today at the Orthopedic Surgeon's request because he received a call from Resident #63's Wound Nurse who stated the medial elbow wound was healing but the wound over the posterior aspect of the elbow had opened up and you could see the plate at the bottom of the wound. The wound over the medial aspect was healing quite nicely and there was a small wound now present over the olecranon with some serosanguineous drainage (thin, pinkish, red drainage) coming from that wound. He wrote that he did think he saw Resident #63's olecranon plate in the base of the wound. The note included an order for doxycycline (antibiotic) 100 mg twice daily for 21 days prescribed on 02/26/25. The Orthopedic Surgeon wanted her to be seen again in 3 weeks. He wrote that the hardware might need to be removed if the wound did not heal up. The resident next appointment date was scheduled on 3/26/25 at 10:30 AM.

The Wound Provider saw Resident #63 on 3/4/25 and wrote in the progress note the right elbow wound had decreased in length and width with an increase in depth noted measuring 0.3 cm x 0.3

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cm x 0.4 cm depth. The Wound Provider wrote there was a decrease in overall wound volume and the exposed surgical hardware was present in wound bed base. The right medial elbow wound had measurements of 0.2 cm x 0.2 cm x 0.2 cm depth with a decrease in overall wound volume. The Wound Provider's treatment orders for the right elbow wound were to continue the treatment of normal saline cleanse to pat dry and apply xeroform to the wound bed. Additionally, to cover it with nonadherent pad and secure with rolled gauze wrap daily to provide topical antimicrobial control and to promote moisture balance. The treatment orders for the wound with exposed hardware were to continue treatment with loosely packing the wound with quarter-strength Dakin's moistened gauze. Then to continue with the current secondary treatment to provide topical antimicrobial control. The progress note included there were no signs of acute infection for any wound.

A physician's order dated 3/05/25 read clean posterior biceps wound with normal saline and pat dry. Apply xeroform (non-adhering wound dressing) to wound bed and cover with a nonstick pad. Wrap with kerlix and secure with soft cloth surgical tape. Change daily.

The Wound Provider progress noted dated 3/11/25 indicated right elbow wound with surgical hardware measured 0.3 cm x 0.4 cm x 0.2 cm depth and was healing. The Wound Provider noted there was a slight decrease in wound width with an increase in granulation tissue in the wound bed and the exposed surgical hardware was present in wound bed base. The wound did not have any signs of acute infection. It was documented that the right medial wound had

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been resolved. The wound treatment order for the right elbow wound was changed to a quarter-strength Dakin's irrigation, followed by loosely packing the wound with quarter strength Dakin's moistened gauze. Then to secure with silicone bordered super absorbent dressing daily to provide topical antimicrobial control.

A Wound Provider order dated 3/11/25 read cleanse right elbow wound with quarter strength Dakin's solution and pat dry and loosely pack with quarter strength Dakin's moistened gauze. Cover with a silicone bordered super absorbent dressing and change daily as needed.

The Wound Provider progress noted dated 3/18/25 revealed the right elbow wound with surgical hardware exposed measured 0.3 cm x 0.2 cm x 0.4 cm depth and the wound had not improved. The Wound Provider's note indicated the wound had signs of infection with moderate edema and mild seropurulent drainage present at the right elbow wound site. The Wound Provider additionally wrote there was no induration, no erythema, no odor, and no calor (warmth). Resident #63 did not have a fever on exam. The wound treatment orders were changed to quarter-strength Dakin's irrigation, followed by loosely packing the wound with Iodoform packing strip then secure the area with silicone bordered super absorbent dressing daily to provide topical antimicrobial control.

A Wound Provider order dated 3/18/25 read to irrigate the right elbow wound with quarter strength Dankins. Pat dry/ loosely pack wound with moistened quarter strength Dakin's gauze. Cover with a large gauze wound dressing and secure with rolled gauze and tape once daily and

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as needed.

A nurse's note written on 3/23/25 at 10:43 AM by the Wound Nurse read, new wound characteristics were observed with moderate seropurulent drainage (cloudy drainage) noted. The Wound Care Provider and attending Medical Director were notified. New orders were received for change in treatment, Ciprofloxacin (antibiotic) 500 mg twice a day for 10 days prophylaxis, and obtain a Complete Blood Count (CBC) with differential, Sedimentation Rate (Sed Rate), /C-Reactive Protein (CRP) on 03/24/2025. The TAR and MAR were updated, and orders were carried out as indicated. The Wound Nurse attempted to reach RP regarding new orders and current plan of care and was unable to reach or leave message.

The Physician's order dated 3/23/25 read irrigate right elbow wound with quarter strength Dakin's, Pat dry/loosely pack wound with moistened quarter strength Dakin's gauze. Cover with a large gauze wound dressing and secure with rolled gauze and tape once daily and as needed.

Physician's order dated 3/24/25 read Ciprofloxacin (antibiotic) 500mg twice a day for 10 days prophylaxis (preventative treatment for infection) and obtain CBC with diff/Sed Rate/CRP on 03/24/2025.

The Wound Nurse wrote on 3/24/25 at 1:25 PM that the orthopedic office was contacted regarding the change in wound characteristics and increased inflammation present with seropurulent drainage noted. The resident's vital signs were 98.3, 85 pulse, 20 respirations, 124/85 blood pressure, 96% oxygen saturation on room

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air with no shortness of breath present. Resident #63 had lab work obtained today and continues on by mouth antibiotic for prophylaxis wound infection.

A physician's order dated 3/25/25 read to irrigate right elbow wound with quarter strength Dakin's solution, pat dry/ loosely pack wound with moistened quarter strength Dakin's gauze. Cover with a large gauze wound dressing and secure with rolled gauze and tape twice daily and as needed.

The Wound Provider saw Resident #63 on 3/25/25 and wrote in the progress note that the right elbow wound with surgical hardware exposed measured 0.9 cm x 0.9 cm x 0.8 cm depth and the wound had not improved. The Wound Provider wrote there was a large amount of edema, induration (thickening and hardening of soft tissue) and moderate erythema (redness) was present in the elbow. The Wound Provider indicated there was a large amount of seropurulent drainage (indicates potential infection) present on exam with no odor noted. The resident was in moderate pain with the palpation of the wound and PRN (as needed) medication was requested and administered by nursing staff. The Wound Provider wrote to premedicate the resident for pain prior to wound care exam. The wound care treatment order was changed to quarter-strength Dakin's irrigation and loosely pack the wound with quarter-strength Dakin's moistened packing strip. The order continued with covering the area with super absorbent dressing and secure with rolled gauze wrap and tape BID (two times daily) to provide topical antimicrobial control.

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A Physician's order dated 3/25/25 read for right elbow wound to irrigate with quarter strength Dakin's, pat dry. Loosely pack wound with moistened quarter strength Dakin's gauze. Cover with and large gauze wound dressing and secure with rolled gauze and tape two times daily and as needed.

The Orthopedic Surgeon's progress note dated 3/26/25 and signed at 11:51 AM wrote Resident #63 returned to the clinic today. The facility had noticed over the past few days increasing redness, swelling and draining from her elbow wound. The Orthopedic Surgeon wrote the resident had developed an infection going down to her plate and in the olecranon bursa (small fluid filled sack at the tip of the elbow). The progress note indicated an x-ray was conducted and the Orthopedic Surgeon reviewed the x-ray and wrote he did not see any indication of osteomyelitis (infection of the bone) from the elbow's bony prominence. The Orthopedic Surgeon noted they should proceed to the operating room today for irrigation, debridement (removing dead damaged or infected tissue) and hardware removal. The Orthopedic Surgeon concluded this would allow the resident to be admitted to the hospital for IV (intravenous) antibiotics and postoperatively and for him to better provide treatment to the resident moving forward.

A nurse's note written on 03/26/25 at 1:30 PM by Nurse #3 indicated Resident #63 returned from her appointment at the orthopedic office with scheduled surgery for hardware removal today (03/26/25). The resident's responsible party was notified, and consent was given.

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Resident #63's hospital discharge summary dated 04/1/25 revealed Resident #63 was brought to the hospital on 03/26/25 for irrigation and debridement of her right elbow with hardware removal. A progress note dated 3/27/25 by the admitting hospitalist wrote Resident #63 was received from the orthopedic office with a swollen and erythematous (red and swollen) right elbow for emergent surgery on 3/26/25. Resident #63 was admitted postoperatively and given IV antibiotics for MRSA (Methicillin-Resistant Staphylococcus aureus). The hospital discharge summary dated 04/01/25 read Resident #63 was to receive PT or OT 2 to 4 days week. The resident will receive IV antibiotics via PICC (peripherally inserted central catheter, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart). The wound dressings were to remain until seen in Orthopedic Surgeons follow up appointment. The discharge summary included orders to assist with IV vancomycin 1 gram every 12 hours for wound and bone infection and end after 5/5/25. Additional orders read to assist with getting labs drawn every Monday for vancomycin trough, CRP, ESR, BMP, and CBC. Furthermore, the resident is to be non-weight bearing to operative arm and to follow-up with the Orthopedic Surgeon on 4/16/25 at 10:45 AM.

A nurse's note dated 04/01/25 written by Nurse #2 indicated Resident #63 was re-admitted to the facility on 04/01/25 at 2:20 pm. Resident #63 was sent to the hospital on 03/26/25 from the orthopedic office due to a right elbow infection. The resident was taken into emergency surgery for irrigation and debridement of her right elbow with hardware removal. Resident #63 was non-weightbearing to the right arm, splint was to

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remain in place and dry until follow-up, if splint got wet a call was to be made to the Orthopedic Surgeon immediately. Resident #63 had a midline port (Intravenous catheter inserted into the upper arm) placed in her right upper chest and received vancomycin (antibiotic) 1 gram every 12 hours until 05/8/25.

A physician order written on 04/01/25 for Resident #63 indicated vancomycin-diluent combo 1 gram/200 milliliters intravenous for right elbow methicillin-resistant Staphylococcus aureus (MRSA). Infuse over one hour with 200 milliliters per hour PICC to right chest, every 12 hours until 05/08/25.

Order written on 04/01/25 for splint to right upper extremity to remain in place until follow-up appointment on 4/16/25. Nurse to assess circulation to right upper extremity every shift.

A review of the April 2025 MAR found the order for assessing circulation to right upper extremity every shift was signed completed each shift.

Review of the medical record revealed Resident #63 was not seen by OT at the facility after the 12/26/24 order from the Orthopedic Surgeon until 04/02/25.

The Therapy Director was interviewed on 04/08/25 at 4:58 PM. She stated she did not receive a referral for Resident #63 to be evaluated or receive treatment until 4/2/25. She stated the splint on Resident #63's arm and elbow was not difficult to remove and was used to keep the elbow and arm stable. The Therapy Director said the splint device might have been able to be changed to another splint to allow for easier

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hygiene care with agreement from the orthopedic provider. The Therapy Director said had she seen a therapy referral for Resident #63, an occupational therapist would have been sent to evaluate the resident specifically for the need indicated on the referral. Resident #63's plan of care for therapy would then be developed for her treatment, and the resident's hygiene under the splint would have been done per the treatment order. The Therapy Director said hygiene for Resident #63's splint would include removing the splint and checking the skin for integrity or infection. She said soap and a washcloth would be used to clean the skin. Additionally, the Therapy Director said when the splint was removed the resident's range of motion and blood flow would be evaluated. The Therapy Director stated she felt Resident #63's range of motion and blood flow might have helped reduce the risk of a pressure wound from developing. She stated it was a collaboration between therapy and nursing to ensure the resident was receiving the care needed for the resident's therapy progression. The Therapy Director went on to say she received therapy referrals from outside providers in different ways such as progress notes or direct referral orders that would have been given to her by nursing. The Therapy Director stated she did think Resident #63 should have been seen by the therapist in the facility for range of motion and hygiene.

A follow-up interview with the Therapy Director occurred on 04/08/25 at 5:30 PM. She stated Resident #63 was last seen by therapy in September 2024 and had not been to therapy until 04/02/25. The Therapy Director stated that HEP as written on the 12/26/24 orthopedic referral meant for the resident to do exercises to

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help with range of motion. She stated Resident #63 had a diagnosis of dementia and would not have been able to do a HEP without assistance.

The DON verified in an interview on 04/07/25 at 3:50 PM that Resident #63 went to a follow-up orthopedic appointment on 02/20/25 and when the splint was removed by the Orthopedic Surgeon, he found a pressure wound under the splint. The DON stated the splint had not been removed from 12/26/24 to 2/20/25 because she thought the resident was not supposed to have the splint removed for any reason as reported to her by the transportation aide on 12/26/25. The DON indicated she saw the 12/26/24 orthopedic progress note but had not seen the referral order. She explained these were separate documents and they were scanned into the electronic medical record on different tabs. The DON stated she thought the orthopedic progress note indicating OT was for the orthopedic OT and not the facility's OT.

The DON stated in an interview on 04/09/25 at 1:57 PM that she was not aware of the orthopedic office referral order dated 12/26/24 for Resident #63 to receive occupational therapy 1 to 2 times per week for hygiene and active range of motion. The DON was first made aware of the referral order during the interview. The DON stated the order from the Orthopedic Surgeon should have been read and reviewed by the nurse who was working on 12/26/25 (Nurse #7) when the resident returned from the appointment, and the order should have been placed in Resident #63's chart in with other orthopedic information. The DON said normally, a referral from an outside provider was handed directly to her by the Transportation Aide or nurse for review and

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sometimes appointment information was given to medical records before the DON. Medical records would scan in the appointment progress notes and then give the hard copy to the DON or nurse. The DON thought the referral order was given to medical records, scanned in and not delivered to her or the residents nurse when Resident #63 returned 12/26/25. The Transportation Aide reported on 12/26/25 that the Orthopedic Surgeon told her the resident was not to remove the splint. The DON said orders are reviewed during each morning meeting, and did not recall any orders from Resident #63's orthopedic appointment on 12/26/24.

The Orthopedic Surgeon was interviewed via phone of 04/09/25 at 3:30 PM. He stated Resident #63 was his patient and had come to his office with a fractured right olecranon on 12/05/24 and had surgery to stabilize the fracture on 12/13/25. The Orthopedic Surgeon stated he saw Resident #63 on 12/26/24 for a follow-up appointment. He stated in his notes he ordered Resident #63's splint to be removed for hygiene and active range of motion therapy with occupational therapy in the resident's facility. The Orthopedic Surgeon said hygiene included removing the splint to look for skin breakdown and cleanliness. Additionally, he would not order an elbow splint to remain on the resident for 2 months because the elbow could become very stiff. He said Resident #63 had a diagnosis of dementia and needed assistance with the splint and was not able to advocate for herself. Resident #63 could not be relied on by herself to care for her splint which included removing it for hygiene and active range of motion. On 12/26/24 the Orthopedic Surgeon ordered Resident #63 to receive occupational therapy in her facility for

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active range of motion and hygiene for 1 to 2 times per week and the orders were sent to Resident #63's facility with the Transportation Aide. He said he recalled the resident having a Transportation Aide with Resident #63 at the appointments and he told her about the care Resident #63 needed along with his orders. He stated he reviewed his orders with the Transportation Aide before Resident #63 left her appointment with him. The Orthopedic Surgeon said Resident #63 was in a skilled nursing facility and should have been receiving occupational therapy as he ordered. The Orthopedic Surgeon went on to say the 2 wounds that developed on Resident #63's elbow could not be attributed directly to the splint that was not removed from 12/26/24 until 2/20/25. The elbow was susceptible to developing wounds with the comorbidities Resident #63 had and her advanced age. The Orthopedic Surgeon stated not removing the splint for hygiene and therapy did increase the risk for the resident to develop pressure wounds under the splint and infection. The splint could have been removed by nursing or therapy to check the skin daily.

The Medical Director was interviewed via phone on 04/08/25 at 4:46 PM. The Medical Director stated normally a copy of notes or orders from an outside provider would have been given to him to review by a nurse, the DON or placed in the doctor's book for him to review. The Medical Director said he did not recall seeing a consultation for an occupational therapist referral for Resident #63 from the orthopedic office in December 2024. The Medical Director went on to say the Orthopedic Surgeon's notes should have been reviewed by a nurse or the DON and then scanned into the electronic medical record for the

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resident. The Medical Director stated he expected orthopedic orders to be followed by the facility.

The Administrator was interviewed on 4/9/25 at 2:03 PM and stated the Orthopedic Surgeon referral orders from 12/26/24 should have been reviewed and the orders followed. The order for the resident to receive OT and hygiene should have been captured.

The facility's Administrator was notified of Immediate Jeopardy on 04/09/25 at 5:15 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 11/28/24 Resident #63 had an unwitnessed fall and was sent to the Emergency Room (ER) where she was diagnosed with a closed fracture of right olecranon (proximal end of elbow) process of ulna. Resident # 63 returned to the facility with a splint in place and had surgery (open reduction with internal fixation) on 12/13/24. On 12/26/24 Resident #63 returned to the orthopedic office for a follow up and returned to the facility with instructions for an Occupational Therapist Referral, long arm posterior slap splint. Instructions included: Needs to wear splint at all times except for hygiene purposes and gentle active range of motion purposes. The facility failed to follow the orthopedic recommendations for Resident #63 by not implementing removing Resident #63's splint for hygiene purposes and gently range of motion. Resident #63 was supposed to see the orthopedic doctor on

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01/23/25 but was sick and the appointment was rescheduled. On 02/20/25 Resident #63 returned to the orthopedic doctor's office. At the visit the splint was removed and a pressure ulcer over the medial aspect of the elbow with some limited range of motion was noted. On 2/20/25 wound nurse received orders from wound provider for wound care orders for resident #63. On 02/25/25 the Wound Provider evaluated the wound and determined that it was a Stage 3 and 4 pressure ulcer and the orthopedic hardware was exposed. The Wound Provider provided wound care orders and instructed the staff to notify the Orthopedic doctor. The Orthopedic doctor was notified and placed Resident #63 on antibiotic and continue daily wound care on 02/28/25.

On 03/26/25 Resident #63 required surgery to remove the exposed hardware and returned to the facility on 04/01/25 on intravenous (IV) antibiotic for Methicillin resistant staphylococcus aureus (MRSA) of the wound.
Because all residents with new orders and splints are at risk when a physician's order is not followed the following plan has been devised:
On 4/9/25 the Administrator and the Director of Clinical Services reviewed all resident orders with outside appointments in the past 90 days to ensure they were in place and correct. No new issues were identified.

On 4/9/25 the Wound Nurse completed a head-to-toe skin assessment on Resident #63 with no new skin issues noted.

On 4/9/25 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Wound Nurse completed an audit of all current facility residents with all pressure and

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non-pressure wound care and splint orders to ensure the correct physician ordered treatment was in place. All resident treatments and dressings were correct and matched the physician's order.

On 4/9/25 the Therapy Director completed an audit of all new admits in the past 30 days and current facility residents with therapy orders to ensure the correct physician ordered treatment was in place. All resident treatments were correct and matched the physician's order.

On 4/9/25 the Director of Clinical Services audited all new admits in the past 30 days and current residents with splints to ensure the order states to check skin integrity before and after applying splint. All residents had orders.

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

On 4/9/25 Regional Operator, Director of Clinical Services, the Director of Nursing, Assistant Director of Nursing, Unit Manager's, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review and determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the referral form was returned with Resident #63 on 12/26/24 but was not given to the nurse to review. Instead, it was placed in the Medical Record folder to be uploaded to the medical record. The recommendations for an Occupational Therapist referral and to take the splint off for hygiene and

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active range of motion were not implemented. To address the root cause the facility implemented education on who will be responsible for ensuring the referral form is brought back to the facility when a resident has an outside appointment so new recommendations or orders can be implemented. The Unit Manager will be responsible for ensuring the referral form returns with the resident. If it is the weekend or after the Unit Manager has left, the hall nurse will be responsible. The transporter will notify the Unit Manager the resident is back from the appointment and will give her any paperwork at that time. If there is no referral form the Unit Manager will call the physician office to obtain a copy of the form.

On 4/9/25, the Director of Clinical Services provided education to the Administrator, DON and ADON, and Transportation driver that included the following:
A) The transportation driver will notify the Unit Manager or hall nurse the resident has returned from the outside appointment, the Unit Manager will be responsible for obtaining a completed referral form or encounter notes from the appointment visit. For appointments/ER visits occurring on weekends the hall nurse will be responsible for obtaining and reviewing the referral.

B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy.

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C.) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed with any new orders entered into the medical record.

D.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse.

E.) On 4/9/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review.

F.) On 4/10/25 an all call was sent to facility residents Responsible Party's to notify the Unit Manager or Hall Nurse when signing the resident out for an outside physician appointment and to return any paperwork/referrals from the appointment to the Unit Manager or Hall Nurse.

G.) Any new admissions that admit with splints or current residents with new splints; the Unit Manager, or designee, will be responsible for ensuring residents have orders for splints. If no orders are present, the Unit Manager, or designee, will be responsible for obtaining splint orders from the provider. Unit manager, or designee, will be responsible for entering orders and ensuring all residents with splints have an order to check skin integrity underneath the splints. DON, or designee, will follow up in clinical meetings to ensure the process has been

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completed.

On 4/9/25 DON and ADON provided education to all facility Licensed Nurses and Nurse Aides that included the following:
A) Unit Manager, or designee, will be responsible for obtaining a completed referral form or encounter note from the appointment visit. For appointments/ER visits on occurring on weekends hall nurse will be responsible for obtaining and reviewing the referral.

B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy.

C.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse.

D) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record.

E.) Any new admissions that admit with splints or current residents with new splints; the Unit Manager, or designee, will be responsible for ensuring residents have orders for splints. If no orders are present, the Unit Manager, or designee, will be responsible for obtaining splint

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orders from the provider. Unit manager, or designee, will be responsible for entering orders and ensuring all residents with splints have an order to check skin integrity underneath the splints. DON, or designee, will follow up in clinical meetings to ensure the process has been completed.

The current facility Licensed Nurses and newly hired nurses not receiving education on 4/9/25 will not be allowed to work until the education has been completed. The DON will utilize an active employee list to track completion of education and validate the post education written test was completed and passed. This responsibility was communicated to the DON by the Administrator on 4/9/25. Education will also be included during orientation for newly hired facility Licensed Nurses, to be completed by Director of Nursing or Nurse Manager.

Effective 4/9/25, the Administrator and Director of Nursing will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 4/11/25

Onsite validation of the facility's immediate jeopardy removal plan was completed on 4/14/25. The facility's QAPI meeting to determine a root cause of the deficient practice was verified to be held on 4/9/25 and included the Administrator, Medical Director, DON, Dietary Manager, Social Worker, Therapy Director, MDS nurse, floor nurses, Regional Operations Manager, and Director of Clinical Services. The 4/9/25 audits were both verified as completed to include a review of all resident's appointment dates and

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F 684	Continued From page 32 locations from the past 90 days and the orders for therapy to ensure the correct physician ordered treatment was in place for all disciplines (PT, OT, ST). Splint and pressure or non-pressure wound care audits were completed and all provider's orders were included in the resident treatment orders. Education was conducted on 4/9/25 as indicated in the removal plan by the Director of Clinical Services to the Administrator, DON, Transportation Driver and ADON. An additional education note in the removal plan was conducted on 4/9/25 that included all licensed nurses and nursing aides. Education was verified as complete by reviewing the education signature sheet and staff interviews. The education included a test that each participant completed and passed, and each participant had signed completion and understanding of the education. Furthermore, the education was verified to be added to orientation for new hires. The immediate jeopardy removal date of 4/11/25 was validated.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		4/17/25

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F 686	Continued From page 33 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and Wound Care Consultant Nurse Practitioner (NP) interviews, the facility failed to obtain orders, and to provide treatment on admission for two mid-spine pressure ulcer wounds for 1 of 3 residents (Resident #61) reviewed for pressure ulcers. Finding included: Resident #61 was admitted to the facility on 3/15/25 with diagnoses which included aftercare following joint replacement surgery and unspecified dementia. The Admission Observation Detail report dated 3/15/25 at 3:37 PM by Nurse #1 revealed skin color normal, skin temperature warm, and skin moisture dry. Alterations in skin were noted as a surgical incision with the location as left shoulder wound vac. No other skin alterations were noted. An interview on 4/07/25 at 3:18 PM with Nurse #1 revealed she had completed Resident #61's Admission Observation Detail report and her admission skin assessment. She stated she left out the two mid upper spine wounds in error. She stated the resident had a dressing on her spine when she arrived at the facility, but she had not documented it. She also stated she was new to the facility and did not know if there were wound care standing orders. Nurse #1 stated she had replaced the wound dressing with the same dressing and then stated she did not remember providing wound care. She also stated that she	F 686	F686 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to document two wounds located on upper spine of resident #61 upon admission to facility on 03/15/25. The facility failed to obtain treatment orders from MD for the two wounds on upper spine for resident # 61 on 03/15/25. The wound nurse identified two wounds located on upper spine on 03/17/25 while conducting 2nd skin check. Wound nurse obtained MD orders on 03/17/25 but failed to transcribe the orders to begin on date of identification, resulting in treatment being initiated on 03/18/25. Facility failed to provide wound care for resident #61 for two wounds located on upper spine on the following dates 03/15/25, 03/16/25 and 03/18/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by this deficient practice. On 04/16/25 the Director of Nursing completed audit of the last 30 days of new admissions. Audit included documentation accuracy with focus on impairments of skin integrity upon admission, MD	

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F 686	Continued From page 34 had not notified anyone to obtain a wound care order on 3/15/25 or 3/16/25. Nurse #1 stated she had no specific reason she had not notified anyone to obtain a wound care order. Resident #61's care plan with start date of 3/15/25 revealed a focus that resident was at risk for skin breakdown related to impaired bed mobility and muscle weakness. Approaches included: assist resident with turning and repositing as needed and encourage weight shift while sitting up in chair. Resident #61's care plan with start date of 3/18/25 revealed another focus that resident had a pressure ulcer/injury to her mid upper back and mid upper lateral back which were both present on admission. Approaches included: consult wound provider as needed and assess the pressure ulcer for location, stage, size, presence/absence of granulation tissue and epithelization weekly. The Weekly Skin Check dated 3/17/25 at 8:00 AM completed by the Wound Care Nurse revealed new skin issues not currently being treated of two pressure ulcers to mid spine. Review of Physician's Orders revealed no wound care orders on 3/15/25, 3/16/25, or 3/17/25. The Wound Provider Evaluation and Management report dated 3/18/25 revealed 2 pressure ulcer wound areas: back mid and back mid lateral. The back mid pressure area measured 0.8 centimeters (cm) length and 1.2 cm width with a 0.3 cm estimated depth. The back mid lateral pressure area measured 1.3 cm length and 0.6 cm width and 0.3 cm estimated depth.	F 686	treatment orders current and in place accurately on day of identification. No variances found. On 04/15/25 Ad Hoc QAPI held to deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 04/16/25 the Director of Nursing provided education for all licensed nurses on accuracy of new admission skin assessments, to include documentation accuracy and obtaining MD treatment orders day of No employee was allowed to work until education provided. Education added to General Orientation for all licensed nurses and wound nurse. On 04/16/25 the Director of Nursing provided education to the Wound Care nurse on accuracy of order entry for wound treatment orders obtained from the MD. Orders are to be obtained and transcribed day of to ensure no delay in wound care treatment and/or documentation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete quality assurance monitoring of new admissions focusing on new	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK HEALTH AND REHABILITATION	455 VICTORIA ROAD ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 35 An order dated 3/18/25 read in part for mid spine wound and mid lateral spine wound, cleanse with normal saline, pat dry. Apply a petroleum dressing to wound bed and cover with a border dressing daily and as needed. Review of Resident #61 Treatment Administration Records for March and April 2025 revealed the daily wound care dressing changes had been signed as completed on 3/18/25 through 4/08/25. Resident #61's most recent Minimum Data Set (MDS) dated 3/21/25 indicated she was severely cognitively impaired and required moderate to maximum staff assistance for most activities of daily living. The MDS further indicated she had 2 unstageable deep tissue injury pressure ulcers that were present on admission. A wound care observation on 4/07/25 at 2:24 PM with the Wound Care Nurse revealed Resident #61 had 1 small mid spine pressure wound. The wound had a small amount of clear drainage, was pink around the edges with a yellow center. An interview on 4/09/25 at 9:14 AM with the Wound Care Nurse revealed he initially observed Resident #61's mid spine wound on 3/17/25, initiated wound care orders, and provided wound care. He stated there was some full thickness skin loss on the initial observation which is why he initiated wound care orders and referred the resident to the Wound Consultant Nurse Practitioner (NP). The Wound Care Nurse stated he had completed the spine wound care dressing changes on 3/17/25 but due to entering the physician's orders late, they did not trigger on the Treatment Administration Record and he had not signed them as completed that day.	F 686	admission skin observation to identify impairments in skin integrity to ensure any areas identified have appropriate wound treatment-initiated day of identification. Monitoring to also include any areas identified during second skin check have wound treatment initiated day of admission and/or identification. All new admissions will be audited 5x per week x 4 weeks, then 5 admissions per week x 6 weeks, then 5 admissions monthly x 3 months. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance. Date of Compliance: 04/17/2025	

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F 686	Continued From page 36 An interview on 4/08/25 at 11:25 AM with the Wound Consultant Nurse Practitioner (NP) revealed she had first assessed Resident #61 on 3/18/25 for her spinal wounds. She stated the mid spine wounds were currently improving, and she felt the resident had sustained no adverse effects from no treatment on 3/15/25 until 3/17/25. The NP stated that Resident #61's back mid lateral pressure wound had been resolved as of 4/01/25 and the resident currently had one spinal pressure wound. The Wound Provider report dated 4/08/25 read in part that the back mid spine pressure wound measured 0.8 cm length and 0.9 cm width with a 0.3 cm depth. Interviews on 4/07/25 at 3:37 PM with the Director of Nursing and the Administrator revealed skin assessments should be completed accurately on resident admission. The physician should be notified and treatment orders obtained for any admission pressure wounds. The Administrator stated Nurse #1 was new to the facility and did not know about wound care protocol orders.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/17/25

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F 761	Continued From page 37 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, the facility failed to secure medications when Nurse #2, Nurse #3, and Nurse #4 left medications at the bedside for 2 of 2 residents observed with medications at the bedside (Resident #78 and Resident #83). Findings included: 1. Resident #78 was admitted to the facility on 12/4/24. The quarterly Minimum Data Set (MDS) assessment dated 12/30/24 revealed Resident #78 was cognitively intact. There was not an assessment for medication self- administration documented in Resident #78's electronic medical record. On 4/6/25 at 9:56 AM an observation and	F 761	F761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure 3 out of 3 residents took their prescribed medication as per medication administration policy on 04/06/25. Medications were left at bedside for 3 out of 3 residents whom were alert and oriented and did not have a medication self-administration plan of care. Residents interviewed on 04/06/25 and denied the request to self- administer their prescribed medications. Medications were removed from bedside for 3 out of 3 residents on 04/06/25.	

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F 761	Continued From page 38 interview were completed of Resident #78 and his room. Resident #78 was observed lying in his bed with his bedside table positioned next to his bed. A medication cup was observed sitting on his bedside table containing multiple pills. He had a small plastic cup filled with water sitting next to the medication cup. Resident #78 stated the nurse always left his pills for him to take. Resident #78 placed the pills from the medication cup in his mouth and swallowed them using the water at his bedside. An interview was conducted on 4/6/25 at 12:18 PM with Nurse #2. Nurse #2 said she was the assigned nurse for Resident #78 and that she had administered his morning medications today. She reported she had left his medications with him because he was alert and oriented. Nurse #2 at first said she thought Resident #78 was able to self-administer his medications and had been assessed to self-administer his medication, but then Nurse #2 stated she had given Resident #78 his medications and thought he had taken them. She reported that she gave Resident #78 his medication, he said thank you, she went to prepare his roommates medications, and she assumed Resident #78 had taken his medications. Nurse #2 explained she did not see Resident #78 take his medications. She did not recall what medications she had given him but said it would have been all his scheduled morning medications on the medication administration record (MAR). Nurse #2 stated she should have stayed and watched to ensure Resident #78 had taken his medications. An interview was conducted with the Director of Nursing (DON) on 4/9/25 at 8:49 AM. The DON stated Nurse #2 should have stayed with	F 761	On 04/06/25 Medical Director notified by the Director of Nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by this deficient practice. On 04/06/25 a 100% audit was completed by the Director of Nursing and Assistant Director of Nursing for medications at bedside. No other variances identified. On 04/15/25 Ad Hoc QAPI held to deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 04/16/25 the Director of Nursing provided education to all licensed nurses and certified mediation aides on medication administration policy, no medications to be left at bedside. If at any time a resident would like to choose to self-administer the employee is to notify the DON/ADON so that the appropriate plan of care can be put into place. No employee was allowed to work until education provided. Education added to General Orientation for all licensed nurses and certified medication aides.	

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F 761	Continued From page 39 Resident #78 and watched while he took his medications. She reported Resident #78 had not been assessed to self-administer medications. The DON said medications should not have been left with Resident #78. She was not sure why Nurse #2 had left Resident # 78's medications at the bedside. An interview was conducted with the Administrator on 4/9/25 at 1:56 PM. The Administrator reported that the process for medication administration was for the nurse to ensure medications were administered and taken by the resident prior to the nurse departing from the room. She was not sure why Nurse #2 had left the medications at Resident #78's bedside. 2. Resident #83 was admitted to the facility on 1/13/25. The admission Minimum Data Set (MDS) dated 1/20/25 revealed that Resident #83 was cognitively intact. There was not an assessment for medication self-administration documented in Resident #83's electronic medical record. On 4/6/25 at 10:19 AM an observation and resident interview was conducted with Resident #83. The observation revealed a plastic medication cup with 5 pills and another plastic medication cup filled with yellow liquid medication on Resident #83's bedside table. Resident #83 stated that Nurse #5 came to his room that morning and gave him his pills and she was very impatient and kept asking him over and over to take his medication. Resident #83 took his pills and the yellow liquid medication during the interview.	F 761	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete quality assurance monitoring of medication administration with focus on medications at bedside. The audit will be as follows: 15 rooms 5x per week x 6 weeks, then 15 rooms 3x per week x 4 weeks, then 15 rooms monthly x 3 months. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance. Date of Compliance: 04/17/2025	

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F 761	Continued From page 40	F 761		

The Medication Administration Records (MARs) dated 3/9/25 through 4/8/25 did not list Nurse #5 as administering any medications to Resident #83 for the past 30 days.

A review of Resident #83's April 2025 MAR revealed an order for lactulose liquid 10 grams/15 milliliter for hepatic encephalopathy (liver failure) to be given at 12am, 6am, 12pm and 6pm. Further review of the MAR revealed Nurse #4 initialed the 6:00 AM dose as administered on 4/6/25.

On 4/7/25 at 5:15 PM a telephone interview was conducted with Nurse #4. Nurse #4 stated that she was instructed by nursing to make sure Resident #83 took his medications in front of her. Nurse #4 indicated she gave Resident #83 his lactulose. Nurse #4 was informed that the liquid medication was on his bedside table at 10:19 AM. Nurse #4 denied leaving the room without him taking the lactulose and could not state why the lactulose was observed on the bedside table.

Continued review of Resident #83's April 2025 MAR revealed the only time Resident #83 received 5 pills was in the morning. Nurse #3 initialed the following medications as administered on 4/6/26:

-furosemide 40 milligrams (mg) give 1 tablet at 9am for edema
-Nadolol 10mg give 1 tablet at 9am for hypertension
-neomycin 500mg give 2 tablets (1000mg) at 8am for hepatic encephalopathy (liver failure)
-spironolactone 100mg give 1 tablet at 9am for edema

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F 761	Continued From page 41	F 761		

On 4/6/05 at 12:36 PM an interview was conducted with Nurse #5. She stated that Resident #83 would argue with her about him wanting his medication left for him to take independently. Nurse #5 stated that there was no doctor's order to leave his medication at bedside. When Nurse #5 was assigned to Resident #83 in the past she would stay with him until he took his medications which could take as long as a half hour. Nurse #5 stated that she was not assigned to Resident #83 and Resident #83's nurse was Nurse #3.

On 4/6/25 at 12:43 PM an interview was conducted with Nurse #3. Nurse #3 stated that Resident #83 came to her in the hall to take his medications. The nurse stated she gave him his pills this morning and not the lactulose. Nurse #3 explained the lactulose would have been given to Resident #83 by Nurse #4. Nurse #3 was informed that an observation was made, and Resident #83 had a medication cup in his room with 5 pills and another medication cup with the lactulose on his bedside table. Nurse #3 denied going into Resident #83's room and then stated that Nurse #4 must have left the pills in his room.

On 4/8/25 at 10:45 AM a second interview was conducted with Nurse #3. She again stated that Resident #83 came to the medication cart in the hall to get his medications. She was unsure where the medications that were in his room came from and again stated it could have been the evening Nurse #4. Nurse #3 was informed that Resident #83 doesn't receive 5 pills in the evening. Nurse #3 stated again he came to her cart to get his medications on 4/6/25.

On 4/8/25 at 11:48 AM an interview was

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F 761	Continued From page 42 conducted with the Medical Director. He stated that Resident #83 was alert and was going to be discharged from the facility soon. The Medical Director stated that it was not the best practice to leave medications in a resident's room without the resident being assessed to take medications independently. Even though Resident #83 was alert and probably could take his medications independently he should not be doing this without an assessment. On 4/9/25 at 8:48 AM an interview was conducted with the Director of Nursing (DON). The DON stated that both Nurse #3 and Nurse #4 should have stayed with Resident #83 and observed him take his medications, unless Resident #83 was assessed to take his medications independently, which he was not. The DON said that medications should not be left with Resident #83. She was unsure why Nurse #3 and Nurse #4 left medications at his bedside. On 4/9/25 at 2:03 PM an interview was conducted with the Administrator. The Administrator stated that it was the nurse's responsibility to ensure the resident takes his or her medication before leaving the room. The Administrator was unsure why Nurse #3 and Nurse #4 left medications Resident #83's bedside.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		4/17/25

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F 812	Continued From page 43 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to remove expired food from 1 of 3 kitchen refrigerators (walk-in refrigerator) and remove food that was past the use by date on the packaging in the dry food storage area. The facility also failed to clean 3 of 3 food storage bin scoop holders and to label those bins with use by dates. These practices had the potential to affect food served to residents. Findings included: a. On 4/6/25 at 10:03 AM an observation in the walk-in refrigerator with the Dietary Manager (DM) found a sealed bag of pre-packaged chopped celery with a use by date of 3/31/25 located on the second shelf. The DM stated during the observation the celery should have been removed and had been overlooked by her. b. On 4/6/25 at 10:16 AM an observation with the DM in the kitchen found 3 large plastic storage bins on wheels with one labeled "flour", one labeled "sugar" and one labeled "rice". The bin	F 812	F 812 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to remove expired food from 1 of 3 kitchen refrigerators and remove food that was past the use by date in the dry storage area. The facility also failed to clean 3 of 3 food storage bin scoop holders and to label those bins with use by dates. The facility failed to date 4 loaves of bread that were removed from the freezer on 04/04/25 with used by date. On 4/06/25 the Dietary Manager disposed of the pre-packaged celery the refrigerator and the dry storage room. On 04/06/25 3 of 3 dry storage bins were emptied and cleaned which included the scoop holder. Dry storage bins were re-stocked with dry food, labeled with date	

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F 812	Continued From page 44 labeled sugar was located in the food prep area of the kitchen and was approximately 25% full. The sugar bin did not contain an open date or a use by date. The bin labeled flour and the bin labeled rice were found in the dry food storage area with each container approximately 50% full. The rice and flour bins were not labeled with an open date or use by date. Each bin had an attached scoop in a holder. Each bins' holder was observed to contain food debris and other debris in the bottom of the holder. The scoop was directly touching the bottom of each holder. The DM stated during the observation that the sugar, flour and rice were good for 30 days and needed to have a use by date label. She stated the scoop holders, and the bins were cleaned every 30 days when the contents had expired. The DM stated she was unaware the last time the bins had been cleaned. c. An observation with the DM in the dry food storage area on 4/6/25 at 10:23 AM found 4 loaves of bread with a use by date of 2/5/25 written on them. The DM stated during the observation the bread had been stored in the freezer and was taken out to be used on 4/4/25. The DM stated she did not realize the bread needed to be dated when removed from the freezer. The Administrator stated on 4/9/25 at 2:03 PM that expired food should have been disposed of when they expired. She stated the food storage bins needed to be dated with a use by date and should have been cleaned. The Administrator also said the bread in the dry storage room needed to dated when removed from the freezer.	F 812	filled and labeled with use by date. On 04/06/25 4 loaves of bread disposed of by the Dietary Manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected by this deficient practice. On 4/06/25 the Dietary Manager completed a 100% audit of food storage including refrigerators, freezers, and dry storage rooms to ensure all food was within usage dates, properly stored, labeled, and items were properly disposed of as identified. No employee was allowed to work until education was provided. On 4/15/25 an ad hoc QAPI was held to discuss deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 04/15/25 the Dietary Manager was educated by the Administrator on the expectation that when bread is pulled from the freezer it is to be dated upon removal from freezer. On 04/15/25 the Dietary Manager was educated by the Administrator on the expectation that the dry storage bins are	

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F 812	Continued From page 45	F 812		

to be labeled with date when filled and the date the contents are to be to used by. The cleaning of the bins occur when empty and/or the contents are out of date as per the label, the scoop storage holders are to be cleaned anytime the bins are re-filled and/or visibly soiled.

On 04/16/25 the Dietary staff were educated by the Registered Dietician on the following: Standard for labeling food with a “pull date” when pulled from the freezer. Monitor produce dates on arrival and daily, discard food that is outdated on the date it out dates. And the “Use By date procedures to ensure food has proper use by dates. Dry storage bins are to be labeled with date when filled and the date the contents are to be to used by. The cleaning of the bins occur when empty and/or the contents are out of date as per the label, the scoop storage holders are to be cleaned anytime the bins are re-filled and/or visibly soiled.

Indicate how the facility plans to monitor its performance to make sure solutions are sustained:
The Dietary Manager/designee will complete quality assurance monitoring of food labeling dates/use by dates to include storage bin labeling and cleanliness 5x week x 6 weeks, then 3x per week x 8 weeks, then monthly x 2 months.
The Dietary Manager will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetings

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F 812	Continued From page 46	F 812	and will make changes to the plan as necessary to maintain compliance. The date of compliance is 4/17/25	
F 825 SS=J	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Medical Director, and Orthopedic Surgeon interviews, the facility failed to communicate to the therapy department an Occupational Therapy (OT) referral ordered by Resident #63's Orthopedic Surgeon for evaluation and treatment of the resident's right olecranon (tip of the elbow). On 12/13/24 the resident underwent an open reduction internal fixation (ORIF) surgical procedure (involves making an incision to realign	F 825	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/26/24 the facility failed to communicate a therapy referral from an orthopedic provider for Resident #63 to have Occupational Therapy (OT) evaluate and treat the right elbow fracture. The	4/15/25

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F 825	Continued From page 47 the bone and then holding the pieces together with hardware like plates, screws, or rods). At Resident #63's follow-up appointment with the Orthopedic Surgeon on 12/26/24 he ordered OT for range of motion (ROM), pain and edema (swelling caused by a buildup of fluid) control, home exercise program (HEP), and splint wear with removal for hygiene purposes and active ROM exercises. Resident #63's splint was not removed until her 2/20/25 follow up appointment with the Orthopedic Surgeon and she was not evaluated by OT until 4/2/25. Resident #63 developed 2 pressure ulcers to the right elbow, she required surgery for an infection with removal of the previously inserted surgical hardware, and treatment with intravenous (IV) antibiotics. Resident #63 had a high likelihood of suffering serious harm as a result of this failure. This deficient practice affected 1 of 1 resident reviewed for therapy. Immediate jeopardy began on 12/26/24 when the facility failed to implement the OT referral that included splint removal placing Resident #63 at high risk for development of pressure wounds and infection. Immediate jeopardy was removed on 04/10/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #63 was admitted on 11/29/23 with diagnoses that included non-traumatic brain	F 825	referral also had recommendations for Resident #63 to wear the splint at all times except for hygiene purposes and gentle active range of motion exercise. Resident #63 was not evaluated by OT until 04/02/25. On 02/20/25 Resident #63 returned to the orthopedic doctor's office. At the visit the splint was removed and a pressure ulcer over the medial aspect of the elbow with some limited range of motion was noted. On 2/20/25 the Wound Nurse received new wound care orders from the wound provider for Resident #63. On 02/25/25 the Wound Provider evaluated the wound and determined that it was a stage 3 and stage 4 pressure ulcer and the orthopedic hardware was exposed. The Wound Provider instructed the staff to notify the Orthopedic doctor and provided new wound care orders. On 03/26/25 Resident #63 required surgery to remove the exposed hardware and returned to the facility on 04/01/25 on intravenous (IV) antibiotic for Methicillin resistant staphylococcus aureus (MRSA) of the wound. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Because all residents with new orders for referrals to therapy services are at risk when a physician's order is not followed the following plan has been devised: On 4/9/25 the Administrator and the Director of Clinical Services reviewed all resident orders with outside appointments in the past 90 days to ensure they were in	

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F 825	Continued From page 48 dysfunction, hypertension, anxiety, depression, and Alzheimer's disease. Resident #63's quarterly Minimum Data Set (MDS) dated 09/07/24 indicated she had severe cognitive impairment and required maximal assistance with upper body dressing and personal hygiene. Resident #63 did not have any pressure wounds and was not receiving any therapy. Resident #63's emergency department (ED) summary dated 11/28/24 revealed Resident #63 was brought to the ED after a fall and had a fractured her right olecranon. The discharge instructions indicated Resident #63 needed to see an orthopedic specialist within 10 days. A nurse's note dated 12/6/24 at 11:08 AM written by the Director of Nursing (DON) indicated Resident #63's responsible party had consented with the orthopedic group for the resident to have surgery on her right upper extremity (RUE) to repair her fracture on 12/13/24. Outpatient surgery had been scheduled with the surgery center and pre-operation orders were received. The hospital discharge instructions dated 12/13/24 indicated Resident #63 had surgery for open reduction internal fixation. The discharge instructions were to follow up with the Orthopedic Surgeon on 12/26/24, take pain medications as instructed, and she was to be non-weight bearing for operated limb (right upper extremity). An orthopedic progress note dated 12/26/24 indicated Resident #63 was seen for follow-up 2 week's status post open reduction internal fixation of a right olecranon fracture. The resident was	F 825	place and correct. No new issues were identified. No other referral orders for therapy were missing. On 4/9/25 the Therapy Director completed an audit of all current facility residents with therapy orders to ensure the correct physician ordered treatment was in place. All resident treatments were correct and matched the physician's order. Director of Nursing, Unit Manager's, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review and determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the referral form was returned with Resident #63 on 12/26/24 but was not given to the nurse to review. Instead, it was placed in the Medical Record folder to be uploaded to the medical record. The recommendations for an Occupational Therapist referral and to take the splint off for hygiene and active range of motion were not implemented. To address the root cause the facility implemented education on who will be responsible for ensuring the referral form is brought back to the facility when a resident has an outside appointment so new recommendations or orders can be implemented. The Unit Manager will be responsible for ensuring the referral form returns with the resident. If it is the weekend or after the Unit Manager has left, the hall nurse will be responsible. The transporter will notify the Unit Manager the resident is back from the appointment and	

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F 825	Continued From page 49 fitted with a custom fitted long arm posterior orthosis (an external device like a brace or a splint) for her right upper extremity by the orthopedic office occupational therapist. The occupational therapist indicated Resident #63 and her caregiver were educated on how to wear and provide care for the orthosis. The progress note indicated to contact the occupational therapy department if needed. The progress note included the goal for Resident #63 to be independent with wearing the orthosis and with its care and to follow surgical precautions with orthosis. The surgical incision was healing well along the posterior aspect of Resident #63's elbow. Gentle range of motion of the elbow did not cause any significant pain and she had stable alignment of her elbow status post open reduction internal fixation with olecranon plate. A signed Orthopedic Surgeon referral order dated 12/26/24 had been scanned into Resident #63's health record on 1/2/25 under the tab "medications and treatments" when all other orthopedic information was found under the "consults" tab. The referral order was for the resident to be evaluated and to treat the right olecranon ORIF with ROM, pain and edema control, modalities, and HEP (home exercise program). Resident #63 needed to wear the splint at all times except for hygiene purposes and gentle AROM (active range of motion) exercises 1 to 2 times weekly for 8 weeks. An Orthopedic Surgeon progress note dated 02/20/25 indicated Resident #63 was seen today for a follow-up of her right olecranon fracture. The Orthopedic Surgeon indicated he last saw the resident on 12/26/24, the resident was supposed to come back 4 weeks after that appointment,	F 825	will give her any paperwork at that time. If there is no referral form, the Unit Manager will call the physician office to obtain a copy of the form. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/9/25, the Director of Clinical Services provided education to the Administrator, DON, Transportation driver and ADON that included the following: A) The transportation driver will notify the Unit Manager or hall nurse the resident has returned from the outside appointment, the Unit Manager will be responsible for obtaining a completed referral form or encounter notes from the appointment visit. For appointments/ER visits occurring on weekends the hall nurse will be responsible for obtaining and reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record. D.) Nurse Aides that accompany a	

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F 825	Continued From page 50 and it had been almost 2 months since he last saw her. The progress note indicated the resident had been wearing the splint at night and the nursing aide with her said the resident had been taking it off during the day. Upon removing the splint, the Orthopedic Surgeon indicated he noticed a pressure wound over the medial (area closest to the body) aspect of the elbow with limited elbow range of motion. Resident #63 still had steri-strips on her elbow from the last visit with the Orthopedic Surgeon and he wrote that it concerned him as to the hygiene of this area and whether she had been spending time out of the splint to work with therapy. He wrote that he questioned if she still had surgical prep (anti-microbial agent used in preparation of a surgical site) on her hands and indicated she definitely had scaly skin in the area. The Orthopedic Surgeon indicated he was completely discontinuing her splint device and ordered wound care for the medial elbow wound. Additionally, he indicated the medial elbow wound was far away from her surgical incision and did not appear infected. He noted there was no concern for exposed hardware in her elbow and wanted to be called right away by the facility if it became infected. A nurse's note dated 2/20/25 at 5:54 PM written by Nurse #2 indicated Resident #63 had arrived back from her orthopedic appointment with an elastic bandage wrap and cast padding on RUE secondary to removal of her splint. When the splint was removed, Resident #63 was noted to have a small open area to her right elbow measuring approximately 0.8 cm (centimeters) x 0.9 cm x 0.1 cm depth with rusty discoloration located around wound edges and mild serosanguineous (cloudy fluid) drainage noted.	F 825	resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork, and the referral form, are returned to the Nurse Manger or hall Nurse. E.) On 4/9/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment, they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review. F.) Unit Managers, or designee will be responsible for taking any therapy referral orders for new admissions to the therapy department on the day of admission. On 4/9/25 DON and ADON provided education to all facility Licensed Nurses and Nurse Aides that included the following: A) Unit Manager, or designee, will be responsible for obtaining a completed referral form or encounter note from the appointment visit. For appointments/ER visits occurring on weekends, the hall nurse will be responsible for obtaining and reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends, the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) Nurse Aides that accompany a resident to an outside appointment are	

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F 825	Continued From page 51 The resident complained of mild pain when palpation (touched with hand) was performed but pain resolved once the stimulus was removed. Resident #63 was observed to have hypergranulation (healing tissue expanding beyond the wound) tissue above the ulcer. The Wound Provider was notified and new orders were received. The treatment administration record (TAR) was updated, and new orders were carried out. A physician order from the Orthopedic Surgeon on 2/26/25 indicated doxycycline hyclate (antibiotic) 100 milligram 2 times daily by mouth for 21 days for medial elbow pressure wound. A progress note dated 02/28/25 from the Orthopedic Surgeon indicated Resident #63 was seen for a follow-up of her fractured right olecranon. Resident #63 was treated with open reduction and internal fixation on 12/13/24. The Orthopedic Surgeon wrote Resident #63 had seen him the previous week and was able to take her splint off and get her moving. The Orthopedic Surgeon noted he did not think Resident #63 had been moving much at the skilled nursing facility and her splint was still in place. Resident #63 returned to the clinic today at the Orthopedic Surgeon's request because he received a call from Resident #63's Wound Nurse who stated the medial elbow wound was healing but the wound over the posterior aspect of the elbow had opened up and you could see the plate at the bottom of the wound. The wound over the medial aspect was healing quite nicely and there was a small wound now present over the olecranon with some serosanguineous explain fluid coming from that wound. He wrote that he did think he saw Resident #63's olecranon plate in the base of the	F 825	there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse. D) The DON will have a list of daily resident appointments and will follow up with the Unit Managers every day to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record. E.) On 4/9/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment, they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review. F.) Unit Managers, or designee will be responsible for taking any therapy referral orders for new admissions to the therapy department on the day of admission. The current facility Licensed Nurses and newly hired nurses not receiving education on 4/9/25 will not be allowed to work until the education has been completed. The DON will utilize an active employee list to track completion of education and validate the post education written test was completed and passed. This responsibility was communicated to the DON by the Administrator on 4/9/25. Education will also be included during orientation for newly hired facility Licensed Nurses, Nurse Aides, and Transportation drivers, to be completed by Director of Nursing or Nurse Manager. Indicate how the facility plans to monitor its performance to make sure solutions	

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F 825	Continued From page 52 wound. The note included an order for doxycycline antibiotic 100 milligrams twice daily for 21 days prescribed on 02/26/25. The Orthopedic Surgeon wanted her to be seen again in 3 weeks. He wrote that the hardware might need to be removed if the wound did not heal up. The Orthopedic Surgeon's progress note dated 3/26/25 and signed at 11:51 AM indicated Resident #63 returned to the clinic today. The facility had noticed over the past few days increasing redness, swelling and draining from her elbow wound. Resident #63 had developed an infection going down to her plate (surgical hardware) and in the olecranon bursa (a small, fluid-filled sac located at the olecranon). An x-ray was completed and the Orthopedic Surgeon reviewed the x-ray and wrote he did not see any indication of osteomyelitis from the elbow's bony prominence. The Orthopedic Surgeon went on to note they should proceed to the operating room today for irrigation, debridement and hardware removal. This will allow the resident to be admitted to the hospital for IV antibiotics and postoperatively and for him to better provide treatment to the resident moving forward. A nurse's note written on 03/26/25 at 1:30 PM by Nurse #3 indicated Resident #63 returned from her appointment at the orthopedic office with scheduled surgery for hardware removal today (03/26/25). The resident's responsible party was notified and consent was given. Resident #63's hospital discharge summary dated 04/1/25 revealed Resident #63 was brought to the hospital on 03/26/25 for irrigation and debridement of her right elbow with hardware removal. A progress note dated 3/27/25 by the	F 825	are sustained: The DON/Designee will complete quality assurance monitoring of outside resident appointments to ensure accuracy, and all referral forms followed up on. Monitoring of referral forms will be completed 5x per week during clinical meeting x 8 weeks, 3x per week x 6 weeks, then weekly x 4 weeks and as necessary thereafter. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetings and will make changes to the plan as necessary to maintain compliance. Date of compliance is 4/15/25	

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admitting hospitalist wrote Resident #63 was received from the orthopedic office with a swollen and erythematous (red and swollen) right elbow for emergent surgery on 3/26/25. Resident #63 was admitted postoperatively and given IV antibiotics for MRSA (Methicillin-Resistant Staphylococcus aureus). The hospital discharge summary dated 04/01/25 read Resident #63 was to receive PT or OT 2 to 4 days week. The resident will receive IV antibiotics via PICC (peripherally inserted central catheter, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart). The wound dressings were to remain until seen in Orthopedic Surgeons follow up appointment. The discharge summary included orders to assist with IV vancomycin 1 gram every 12 hours for wound and bone infection and end after 5/5/25. Additional orders read to assist with getting labs drawn every Monday for vancomycin trough, CRP, ESR, BMP, and CBC. Furthermore, the resident is to be non-weight bearing to operative arm and to follow-up with the Orthopedic Surgeon on 4/16/25 at 10:45 AM.

A nurses note dated 04/01/25 written by Nurse #2 indicated Resident #63 was re-admitted to the facility on 04/01/25 at 2:20 pm. Resident #63 was sent to the hospital on 03/26/25 from the orthopedic office due to a right elbow infection. The resident was taken into emergency surgery for irrigation and debridement of her right elbow with hardware removal. Resident #63 was non-weightbearing to the right arm, splint was to remain in place and dry until follow-up, if splint got wet a call was to be made to the Orthopedic Surgeon immediately. Resident #63 had a midline port (Intravenous catheter inserted into the upper arm) placed in her right upper chest and received

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vancomycin (antibiotic) 1 gram every 12 hours until 05/08/25.

A physician order written on 04/01/25 for Resident #63 indicated vancomycin-diluent combo 1 gram/200 milliliters intravenous for right elbow methicillin-resistant Staphylococcus aureus (MRSA). Infuse over one hour with 200 milliliters per hour PICC (thin tube inserted into a vein in the upper arm that extends into a larger vein leading to the heart) to right chest, every 12 hours until 05/08/25.

The medical record revealed Resident #63 was not seen by OT at the facility after the 12/26/24 order from the Orthopedic Surgeon until 04/02/25.

The DON verified in an interview on 04/07/25 at 3:50 PM that Resident #63 went to a follow-up orthopedic appointment on 02/20/25 and when the splint was removed by the Orthopedic Surgeon, he found a pressure wound under the splint. The DON stated the splint had not been removed from 12/26/24 to 02/20/25 because the Transportation Aide told her on 12/26/24 that the splint was not supposed be removed for any reason. The DON indicated she saw the 12/26/24 orthopedic progress note but had not seen the referral order. She explained these were separate documents and they were scanned into the electronic medical record on different tabs. The DON stated she thought the orthopedic progress note indicating OT was for the orthopedic OT and not the facility's OT.

The DON stated in interview on 04/09/25 at 1:57 PM that she was not aware of the orthopedic office referral order dated 12/26/24 for Resident #63 to receive occupational therapy 1-2 times per

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week for hygiene and active range of motion. The DON stated the order from the Orthopedic Surgeon should have been read and reviewed by the nurse who was working when the resident returned from the appointment (Nurse #7), and the order should have been placed in Resident #63's chart in with other orthopedic information. The DON said normally, a referral from an outside provider was handed directly to her by the Transportation Aide or nurse for review and sometimes appointment information was given to medical records before the DON. Medical records would scan in the appointment progress notes and then give the hard copy to the DON or nurse. The DON indicated she thought the referral order was given to medical records by the Transportation Aide because she was unaware of the order. She explained she thought this because the referral order was scanned in and not delivered to her or the resident's nurse when she returned to the facility because no one was aware of the order.

The Transportation Aide was not available for interview.

The Orthopedic Surgeon was interviewed via phone of 04/09/25 at 3:30 PM. He stated Resident #63 was his patient and had come to his office with a fractured right olecranon on 12/05/24 and had surgery to stabilize the fracture on 12/13/25. The Orthopedic Surgeon stated he saw Resident #63 on 12/26/24 for a follow-up appointment. He stated in his notes he ordered Resident #63's splint to be removed for hygiene and active range of motion therapy with occupational therapy in the resident's facility. The Orthopedic Surgeon said hygiene included removing the splint to look for skin breakdown

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and cleanliness. Additionally, he would not order an elbow splint to remain on the resident for 2 months because the elbow could become very stiff. He said Resident #63 had a diagnosis of dementia and needed assistance with the splint and was not able to advocate for herself. Resident #63 could not be relied on by herself to care for her splint which included removing it for hygiene and active range of motion. On 12/26/24 the Orthopedic Surgeon ordered Resident #63 to receive occupational therapy in her facility for active range of motion and hygiene for 1 to 2 times per week and the orders were sent to Resident #63's facility with the Transportation Aide. He said he recalled the resident having a Transportation Aide with Resident #63 at the appointments and he told her about the care Resident #63 needed along with his orders. He stated he reviewed his orders with the Transportation Aide before Resident #63 left her appointment with him. The Orthopedic Surgeon said Resident #63 was in a skilled nursing facility and should have been receiving occupational therapy as he ordered. The Orthopedic Surgeon went on to say the 2 wounds that developed on Resident #63's elbow could not be attributed directly to the splint that was not removed from 12/26/24 until 02/20/25. The elbow was susceptible to developing wounds with the comorbidities Resident #63 had and her advanced age. The Orthopedic Surgeon stated not removing the splint for hygiene and therapy did increase the risk for the resident to develop pressure wounds under the splint and infection.

The Therapy Director was interviewed on 04/08/25 at 4:58 PM. She stated she did not receive a referral for Resident #63 to be evaluated or receive treatment until 4/2/25. She

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stated the splint on Resident #63's arm and elbow was not difficult to remove and was used to keep the elbow and arm stable. The Therapy Director said the splint device might have been able to be changed to another splint to allow for easier hygiene care with agreement from the orthopedic provider. The Therapy Director said had she seen a therapy referral for Resident #63, an occupational therapist would have been sent to evaluate the resident specifically for the need indicated on the referral. Resident #63's plan of care for therapy would then be developed for her treatment, and the resident's hygiene under the splint would have been done per the treatment order. The Therapy Director said hygiene for Resident #63's splint would include removing the splint and checking the skin for integrity or infection. She said soap and a washcloth would be used to clean the skin. Additionally, the Therapy Director said when the splint was removed the resident's range of motion and blood flow would be evaluated. The Therapy Director stated she felt Resident #63's range of motion and blood flow might have helped reduce the risk of a pressure wound from developing. She stated it was a collaboration between therapy and nursing to ensure the resident was receiving the care needed for the resident's therapy progression. The Therapy Director went on to say she received therapy referrals from outside providers in different ways such as progress notes or direct referral orders that would have been given to her by nursing. The Therapy Director stated she did think Resident #63 should have been seen by the therapist in the facility for range of motion and hygiene.

A follow-up interview with the Therapy Director occurred on 04/08/25 at 5:30 PM. She stated

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Resident #63 was last seen by therapy in September 2024 and had not been to therapy until 04/02/25. The Therapy Director stated that HEP as written on the 12/26/24 orthopedic referral meant for the resident to do exercises to help with range of motion. She stated Resident #63 had a diagnosis of dementia and would not have been able to do a HEP without assistance.

The Medical Director (MD) was interviewed via phone on 04/08/25 at 4:46 PM. The MD stated normally a copy of notes or orders from an outside provider would have been given to him to review by a nurse, the DON or placed in the doctor's book for him to review. The MD said he did not recall seeing a consult for an occupational therapist referral for Resident #63 from the orthopedic office in December 2024. The MD went on to say the Orthopedic Surgeon's notes should have been reviewed by a nurse or the DON and then scanned into the electronic medical record for the resident. The MD stated he expected orthopedic orders to be followed by the facility.

The Administrator was interviewed on 4/9/25 at 2:03 PM and stated the Orthopedic Surgeon referral orders from 12/26/24 should have been reviewed and the orders followed. The order for the resident to receive OT and hygiene should have been captured.

The facility's Administrator was notified of Immediate Jeopardy on 04/09/25 at 5:15 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those residents who have suffered, or

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likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 12/26/24 the facility failed to communicate a therapy referral from an orthopedic provider for Resident #63 to have Occupational Therapy (OT) evaluate and treat the right elbow fracture. The referral also had recommendations for Resident #63 to wear the splint at all times except for hygiene purposes and gentle active range of motion exercise. Resident #63 was not evaluated by OT until 04/02/25. On 02/20/25 Resident #63 returned to the orthopedic doctor's office. At the visit the splint was removed and a pressure ulcer over the medial aspect of the elbow with some limited range of motion was noted. On 02/20/25 the Wound Nurse received new wound care orders from the wound provider for Resident #63. On 02/25/25 the Wound Provider evaluated the wound and determined that it was a stage 3 and stage 4 pressure ulcer and the orthopedic hardware was exposed. The Wound Provider instructed the staff to notify the Orthopedic doctor and provided new wound care orders. On 03/26/25 Resident #63 required surgery to remove the exposed hardware and returned to the facility on 04/01/25 on intravenous (IV) antibiotic for Methicillin resistant staphylococcus aureus (MRSA) of the wound.

Because all residents with new orders for referrals to therapy services are at risk when a physician's order is not followed the following plan has been devised:

On 04/09/25 the Administrator and the Director of Clinical Services reviewed all resident orders with outside appointments in the past 90 days to ensure they were in place and correct. No new

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issues were identified. No other referral orders for therapy were missing.

On 04/09/25 the Therapy Director completed an audit of all current facility residents with therapy orders to ensure the correct physician ordered treatment was in place. All resident treatments were correct and matched the physician's order.

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.

Director of Nursing, Unit Manager's, Minimum Data Set (MDS) Nurse, and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to review and determine root cause of the deficient practice. By root cause analysis, the QAPI committee determined that the referral form was returned with Resident #63 on 12/26/24 but was not given to the nurse to review. Instead, it was placed in the Medical Record folder to be uploaded to the medical record. The recommendations for an Occupational Therapist referral and to take the splint off for hygiene and active range of motion were not implemented. To address the root cause the facility implemented education on who will be responsible for ensuring the referral form is brought back to the facility when a resident has an outside appointment so new recommendations or orders can be implemented. The Unit Manager will be responsible for ensuring the referral form returns with the resident. If it is the weekend or after the Unit Manager has left, the hall nurse will be responsible. The transporter will notify the Unit Manager the resident is back from the

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appointment and will give her any paperwork at that time. If there is no referral form, the Unit Manager will call the physician office to obtain a copy of the form.

On 04/09/25, the Director of Clinical Services provided education to the Administrator, DON, Transportation driver and ADON that included the following:

A) The transportation driver will notify the Unit Manager or hall nurse the resident has returned from the outside appointment, the Unit Manager will be responsible for obtaining a completed referral form or encounter notes from the appointment visit. For appointments/ER visits occurring on weekends the hall nurse will be responsible for obtaining and reviewing the referral.

B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy.

C.) The DON will have a list of daily resident appointments and will follow up with the Unit Managers daily to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record.

D.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork, and the referral form, are returned to the Nurse Manger or

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F 825	Continued From page 62 hall Nurse. E.) On 04/09/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment, they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review. F.) Unit Managers, or designee will be responsible for taking any therapy referral orders for new admissions to the therapy department on the day of admission. On 04/09/25 DON and ADON provided education to all facility Licensed Nurses and Nurse Aides that included the following: A) Unit Manager, or designee, will be responsible for obtaining a completed referral form or encounter note from the appointment visit. For appointments/ER visits occurring on weekends, the hall nurse will be responsible for obtaining and reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends, the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) Nurse Aides that accompany a resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsible for ensuring any paperwork and the referral form are returned to the Unit Manager or hall Nurse.	F 825		

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D) The DON will have a list of daily resident appointments and will follow up with the Unit Managers every day to ensure all referral forms have been returned and reviewed, with any new orders entered into the medical record.

E.) On 04/09/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment, they are to follow up with the family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review.

F.) Unit Managers, or designee will be responsible for taking any therapy referral orders for new admissions to the therapy department on the day of admission.

The current facility Licensed Nurses and newly hired nurses not received education on 04/09/25 will not be allowed to work until the education has been completed. The DON will utilize an active employee list to track completion of education and validate the post education written test was completed and passed. This responsibility was communicated to the DON by the Administrator on 04/09/25. Education will also be included during orientation for newly hired facility Licensed Nurses, Nurse Aides, and Transportation drivers, to be completed by Director of Nursing or Nurse Manager.

Effective 4/09/25, the Administrator and Director of Nursing will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of Immediate Jeopardy Removal:

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F 825	Continued From page 64 4/10/25 Onsite validation of the facility's immediate jeopardy removal plan was completed on 4/14/25. The facility's QAPI meeting to determine a root cause of the deficient practice was verified to be held on 4/9/25 and included the Administrator, Medical Director, DON, Dietary Manager, Social Worker, Therapy Director, MDS nurse, floor nurses, Regional Operations Manager, and Director of Clinical Services. The 4/9/25 audits were both verified as completed to include a review of every resident's appointment dates and locations from the past 90 days and the orders for therapy to ensure the correct physician ordered treatment was in place for all disciplines (PT, OT, ST). Education was conducted on 4/9/25 as indicated in the removal plan by the Director of Clinical Services to the Administrator, DON, Transportation Driver and ADON. Additional education note in the removal plan was conducted on 4/9/25 that included all licensed nurses, nursing aides. Education was verified as complete by reviewing the education signature sheet and staff interviews. The education included a test that each participant completed and passed, and each participant had signed completion and understanding of the education. Furthermore, the education was verified to be added to orientation for new hires. The immediate jeopardy removal date of 4/10/25 was validated.	F 825		