STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105672	A. Building B. Wing	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide the necessary care and services to prevent the development and promote healing of advanced stage pressure ulcers for 3 of 11 sampled residents (Resident #55, #27, and #74) identified at risk for pressure ulcer development. Resident #55 was admitted on [DATE] with a stage 3 (full thickness tissue loss) pressure ulcer to the coccyx and was dependent on staff for all activities of daily living. The facility neglected to complete a thorough skin assessment upon admission. The pressure ulcer was not identified until 11/4/22 and the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The facility also failed to assess, obtain orders, and treat an additional in-house acquired pressure ulcer to the right inner knee identified on 11/8/22 and not treated until 11/15/22 for Resident #55. Resident #27 was readmitted to the facility on [DATE] after a surgical repair of a right [CONDITION(S)] and was dependent on staff for repositioning. The facility neglected to consistently implement preventive measures to prevent the development of an avoidable advanced stage pressure ulcer. On 11/4/22, the facility identified an infected pressure ulcer of the right heel. On 11/9/22, the wound care physician diagnosed an unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) right heel pressure ulcer with 100% thick necrotic (dead) tissue. The facility neglected to consistently implement the daily wound care and offload the area to promote healing. On 11/16/22, the wound care physician documented the wound had deteriorated. Resident #74 admitted on [DATE] and was at moderate risk for development of pressure ulcers and was dependent on staff for turning and repositioning. The facility failed to consistently offload the resident's heels, turn, and reposition the dependent resident. On 9/14/22 Resident #74 developed an avoidable unstageable pressure ulcer of the right heel requiring surgical debridement. The facility failed to consistently apply the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #55, #27 and #74 suffered serious harm from the development and/or worsening of pressure ulcers. The facility's failure to provide the necessary care and services to prevent the development and worsening of pressure ulcers resulted in a determination of Immediate Jeopardy at a scope and severity of isolated (J). (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified of the determination of Immediate Jeopardy on 11/17/22 at 1:17 p.m. The findings included: Cross reference to F686, F835 and F867. The facility's policy and procedure titled, Abuse, Neglect, Mistreatment And Misappropriation Of Resident Property with a date revised of 9/2019 noted, An .employee . of a nursing home shall not .mistreat or neglect a resident . Mistreatment means inappropriate treatment or exploitation of a resident . Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility's Policy and Procedure for the Prevention and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care . Nursing: Monitoring of skin integrity. Upon admission, all new residents will have the following orders in place: [brand name] No Sting Barrier Film liquid to bilateral heels every 3 days for 14 days. Offload bilateral heels while in bed. Air mattress for any resident with a Braden Scale of 14 or less . Nutrition. The Dietitian will be notified: If a resident is considered nutritionally at risk, upon the discovery of a wound, when a wound declined unexpectedly. 1. Review of the clinical record revealed Resident #27 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On 9/25/22 Resident #27 sustained a fall at the facility and was transferred to an acute care hospital for increased right hip pain. Resident #27 returned to the facility on [DATE] with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The Nursing Data Collection-Admission/Readmission form with an effective date of 10/3/22 noted the resident was at risk for skin breakdown. She was not able to reposition herself while lying in bed, or when sitting in a chair or wheelchair. Staff was to assist as needed with the repositioning. The Braden Scale (gold standard tool used for identifying pressure ulcer risk) completed on 10/3/22 by a Licensed Practical Nurse (LPN) noted a score of 14 indicative of moderate risk for pressure ulcer. The Significant Change in Status MDS (Minimum Data Set) assessment with a target date of 10/6/22 noted Resident #27 has severe cognitive impairment. The resident required extensive physical assistance of staff for bed mobility and transfer. The Care Area Assessment noted the resident triggered for pressure ulcer and it was addressed in the care plan. The MDS did not include a turning and repositioning program as part of preventive measures. The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . The clinical record did not include a rationale for discontinuing the air mattress. The MARs for October 2022 and November 2022 did not contain documentation the No Sting Barrier Film Liquid was applied to the resident's bilateral heels every three days for 14 days as per facility policy. On 11/9/22 at 7:09 p.m., the Director of Nursing (DON) said she did not know why the mattress was discontinued and it shouldn't have been. The DON also verified the facility failed to implement their policy and procedure and did not obtain an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The Certified Nursing Assistant (CNA) tasks list for October 2022 and November 2022 had instructions for a turning and repositioning program and encourage the resident to float heels while in bed each shift. On 10/7/22, 10/10/22, 10/22/22, 10/24/22, 10/28/22, 10/30/22 and 11/4/22 the turning and repositioning and encouraging the resident to float heels while in bed were noted as completed only once in a 24-hour period. On 11/4/22 Licensed Practical Nurse (LPN) Staff R documented on a nursing weekly skin check Resident #27 had a right heel pressure area, Open blistered area. has odor. On 11/4/22 the physician issued an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . He also ordered to use podus boots (helps in prevention and healing of heel ulcers) to offload heels while in bed. On 11/9/22 from 12:00 p.m. to 2:09 p.m., during multiple random observations, Resident #27 was observed in her room in a wheelchair wearing nonskid socks. Her heels were not offloaded and were pressing into the hard plastic footrests of the wheelchair. Resident #27 was not able to move her right leg upon command. On 11/9/22 at 2:12 p.m., LPN Staff FF said there was no measure to offload Resident #27's heels when she was out of bed. She verified the resident's heels were not offloaded and pressing into the hard plastic footrests of the wheelchair. She said, I questioned it this morning. Her heels are pressing on the footrests. She said not offloading the resident's heels in the wheelchair was a problem. On 11/9/22 at 2:36 p.m., the nurse obtained a physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/9/22 at 3:05 p.m., observation of Resident #27's right heel with the wound care physician revealed an advanced stage black, necrotic ulcer with moderate amount of drainage. The wound care physician said a resident with a broken hip, and immobile is at risk for developing a pressure ulcer. He said they should offload the heels in bed and out of bed. He said they cannot move, and they are in pain. They cannot rotate the leg. They may develop a pressure ulcer on the heel, ankle, lateral heel. They should have an orthotic device (device designed to protect an existing limb) in place in the wheelchair. The wound care physician said sometimes they develop a pressure ulcer despite all interventions, but you don't know until you try all interventions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/9/22 the wound care physician documented in a progress note Resident #27 had an unstageable (due to necrosis) pressure ulcer of the right heel, full thickness of duration greater than 10 days with moderate serous exudate and thick adherent devitalized necrotic tissue covering 100% of the wound. The physician performed a surgical excisional debridement (removal of dead tissue to promote wound healing) of the right heel. The recommendations included to offload wound. Reposition per facility protocol. Turn side to side and front to back in bed every 1-2 hours if able. On 11/9/22 at 7:09 p.m., the DON said she completed an investigation when Resident #27 developed the pressure ulcer. She said after looking at all the documentation, she concluded the pressure ulcer was avoidable. She said she did not consider it neglect since at the beginning, Resident #27 had all the interventions in place. She said the facility was using a lot of agency nurses and she had not educated them. She said she didn't know if all nurses were educated on pressure ulcer preventive measures. The DON said she did not look into why the air mattress was discontinued or why preventive measures, including applying the No Sting Barrier Film liquid were not implemented. On 11/14/22 at 9:30 a.m., Resident #27 was observed on her back in bed. She was not wearing the offloading boots and her heels were pressing onto a folded sheet placed on the air mattress. On 11/14/22 at 9:35 a.m., CNA HH said she was from a staffing agency and was assigned to care for Resident #27. She said she came on duty at 7:00 a.m. but has not had time to make rounds and see her assigned residents. She said she has not received any orientation before starting to work at the facility. She did not know where to get the information to safely care for the residents. She did not know what preventive measures needed to be in place for Resident #27. On 11/14/22 at 9:40 a.m., Registered Nurse (RN) Staff CC said she was assigned to care for Resident #27. She verified the resident has a pressure ulcer to the right heel. She said she normally gives report to the CNAs when they come in, but she has not given report to CNA BB assigned to Resident #27 and offered no explanation. She said the resident should have a pillow between her legs, so they don't touch the mattress, be careful so we won't bump her legs to anything, turn every 2 hours in bed. After looking at the Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/14/22 at 9:45 a.m., RN Staff CC verified Resident #27 was not wearing the offloading boots as ordered and said she didn't know why. On 11/14/22 at 12:00 p.m., Resident #27 remained on her back in bed. Observation of the dressing change with RN Staff CC revealed a dressing to the resident's right heel with a date of 11/11/22. The dressing bore RN Staff CC's initials. She said the dressing was the one she applied to the resident's right heel on 11/11/22. The soiled dressing was saturated with a large amount of malodorous bloody drainage. Review of the MAR for November 2022 showed RN Staff DD signed on 11/12/22 and 11/13/22 he performed the wound care as ordered to the resident's right heel. On 11/14/22 at 2:40 p.m., the Director of Nursing (DON) said, It's a huge issue if you are signing for things you didn't do, it's neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/22 at 3:15 p.m., RN Staff DD said in a telephone interview he may have made a mistake signing he completed the treatment on 11/12/22 and 11/13/22. He said he was only human and had a lot of work to do. On 11/16/22 at 4:20 p.m., the wound care physician said Resident #27's pressure ulcer was probably avoidable. On 11/16/22 the wound care physician wrote deteriorated on the wound progress section for the unstageable full thickness right heel pressure ulcer. Review of the Nursing Homes Federal Reporting website revealed on 11/15/22 the facility submitted an Immediate Report to the State Survey Agency for an allegation of neglect. The report read, It was noted by the floor nurse (name) RN during her rounds on 11/14/22 that the resident [Resident #27] had a dressing on her wound that was dated 11/11/22. This resident had treatment orders for daily dressing changes. Therefore, it was determined that the treatment was not completed for 2 days. However, the treatment was signed off as completed on the treatment record by nurse [RN Staff DD] on 11/12/22 and 11/13/22, although it was not completed. Review of the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/9/22 at 2:50 p.m., the Registered Dietitian said the nursing staff was supposed to document the percent of the supplement consumed. She said she looks in the clinical record to check if the resident is taking the supplement or not. She also asks the nurse if the resident is taking the supplements. She said the facility only notified her today (11/9/22) of Resident #27's pressure ulcer. Review of the MAR from 11/1/22 through 11/8/22 revealed the licensed nurses placed a check mark on the MAR indicated [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/11/22, RN Staff CC documented Resident #27 consumed 100% of the house shake at 9:00 a.m. and 5:00 p.m., and 50% of the house shake at 1:00 p.m. On 11/14/22 RN Staff CC documented Resident #27 consumed 100% of the house shake at 9:00 a.m. On 11/14/22 at 9:35 a.m., Resident #27's breakfast tray was observed and did not contain a house shake. On 11/14/22 at 12:15 p.m., Resident #27's lunch tray was observed and did not include a frozen nutritional supplement. On 11/14/22 at 12:20 p.m., RN Staff CC verified she documented the amount of supplement Resident #27 consumed on 11/11/22 and 11/14/22 at 9:00 a.m. She said the supplements come on the resident's meal trays. She said she documented the percentage consumed based on what the CNA reported but did not personally see the resident taking the supplements. On 11/14/22 at 12:50 p.m., the Certified Dietary Manager (CDM) provided a list of residents who received supplements on their meal trays. Resident #27 was not included in the list. She said the dietary department did not provide any supplement to Resident #27. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/22 at 1:05 p.m., Agency CNA EE said the resident did not receive any supplement with her breakfast or lunch meal. RN Staff CC present during the interview said it was a problem and she'll let the DON know about it. On 11/15/22 at 10:15 a.m., the Registered Dietitian (RD) said she needed an accurate report of the resident's meals and supplement intake for her assessments. She said it's been a struggle to obtain the wound report to implement adequate nutritional interventions for residents with pressure ulcers. She said she emailed her concerns to the administrative staff on 10/11/22. The RD provided a copy of an email dated 10/11/22 at 3:15 p.m., addressed to the Administrator, the DON and the CDM that read, Just wanted to let you know I have not received a wound report for several weeks. I am concerned that there may be pressure injuries that have not been addressed. She said the very next day she got a wound report but the next one she received was on 11/9/22. 2. Clinical record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The MAR for 10/1/22 through 10/13/22 noted Resident #55 had a stage 2 (partial thickness loss of tissue) pressure ulcer to the buttocks. Resident #55 was discharged to an acute care hospital on 10/13/22 and returned to the facility on [DATE]. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Agency for Health Care Administration form 3008) signed and dated 10/24/22 by a physician, revealed a skin assessment noting Resident #55 had a stage 3 (full thickness tissue loss) pressure injury to the buttock and a stage 1 (pressure related alteration of intact skin) pressure injury to the right buttock. The facility's Nursing Data Collection-Admission/Readmission Day dated 10/25/22 did not identify the presence of the existing pressure ulcer to the buttocks or the coccyx (tailbone). The form noted Resident #55 was Alert. Confused/Dementia/Alzheimer's. The resident was not able to reposition self while lying in bed or sitting. On 11/2/22, the Nursing Weekly Skin Check completed by a Registered Nurse (RN) noted Resident #55 had a pressure ulcer to the coccyx. The nurse answered No to the question Is this a new skin injury?. The clinical record lacked documentation of treatment to the existing pressure ulcer. On 11/4/22, RN Staff DD completed a skin check and documented a stage 2 (shallow open ulcer with a red, pink wound bed without dead tissue) pressure ulcer to the left, and right gluteal (buttock) fold. On 11/4/22, the wound care physician assessed and documented in a progress note Resident #55 had an unstageable (due to necrosis) pressure ulcer to the coccyx measuring 4.5 centimeters (cm) length by 3.7 cm width with moderate amount of serous exudate. The physician documented performing a surgical excisional debridement (removal of dead tissue) to establish the margins of viable tissue. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The physician issued an order to cleanse the coccyx wound, pat dry, apply Santyl (ointment to remove dead tissue), apply Alginate Calcium sheet (used on wounds with moderate to heavy drainage) and cover with boarded gauze dressing daily. There was no documentation the Santyl was applied to the wound as ordered until 11/7/22. The ordered dressing with Alginate Calcium sheet and boarded gauze dressing was not documented as implemented until 11/8/22. Review of the Nursing Homes Federal Reporting website revealed on 11/10/22 the facility submitted a report to the State Survey Agency substantiating the allegation of neglect. The report read, Resident has an unstageable wound that went untreated for [MEDICAL RECORD OR PHYSICIAN ORDER] . The report indicated the resident had a stage 3 pressure ulcer on his coccyx that was identified on the hospital documents upon readmission (on 10/25/22) but not documented by facility staff until 11/2/22. Resident was seen by the wound physician on 11/2/22 but treatment orders were not entered or initiated until 11/7/22. On 11/14/22 at 10:45 a.m., Resident #55 was observed in bed, on his back on an air mattress. A soiled dressing dated 11/11/22 was observed to the resident's right inner knee. On 11/14/22 at 10:55 a.m., observation of the resident's right inner knee with RN Staff CC revealed a stage 2 pressure ulcer with copious amount of greenish/brownish malodorous exudate. RN Staff CC said Resident #55 acquired the pressure ulcer to the right inner knee due to the resident's knees pressing against each other. She said there was no treatment order in place for the pressure ulcer to the right inner knee. On 11/14/22 at 5:15 p.m., the Director of Nursing (DON) presented the survey team with a single sheet of paper titled Skin check audit dated 11/8/22 handwritten by an LPN which noted Resident #55 had an abrasion to the right knee. She said she could not find documentation the physician was notified of the new pressure ulcer to obtain treatment orders. There was no documentation of an RN assessment to the new impaired skin integrity noted by the LPN on 11/8/22. On 11/16/22 at 4:20 p.m., the wound care physician said he had just assessed the resident's pressure ulcer to the coccyx. He said no one told him Resident #55 had an open area to the right inner knee. The wound care nurse, LPN Staff R, present during the interview said, I knew about it, but I didn't tell him (the wound care physician) because it's just an abrasion. On 11/16/22 at 4:30 p.m., the wound care physician assessed and diagnosed Resident #55 with a stage 2 pressure ulcer to the right inner knee with redness to the surrounding area. On 11/16/22 the wound care physician wrote on a progress note Resident #55 had a stage 2 partial thickness pressure wound of the right medial knee. The objective was healing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Review of the clinical record revealed Resident #74 was admitted on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #74 required extensive assistance of one person for bed mobility, transfers, and toileting. The MDS documented Resident #74 was at risk for pressure ulcer and had no pressure ulcers at the time the assessment was completed. Resident #74 had a Brief Interview for Mental Status score of 4 indicating severe cognitive impairment. The Braden Scale for predicting pressure sore dated 9/17/22 documented the risk score was 14, indicating Resident #74 was at moderate risk for developing a pressure wound. A review of Resident #74's clinical record revealed a care plan initiated on 9/7/22 identifying Resident #74 had skin concerns on both heels. The care plan interventions included to offload heels to decrease pressure. On 9/14/22, the Nurses Weekly Wound Documentation completed by the DON identified Resident #74 had a new onset, in-house acquired, stage 2 pressure wound to the right heel measuring 2.0 centimeters (cm) length by 2.0 cm width with 0.2 cm depth, with small amount of serosanguineous exudate. On 10/5/22 the wound care physician assessed and documented in a progress note Resident #74 had an unstageable (due to necrosis) pressure ulcer to the right heel measuring 2.3 centimeters (cm) length by 1.5 cm width with moderate amount of serous exudate. The physician documented performing a surgical excisional debridement (removal of dead tissue) to establish the margins of viable tissue. The wound care physician specified to offload pressure to the heels. The record showed a physician order [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/14/22 at 8:30 a.m., Resident #74 was observed in a wheelchair with grip socks. Her feet and heels were planted firmly on the floor and not offloaded to reduce pressure. There was no dressing noted on the right foot. Licensed Practical Nurse (LPN) Staff AA said she had not completed the scheduled wound care but would do it later in the day. On 11/14/22 at 12:30 p.m., the wound on Resident #74's heel was observed with LPN Staff AA. There was no dressing observed on the right heel to cover the resident's wound, exposing the wound to lint from the sock. LPN Staff AA said she had not removed any dressings from the resident's right foot. LPN Staff AA said she had not completed wound care yet. She said it was just Dakin's solution to the right heel, no dressing was required, the order was to just apply the solution to the wound. A heel protector was noted on the left foot, and there was none on the right foot. On 11/14/22 at 2:45 p.m., the Director of Nursing (DON) said she was ultimately responsible to make sure the wound care was carried out as ordered by the physician. On 11/15/22 at 8:30 a.m., Resident #74 was observed seated in a wheelchair in the activity room. Her feet were firmly planted on the floor, she had grip socks on, and her heels were not offloaded to decrease pressure. LPN Staff Q confirmed the resident's heels were not offloaded and there was no dressing covering Resident #74's right heel wound. Review of the Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . The reason provided was Dakin's Solution on order. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/15/22 at 9:00 a.m., LPN Staff Q said the Dakin's Solution was in the medication cart and retrieved it form the cart. LPN Staff Q said the pharmacy filled the Dakin's Solution on 11/7/22, the date written on the label. On 11/15/22 at 9:45 a.m., the DON said the process for wound care when an ordered treatment was not available, was the nurse was responsible to contact the physician and obtain an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The DON confirmed Resident #74 did not receive the physician ordered wound care on 11/4/22, 11/7/22, 11/12/22, and 11/13/22 and said there was no documentation the physician was notified the wound care was not provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record reviews, the facility failed to report to the State Agency, alleged violations which could constitute neglect, resulting in serious bodily injury for 2 (Resident #82 and #27) of 5 residents reviewed for falls. The findings included: The facility Mandatory Reporting policy revised 6/10/22 reads, All associates employed by Gulf Coast Village/Palmview are mandated by law to report any allegations or suspicion of abuse, neglect, exploitation or misappropriation to a vulnerable adult or child . Situations that are considered incidents which require immediate notification to the Executive Director/Resident Director and Risk Management include: Falls (witnessed/Unwitnessed) Incidents that require an immediate report . Fall with injury that requires significant treatment or possible significant injury (where there was a potential of abuse or neglect of care plan that was not followed). 1. Review of the incident and investigation report for Resident #82 dated 10/24/22 at 10:34 p.m., showed Resident #82 was found on the floor lying on his back fallen out of bed. The incident and investigation report noted Resident #82 was assessed, complained of a lot of neck pain, sent to the emergency room (ER) for evaluation. The resident's mental status was noted to be alert and confused. The incident and investigation noted the root cause was the resident got out of bed without assistance but could not say what happened. Resident #82 returned to the facility on [DATE] at 4:00 p.m. with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/16/22 at 10:10 a.m., the Administrator (AD) said she did not report this incident because they did everything possible for the resident, there was nothing else they could do. 2. Review of the incident for Resident #27 created on 9/25/22 at 5:13 a.m., showed, CNA found resident lying on the floor on the window side of the bed when she entered to do morning care. Resident #27 was sent to theER on [DATE] at 12:25 p.m., diagnosed and admitted with a fracture of unspecified part of neck of right femur. The report noted at the time of the incident, the resident was alert and oriented X 1 (Person). The incident and investigation report did not list steps completed to determine the root cause which was noted to be the resident did not ask for assistance. The investigation did not contain documentation the incident was reported to the State Survey Agency and Adult Protective Services in accordance with State laws as per regulation. On 11/16/22 at 5:03 p.m., the AD stated, I did not report as an adverse. There was nothing we could have done to prevent it, that's why we didn't report it. Further review of the clinical record revealed Resident #27 returned to the facility on [DATE]. The Nursing Data Collection-Admission/Readmission form with an effective date of 10/3/22 noted the resident was at risk for skin breakdown. She was not able to reposition herself while lying in bed, or when sitting in a chair or wheelchair. Staff was to assist as needed with the repositioning. (continued on next page)

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	105672	A. Building B. Wing	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Medication Administration Record [MEDICAL RECORD OR PHYSICIAN ORDER] . The clinical record did not include a rationale for discontinuing the air mattress. The Certified Nursing Assistant (CNA) tasks list for October 2022 and November 2022 had instructions for a turning and repositioning program and encourage the resident to float heels while in bed each shift. On 10/7/22, 10/10/22, 10/22/22, 10/24/22, 10/28/22, 10/30/22 and 11/4/22 the turning and repositioning and encouraging the resident to float heels while in bed were noted as completed only once in a 24-hour period. On 11/4/22 Licensed Practical Nurse (LPN) Staff R documented on a nursing weekly skin check Resident #27 had a right heel pressure area, Open blistered area. has odor. On 11/4/22 the physician issued an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . He also ordered to use podus boots (helps in prevention and healing of heel ulcers) to offload heels while in bed. On 11/9/22 the wound care physician documented in a progress note Resident #27 had an unstageable (due to necrosis) pressure ulcer of the right heel, full thickness of duration greater than 10 days with moderate serous exudate and thick adherent devitalized necrotic tissue covering 100% of the wound. The physician performed a surgical excisional debridement (removal of dead tissue to promote wound healing) of the right heel. The recommendations included to offload wound. Reposition per facility protocol. Turn side to side and front to back in bed every 1-2 hours if able. On 11/9/22 at 7:09 p.m., the DON said she completed an investigation when Resident #27 developed the pressure ulcer. She said after looking at all the documentation, she concluded the pressure ulcer was avoidable. She said she did not consider it neglect since at the beginning, Resident #27 had all the interventions in place. On 11/16/22 at 4:20 p.m., the wound care physician said Resident #27's pressure ulcer was probably avoidable.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, review of facility's policies, resident and staff interviews, the facility failed to provide the necessary care and services to maintain personal hygiene for 3 (Resident #1, #10 and #399) of 3 residents reviewed for activities of daily living (ADLs). The findings included: The facility policy Activities of Daily Living (ADL) revised October 2021 specified, Facility ensures a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene . When the facility has recognized and assessed an inability to perform ADL's, or a risk for decline in ability they have to perform ADL's, facility will: Develop and implement interventions in accordance with the residents assessed, needs, goals for care, preferences, and recognized standards of practice that address the identified limitations in ability to perform ADL. Monitor and evaluate the residents response to care plan interventions and treatment and revise the approaches as appropriate. 1. Review of Resident #1's Quarterly Minimum Data Set (MDS) (a tool used to gather resident information) Assessment with a reference date of 10/1/22 revealed documentation Resident #1 required limited physical assistance of one person for hygiene, and extensive physical assistance with bathing, transfers, toileting, dressing. The care plan initiated on 6/9/22 identified Resident #1 had preferences with her ADLs (activities of daily living) care and was not able to shower herself. The care plan instructed staff to assist the resident with showering. On 11/8/22 at 11:15 a.m., Resident #1 said she does not always get the assistance she needs with her ADLs. The resident said, I have not received my showers since I don't know when. I ask the CNA (certified nursing assistant) and they say they will be back to give it to me, but the CNA does not return. I would just like to feel clean. Review of the CNA documentation for October 2022 and November 2022 showed documentation Resident #1 was to receive showers on the morning shift every Tuesday, Thursday, and Saturday. The CNA documentation lacked documentation Resident #1 received her scheduled showers on 10/1/22, 10/4/22, 10/6/22, 10/8/22, 10/11/22, 10/13/22, 10/15/22, 10/18/22, 10/20/22, 10/22/22, 10/25/22,10/29/22, 11/1/22, 11/3/22, and 11/8/22. There was no documentation Resident #1 had refused the scheduled showers. On 11/8/22 at 12:13 p.m., CNA Staff L said Resident #1 did not refuse care and required some assistance with ADL's and bathing. CNA Staff L said, We help her, but she can do some things on her own, we just help her. She can't shower herself; we must help her. The CNA said once the care was completed, the showers were documented in the resident's electronic record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident #10's clinical record showed a quarterly MDS assessment with a reference date of 8/17/22 revealed the resident was dependent on staff for dressing, hygiene, and bathing. The MDS documented Resident #10 required supervision from staff with her meals. The care plan initiated on 2/12/22 documented Resident #10 required assistance with ADL's due to decreased mobility. On 11/8/22 at 9:16 a.m., Resident #10 was observed in bed with the breakfast meal in front of her. She had eaten a few bites of a pancake. A carton of [brand name for nutritional supplement], a container of juice and a carton of milk were observed unopened on the meal tray. Four unopened cartons of nutritional supplements and two unopened cups of juice were stored on the nightstand. On 11/8/22 at 9:20 a.m., Resident #10 said she asks for help from the staff but does not receive it. Resident #10 said she does not always get her showers. On 11/8/22 at 9:25 a.m., CNA Staff L entered the room and asked Resident #10 if she was finished with her meal and could remove the meal tray. Resident #10 said she had not started eating. CNA Staff L opened the carton of supplement and juice and began assisting the resident with the breakfast meal. The CNA said the breakfast meal was delivered to the unit at 7:30 a.m. and the resident required some assistance with her meal. On 11/9/22 at 11:27 a.m., the Registered Dietician (RD) said Resident #10 needed the dietary supplement. She said she was not aware the staff were not opening and assisting Resident #10 to drink the supplement. A review of the CNA documentation for October 2022 and November 2022 documented Resident #10 was to receive showers on the morning shift every Monday, Wednesday, and Friday. The documentation showed Resident #10 did not receive the scheduled showers on 10/3/22, 10/5/22, 10/7/22, 10/10/22, 10/14/22, 10/17/22, 10/19/22, 10/21/22, 10/24/22, 10/28/22, 10/31/22, 11/4/22 and 11/7/22. There was no documentation Resident #10 had refused the scheduled showers. On 11/9/22 at 10:46 a.m., Resident #10 said they gave her sponge baths with a cloth, but it was not the same as a shower. Resident #10 said even if they had to wheel her in there, a shower was just a good thing. On 11/9/22 at 11:09 a.m., the Director of Nursing (DON) said some resident records were completed on paper after the hurricane on 9/28/22. After reviewing the paper chart, the DON confirmed she was not able to locate any paper documentation that Resident #10 received her scheduled showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said all CNA documentation was completed in the electronic record, and if a resident refused a shower, it should be documented in the electronic record. 3. On 11/8/22 at 8:11 a.m., Resident #399 was observed in bed, unshaven with approximately a three-day beard growth. Resident #399 said he was not able to recall when he was assisted to shave. Resident #399 said he was not receiving his scheduled showers. The call light was observed under the bed and not within the resident's reach. On 11/8/22 at 2:10 p.m., Resident #399 was in bed. He remained unshaven; the call light remained on the floor out of reach of the resident. Resident #399 said often he was not able to get the call light because he had left sided weakness due to a previous stroke. He said he does not get the help he needs. He said he had asked the CNAs to shave and shower him, but they do not help him. He said he had requested but had not received a shower for several weeks. Review of Resident #399's clinical record revealed a quarterly MDS assessment with a reference date of 10/19/22, revealed Resident #399 was dependent on two-person physical assistance for bathing. The MDS specified the resident required extensive physical assistance of one with personal hygiene needs. The CNA Kardex (specifies care needs the resident requires), documented Resident #399's bathing preference was showers on the day shift on Monday, Wednesday, and Friday. A review of the CNA documentation for October 2022 and November 2022 showed Resident #399 did not receive a shower in October 2022. The showers were scheduled for 10/3/22, 10/5/22, 10/7/22, 10/10/22, 10/12/22, 10/14/22, 10/17/22, 10/19/22, 10/21/22, 10/24/22, 10/26/22, 10/28/22, and 10/31/22. The CNA documentation for November 2022 failed to show Resident #399 received his scheduled showers on 11/2/22, 11/4/22, and 11/7/22. There was no documentation the resident had refused the scheduled showers. On 11/8/22 at 4:30 p.m., CNA Staff J said Resident #399 was dependent for bathing and did not refuse care. The CNA said the resident required two-person assistance with bathing. CNA Staff J said the resident care provided was documented in the CNA charting in the electronic record. On 11/9/22 at 11:00 a.m., CNA Staff M said all the CNA charting is done in the computer, nothing is completed on paper. There is a shower schedule, and we follow it. If the resident refuses, we tell the nurse and document it. On 11/9/22 at 11:09 a.m., the Director of Nursing (DON) said she was not aware showers were not being provided as scheduled. The DON said all CNA documentation was in the residents' electronic record, and if a resident refused a shower, it should be documented in the electronic record.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of policies and procedures, and staff interview, the facility failed to provide the necessary care and services to prevent the development and worsening, and to promote healing of advanced stage pressure ulcers for 4 of 11 sampled residents (Resident #55, #27, #72 and #74) identified at risk for skin breakdown. Resident #27 was dependent on staff for turning and repositioning following a fall and fracture of the right femur. The facility failed to consistently offload the heels of the resident. On 11/4/22, the facility identified an avoidable, infected, advanced stage pressure ulcer of the right heel. On 11/9/22, the wound care physician diagnosed an unstageable (wound bed covered with dead tissue) pressure ulcer of the right heel with 100% necrotic (dead) tissue requiring surgical removal of the devitalized tissue. The facility failed to consistently implement the physician's orders to prevent the worsening of the pressure ulcer. On 11/16/22, the wound care physician documented the pressure ulcer had deteriorated. Resident #55 admitted on [DATE] and was dependent on staff for all activities of daily living including turning and repositioning. The facility failed to identify, assess, and obtain treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/4/22, the wound care physician diagnosed an unstageable 100% necrotic pressure ulcer to the coccyx (tail bone) requiring surgical debridement. On 11/8/22 the Licensed Practical Nurse (LPN) documented an abrasion to Resident #55's right knee. The area was not assessed or treated until 11/15/22. On 11/16/22, the wound care physician diagnosed a stage 2 (partial thickness loss of tissue) pressure ulcer to the right inner knee. Resident #74 admitted on [DATE] was at moderate risk for development of pressure ulcer and was dependent on staff for turning and repositioning. The facility failed to consistently offload the resident's heels, turn, and reposition the dependent resident. On 9/14/22, Resident #74 developed an avoidable unstageable pressure ulcer of the right heel requiring surgical debridement. The facility failed to consistently apply the physician ordered treatment and protective dressing to promote the healing of the in-house acquired advanced stage pressure ulcer. Resident #27, #55, and #74 suffered serious harm from the development and/or worsening of the pressure ulcers. The facility's failure to consistently ensure accurate assessment, implement preventive measures, treatments, and physician's orders timely resulted in a determination of Immediate Jeopardy at a scope and severity of isolated (J) beginning on 11/4/22. The Facility Administrator was notified of the determination of ongoing Immediate Jeopardy on 11/17/22 at 1:17 p.m. The findings included: Cross reference to F600, F835 and F867. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Body Audit Policy and Procedures with a revision date of 7/2022 indicated, To be completed on admission and weekly for all residents to identify any alterations in skin integrity. On admission the licensed nurse will complete the body audit/integumentary system section on the Admission Day/Data Collection form in the electronic health record. The licensed nurse will need to complete the Nursing Weekly Skin Check weekly thereafter . The Licensed Nurse completes a head to toe inspection of the skin with notation of any new alterations in skin condition on the electronic medical record . Communicate to Interdisciplinary Team, Physician . any changes in skin integrity . 1. Review of the clinical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #55 was discharged to an acute care hospital on 10/13/22 and returned to the facility on [DATE]. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Agency for Health Care Administration form 3008) signed and dated 10/24/22 by a physician revealed a skin assessment noting Resident #55 had a stage 3 (full thickness tissue loss) pressure injury to the buttock and a stage 1 (pressure related alteration of intact skin) pressure injury to the right buttock. The facility's Nursing Data Collection-Admission/Readmission Day dated 10/25/22 noted Resident #55 was Alert. Confused/Dementia/Alzheimer's. The resident was not able to reposition self while lying in bed or sitting. The licensed nurse completing the form did not document the presence of the existing pressure ulcer to the buttocks or the coccyx. On 11/2/22, the Nursing Weekly Skin Check completed by Agency Registered Nurse (RN) K noted Resident #55 had a pressure ulcer to the coccyx. The nurse answered No to the question Is this a new skin injury?. The clinical record lacked documentation of treatment to the existing pressure ulcer. On 11/4/22, the wound care physician assessed and documented in a progress note Resident #55 had an unstageable (due to necrosis) pressure ulcer to the coccyx measuring 4.5 centimeters (cm) length by 3.7 cm width with moderate amount of serous exudate. The physician documented performing a surgical excisional debridement (removal of dead tissue) to establish the margins of viable tissue. The physician issued an order to cleanse the coccyx wound, pat dry, apply Santyl (ointment to remove dead tissue), apply Alginate Calcium sheet and cover with boarded gauze dressing daily. There was no documentation the Santyl was applied to the wound as ordered until 11/7/22. The ordered dressing with Alginate Calcium sheet (used on wounds with moderate to heavy drainage) and boarded gauze dressing was not documented as implemented until 11/8/22. On 11/14/22 at 10:45 a.m., Resident #55 was observed in bed, on his back on an air mattress. His heels were not offloaded and were firmly pressing into the mattress. A soiled dressing dated 11/11/22 was observed to the resident's right inner knee. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/22 at 10:55 a.m., RN Staff CC verified the dressing to the resident's right inner knee was dated 11/11/22. Observation of the right inner knee wound with RN Staff CC revealed an open ulcer (stage 2) with copious amount of greenish/brownish malodorous exudate. RN Staff CC said Resident #55 acquired the pressure ulcer to the right inner knee due to the resident's knees pressing against each other. RN Staff CC said she would classify the pressure ulcer as a stage 1 (intact skin with non-blanchable redness) even though the wound was open and draining. Upon review of the clinical record, RN Staff CC said she could not find a physician's wound care order for the pressure ulcer to the right inner knee. On 11/14/22 at 5:15 p.m., the Director of Nursing (DON) presented the survey team with a single sheet of paper titled Skin check audit dated 11/8/22 in which a Licensed Practical Nurse (LPN) noted Resident #55 had an abrasion to the right knee. The DON said she just assessed the area to the resident's right inner knee as a stage 2 pressure ulcer. She said she could not find documentation the physician was notified of the new pressure ulcer to obtain treatment orders. On 11/15/22 at 7:40 a.m., Resident #55 was observed in bed, on his back with legs rotated to the right. The resident's heels were not offloaded and pressing firmly into a folded sheet placed on the air mattress. On 11/15/22 at 7:45 a.m., the Agency Nurse assigned to the resident said he could not help or answer any questions regarding Resident #55 as this was his first day working at the facility. On 11/15/22 at 7:45 a.m., Agency Certified Nursing Assistant (CNA) GG said she was assigned to Resident #55, and verified his heels were not offloaded. She said no one gave her report and she did not know how to care for the resident. On 11/15/22 at 8:00 a.m., the DON said approximately a year ago she implemented printing the Kardex (document that provides a summary and overview of the resident's care) and placing them inside the residents' closets. This way any staff member could answer call lights and it would be easier for agency staff to care for the residents. She said she did not know if the two agency CNAs on the unit today were aware of it. On 11/15/22 at 8:15 a.m., the DON verified the resident's heels were not offloaded and said they should have been. The DON verified the Kardex was in the closet and specified to elevate heels off the bed to maintain pressure relief. The Kardex also had instructions for the CNAs to re-educate/encourage on positioning in bed. On 11/15/22 at 8:20 a.m., Agency CNA GG said she did not know where to locate the Kardex and said, Maybe in the chart?. The DON was present during the interview. Review of the CNA documentation from 10/25/22 through 11/17/22, revealed instructions for the CNAs to encourage to turn and reposition in bed every two hours and as needed. There was no documentation the resident was encouraged or assisted to turn and reposition every two hours and as needed from 11/1/22 through 11/13/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/16/22 at 4:20 p.m., the wound care physician said he had just assessed the resident's pressure ulcer to the coccyx. The wound care physician said no one told him about an open area to the right inner knee. The wound care nurse Licensed Practical Nurse Staff R was present during the interview. She said she knew about the resident's wound to the right inner knee. She said, I knew about it, but I didn't tell him (the wound care physician) because it's just an abrasion. On 11/16/22 at 4:30 p.m., the wound care physician assessed Resident #55's right inner knee and said it was a stage 2 pressure ulcer with redness to the surrounding area. On 11/16/22 the wound care physician wrote on a progress note Resident #55 had a stage 2 partial thickness pressure wound of the right medial knee. The objective was healing. The facility's policy and procedure for the prevention and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care . Nursing: Monitoring of skin integrity. Upon admission, all new residents will have the following orders in place: [brand name] No Sting Barrier Film liquid to bilateral heels every 3 days for 14 days. Offload bilateral heels while in bed. Air mattress for any resident with a Braden Scale of 14 or less. The manufacturer's insert for the No Sting Barrier Film Liquid noted it was intended for use as a film-forming product that upon application to intact or damaged skin forms a long-[MEDICATION(S)] waterproof barrier, which acts as a protective interface between the skin. and friction and shear. 2. Review of the clinical record revealed Resident #27 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On 9/25/22, Resident #27 sustained a fall at the facility and was transferred to an acute care hospital for increased right hip pain. Resident #27 returned to the facility on [DATE] with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The Braden scale (gold standard tool used for identifying pressure ulcer risk) completed on 10/3/22 by an LPN noted a score of 14 indicative of moderate risk for pressure ulcer. The Nursing Data Collection-Admission/Readmission form with an effective date of 10/3/22 noted the resident was at risk for skin breakdown. She was not able to reposition herself while lying in bed, or when sitting in a chair or wheelchair. Staff was to assist as needed with the repositioning. The Significant Change in Status MDS (Minimum Data Set) assessment with a target date of 10/6/22 noted Resident #27 has severe cognitive impairment. The resident required extensive physical assistance of staff for bed mobility and transfer. The Care Area Assessment noted the resident triggered for pressure ulcer and it was addressed in the care plan. The MDS did not include a turning and repositioning program as part of preventive measures. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The physician's orders dated 10/3/22 included an air mattress to the bed for pressure ulcer prevention. Review of the Medication Administration Record (MAR) for October 2022 showed documentation the air mattress was applied on 10/3/22 and discontinued on 10/11/22. The clinical record did not include a rationale for discontinuing the air mattress. The MARs for October 2022 and November 2022 did not contain documentation the No Sting Barrier Film Liquid was applied to the resident's bilateral heels every three days for 14 days as per facility policy. On 11/9/22 at 7:09 p.m., the DON said she did not know why the mattress was discontinued and it shouldn't have been. The DON also verified the facility failed to implement their policy and procedure and did not obtain an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The Certified Nursing Assistant (CNA) tasks list for October 2022 and November 2022 had instructions for a turning and repositioning program and encourage the resident to float (offload) heels while in bed each shift. On 10/7/22, 10/10/22, 10/22/22, 10/24/22, 10/28/22, 10/30/22 and 11/4/22 the turning and repositioning and encouraging the resident to float heels while in bed were noted as completed only once in a 24-hour period. On 11/4/22 LPN Staff X documented on a nursing weekly skin check Resident #27 had a right heel pressure area, Open blistered area. has odor. On 11/4/22 LPN Staff X documented on an Incident-Post incident review form Resident #27 developed a pressure injury to the right heel. The form noted the resident was resting in bed and the nurse observed drainage to the bed linen. The clinical record lacked documentation of a Registered Nurse assessment of the right heel ulcer. On 11/4/22 the physician issued an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . He also ordered to use podus boots (helps in prevention and healing of heel ulcers) to offload heels while in bed. On 11/9/22 at 5:54 p.m., the Area Clinical Manager verified the lack of an RN assessment of the right heel pressure ulcer. She said it should have been communicated to the Nurse Manager who would have completed an assessment of the wound. On 11/9/22 from 12:00 p.m. to 2:09 p.m., during random observations, Resident #27 was observed in her room in a wheelchair wearing nonskid socks. Her heels were not offloaded and were pressing into the hard plastic footrests of the wheelchair. Resident #27 was not able to move her right leg upon command. On 11/9/22 at 2:12 p.m., LPN Staff FF said there was no measure to offload Resident #27's heels when she was out of bed. She verified the resident's heels were not offloaded and pressing into the hard plastic footrests of the wheelchair. She said, I questioned it this morning. Her heels are pressing on the footrests. She said not offloading the resident's heels in the wheelchair was a problem. (continued on next page)

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	105672	A. Building B. Wing	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Coast Village	1333 Santa Barbara Blvd Cape Coral, FL 33991

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/22, three days after the advanced stage pressure ulcer to the right heel was identified, the physician issued an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/9/22 at 1:35 p.m., the wound care physician said if a resident has a broken hip and is not able to move, preventive measures would include prevalon boots (help reduce the risk of bed sores by keeping the heel floated, relieving pressure), offload on pillows, cover bony prominences, cushions, even a low air loss mattress. On 11/9/22 at 2:36 p.m., the nurse obtained a physician's order to apply podus boots to offload Resident #27's heels while in bed and out of bed. On 11/9/22 at 3:05 p.m., observation of Resident #27's right heel with the wound care physician revealed an advanced stage black, necrotic ulcer with moderate amount of drainage. The wound care physician said a resident with a broken hip and immobile is at risk for developing a pressure ulcer. He said they should offload the heels in bed and out of bed. He said they cannot move, and they are in pain. They cannot rotate the leg. They may develop a pressure ulcer on the heel, ankle, lateral heel. They should have an orthotic device in place in the wheelchair. The wound care physician said sometimes they develop a pressure ulcer despite all interventions, but you don't know until you try all interventions. On 11/9/22 the wound care physician documented in a progress note Resident #27 had an unstageable (due to necrosis) pressure ulcer of the right heel, full thickness of duration greater than 10 days with moderate serous exudate and thick adherent devitalized necrotic tissue covering 100% of the wound. The physician performed a surgical excisional debridement of the right heel. The recommendations included to offload wound. Reposition per facility protocol. Turn side to side and front to back in bed every 1-2 hours if able. On 11/9/22 at 7:09 p.m., the DON said she completed an investigation when Resident #27 developed the pressure ulcer. She said after looking at all the documentation, she concluded the pressure ulcer was avoidable. She said the facility was using a lot of agency nurses and she has not educated them. She said she didn't know if all nurses were educated on pressure ulcer preventive measures. On 11/14/22 at 9:30 a.m., Resident #27 was observed on her back in bed. She was not wearing the offloading boots and her heels were pressing onto a folded sheet placed on the air mattress. On 11/14/22 at 9:35 a.m., CNA HH said she was from a staffing agency and was assigned to care for Resident #27. She said she came on duty at 7:00 a.m. but has not had time to make rounds and see her assigned residents. She said she has not received any orientation before starting to work at the facility. She did not know where to get the information to safely care for the residents. She did not know what preventive measures needed to be in place for Resident #27. On 11/14/22 at 9:40 a.m., RN Staff CC said she was assigned to care for Resident #27. She verified the resident has a pressure ulcer to the right heel. She said the resident should have a pillow between her legs, so they don't touch the mattress, be careful so we won't bump her legs to anything, turn every 2 hours in bed. She said she normally gives report to the CNA when they come in, but she has not given report to CNA HH assigned to Resident #27 and offered no explanation. After looking at the Medication Administration Record (MAR) RN Staff CC said Resident #27 was supposed to wear offloading boots in and out of the bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/22 at 9:45 a.m., RN Staff CC verified Resident #27 was not wearing the offloading boots and said she didn't know why. On 11/14/22 at 12:00 p.m., Resident #27 remained on her back in bed. Observation of the dressing change with RN Staff CC revealed a dressing to the resident's right heel with a date of 11/11/22 and RN Staff CC's initials. She said the dressing was the one she applied to the resident's right heel on 11/11/22. The soiled dressing was saturated with a large amount of malodorous bloody drainage. Review of the MAR for November 2022 showed RN Staff DD signed on 11/12/22 and 11/13/22 he performed the wound care as ordered. On 11/14/22 at 3:15 p.m., RN Staff DD said in a telephone interview he may have made a mistake signing he completed the treatment on 11/12/22, and 11/13/22. He said he was only human and had a lot of work to do. On 11/15/22 at 8:10 a.m., a joint observation with the DON of Resident #27's closet failed to reveal a Kardex available for staff to safely care for the resident. On 11/16/22 at 4:20 p.m., the wound care physician said Resident #27's pressure ulcer was probably avoidable. On 11/16/22 the wound care physician wrote deteriorated on the wound progress section for the in house acquired unstageable full thickness right heel pressure ulcer. 3. Resident #74 was admitted to the facility on [DATE] with [CONDITION(S)], hypertension, dementia, difficulty walking and muscle weakness, depression, and anxiety. The most recent Minimum Data Set (MDS) dated [DATE] showed Resident #74 had a Brief Mental Health Interview Score (BIMS) of 7 which indicated a severe cognitive deficit. A Nurses Weekly Wound Documentation dated 9/14/22 showed a new onset, stage 2 pressure ulcer to Resident #74's right heel. The wound measured 2 centimeters (cm) in length by 2 cm in width by 0.2 cm in depth. There were no further wound assessments documented until 10/5/22 (more than 3 weeks later). The nurses weekly wound documentation dated 10/5/22 showed the pressure ulcer to the resident's right heel had worsened to an unstageable pressure ulcer measuring 2.5 cm in length by 2 cm in width. On 10/10/22, five days after documentation of the worsening of the pressure ulcer, the physician ordered Santyl ointment (used to remove dead tissue) to be applied to the wound bed. The facility also had a two-week gap in assessing the wound from 10/19/22 to 11/3/22. On 11/9/22 at approximately 2:00 p.m., Resident #74's right outer heel was observed to have a round unstageable pressure ulcer measuring approximately 2.1 cm circumference. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/9/22 at approximately 7:00 p.m., the Director of Nursing (DON) said the facility had no additional wound documentation assessments. The DON verified Resident #74's pressure ulcer to the right heel had not been assessed weekly. The DON said the facility had identified the nurses were not completing the weekly wound assessments but provided no documentation of staff education or audits to ensure weekly completion of wound assessments. Resident #74's clinical record showed a physician order dated 11/3/22 to cleanse the right heel pressure ulcer with Dakin's solution (strong topical antiseptic) 1/4 strength wet to moist packing, apply border gauze dressing once daily for 16 days. Review of the MAR for November 2022 revealed the wound care was not provided 11/4/22, 11/7/22, 11/12/22, and 11/13/22. The reason provided was Dakin's Solution on order. On 11/15/22 at 9:00 a.m., LPN Staff Q retrieved the Dakin's solution dated 11/7/22 from the medication cart. LPN Staff Q confirmed the Dakin's solution was filled by the pharmacy on 11/7/22. On 11/15/22 at 9:45 a.m., the DON said the process for wound care when an ordered treatment was not available, was the nurse was responsible to contact the physician and obtain an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The DON confirmed Resident #74 did not receive the physician ordered wound care on 11/4/22, 11/7/22, 11/12/22, and 11/13/22 and said there was no documentation the physician was notified the wound care was not provided. Further review of Resident #74's clinical record revealed a care plan initiated on 9/7/22 to offload the resident's heels to decrease pressure due to skin concerns on both heels which identified Resident #74 had a skin concern on both heels. On 11/14/22 at 8:30 a.m., Resident #74 was observed in a wheelchair with grip socks on. Her feet and heels were planted firmly on the floor. There was no dressing noted on the right foot. Licensed Practical Nurse (LPN) Staff BB said she had not completed the scheduled wound care but would do it later in the day. On 11/14/22 at 12:30 p.m., Resident #74's right heel in-house acquired advanced stage pressure ulcer was observed with LPN Staff BB. The right heel ulcer was not covered with the border gauze dressing as per the physician's order, exposing the wound to the lint from the sock. LPN Staff BB verified the pressure ulcer was not covered with the physician's ordered dressing. She said she had not removed any dressing from the resident's right foot. LPN Staff BB said the wound care order was to just apply the Dakin's solution to the right heel and no dressing was required. On 11/14/22 at 2:45 p.m., the Director of Nursing (DON) said she was ultimately responsible to make sure the wound care was carried out as ordered by the physician. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/15/22 at 8:30 a.m., Resident #74 was observed seated in a wheelchair in the activity/day room. There was no dressing covering the resident's right heel pressure ulcer, and her heels were not offloaded. The resident was wearing grip socks and both her feet and heels were firmly planted on the floor. LPN Staff Q confirmed there was no dressing covering the right heel wound. 4. Review of the facility Policy and Procedure for the Prevention and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Significant Change Minimum Data Set (MDS) for Resident #72 with an assessment reference date of 8/21/22 revealed Resident #72 was at risk for developing pressure ulcers but did not have any unhealed pressure ulcers. Review of the Nursing Weekly Skin Checks dated 8/17/22, 8/24/22 and 8/31/22 indicated Resident #72 did not have any pressure ulcers to the coccyx area. Review of the Nursing Weekly Skin Checks dated 10/7/22 and 10/14/22 revealed Resident #72 had blanchable redness to the coccyx indicating no skin damage. Review of the Nursing Weekly Skin Check dated 10/21/22 revealed Resident #72 had a new (single) blister to the left gluteal fold described as a Purple/maroon area/blood blister. Review of the October 2022 Medication Administration Record (MAR) indicated a new treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of the Nursing Weekly Skin Check dated 10/28/22 revealed Resident #72 had two blisters, one to the right gluteal fold, and one to the left gluteal fold, Review of the Nursing Weekly Skin Check dated 11/4/22 revealed Resident #72 had blisters to bilateral buttocks. Review of the Initial Wound Evaluation and Management Summary dated 11/4/22 revealed Resident #72 was assessed by the wound care physician and had a (single) stage 2 pressure wound to the coccyx for at least 14 days. The new treatment plan for Resident #72 included collagen sheet (supports wound healing) apply once daily for 30 days; Alginate Calcium - apply once daily for 30 days; foam silicone border - apply once daily for 30 days. The Initial Wound Evaluation and Management Summary did not indicate Resident #72's pressure ulcer was unavoidable. Review of Resident #72's MARs from 11/4/22 through 11/9/22 did not include the new treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/7/22 at 11:15 a.m., during an observation, Resident #72 was in her room, lying in bed on her back, yelling out, My butt hurts and I don't know what to do about it. On 11/7/22 at 11:18 a.m., Resident #72 yelled out, My butt is on fire. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These complaints by Resident #72 were loud and could be heard in the hall. On 11/7/22 at 11:20 a.m., Licensed Practical Nurse (LPN) Staff Q entered Resident #72's room. On 11/7/22 at 11:23 a.m., Staff Q exited Resident #72's room and said she gave Resident #72 a pain medication and positioned her on her right side. On 11/7/22 at 11:25 a.m., Resident #72 was observed in bed, lying on her back. On 11/7/22 at 11:39 a.m., Resident #72 yelled, Help I want to move, but I can't move. On 11/7/22 at 11:41 a.m., Staff Q offered Resident #72 a drink of water. On 11/7/22 at 11:43 a.m., Resident #72 yelled, My butt is on fire. On 11/7/22 at 8:51 p.m., during a telephone interview, Resident #72's son said he was visiting his mother at the facility on Sunday, and she complained to him about her butt hurting. He said his brother told him she said it feels like her butt is on fire. On 11/8/22 at 8:11 a.m., observed Resident #72 in her room, in bed lying flat on her back. There were no pressure relieving pillows or devices on Resident #72's bed to relieve pressure on the coccyx. On 11/8/22 at 9:22 a.m., an observation of Resident #72's coccyx revealed a palm-size, purple-pink area of intact skin above the gluteal (buttocks) folds. Within this purple- pink area, there were two dime-size, open ulcers with red-pink wound beds. Staff Q applied barrier film swabs to the open ulcers. Resident #72 moaned during the application of the barrier film, and said the area was painful. On 11/8/22 at 9:42 a.m., Certified Nursing Assistant (CNA) BB said Resident #72 complains her butt is on fire when she cleans her. On 11/9/22 at 10:30 a.m., the Director of Nursing (DON) said the barrier film was part of the facility's wound care protocol for stage 2 pressure ulcers. She acknowledged the wound care physician saw Resident #72 on 11/4/22 for an initial wound care evaluation and ordered a new treatment plan for the stage 2 pressure ulcer. She acknowledged the new treatment order from the wound care physician of collagen sheets, Alginate Calcium, and foam silicone border had not been added to Resident #72's MAR and the resident would not be benefiting from the new treatment. On 11/9/22 at 12:31 p.m., the wound care physician confirmed he saw Resident #72 on 11/4/22 for an initial wound evaluation for a stage 2 pressure ulcer to the coccyx. The wound care physician said the facility uses a wound protocol including a barrier film he does not always agree with. He said the barrier film can sting even if it is the no-sting version and it has no healing properties. He said he would not use the barrier film if the wound was open. He said the new treatment he prescribed on 11/4/22 would promote healing to the Resident #72's stage 2 pressure ulcer of the coccyx. He said he was not aware the facility was not using the new treatment plan. The wound care doctor said he could not conclude Resident #72's pressure ulcer was unavoidable.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of the policies and procedures, and staff interview, the facility failed to evaluate and modify interventions to prevent avoidable accidents for 3 of 5 residents (Resident #82, #9 and #27) reviewed who were identified as being at risk for falls and sustained multiple falls at the facility, including falls with major injury. The failure to implement appropriate interventions to prevent falls and fall-related injuries resulted in Resident #82, #9 and #27 sustaining preventable falls, including falls with major injury requiring the residents to be transferred to a higher level of care. The findings included: The facility policy Fall Data Collection Policy and Protocol specified, All residents are assessed to identify risk for falls and individualized fall precautions will be developed on their care plan. Preventive measures shall be taken to decrease the number of falls whenever possible . All staff will be responsible for fall prevention and monitoring. 1. Review of the clinical record revealed Resident #82 admitted to the facility on [DATE] with diagnoses including [CONDITION(S)], cognitive communication deficit, and Alzheimer's disease. The Significant Change Minimum Data Set (MDS) with an assessment reference date of 9/20/22 documented Resident #82 scored a 14 on Brief Interview of Mental Status (BIMS), indicating intact cognition. Resident #82 required limited physical assistance of one for transfers and toileting. The Morse Fall Scale Data Collection (tool used to identify risk factors for falls) with an effective date of 8/28/22 noted Resident #82 was at high risk for falls. The form noted the resident had weak gait, stooped but able to lift head without losing balance, steps were short, resident may shuffle. The form also noted under mental status, Resident #82 knows own limits. The plan of care initiated on 5/14/22 identified Resident #82 was at risk for falls. The care plan also noted the resident had muscle weakness and reduced functional mobility related to left knee [CONDITION(S)] and effusion. The interventions included to anticipate and meet needs, be sure call light is within reach and encourage to use it for assistance as needed. Prompt response to all requests for assistance, keep needed items, water, etc., in reach, and make sure personal needs were met-pain, hunger, and toileting needs. A review of the facility's Incident Report and Investigation Report forms revealed Resident #82, from his admission on 5/13/22 to 10/24/22, had 14 unwitnessed falls including a fall with major injury on 10/24/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident report created on 6/9/22 at 5:35 a.m. noted Resident #82 was found in a crawling position around at 5:35 a.m., no injuries found. The incident and investigation report dated 6/9/22 said they took vital signs and started neurological (neuro) checks. The incident and investigation report did not document the timeline of the event and only one witness statement was obtained. The incident and investigation form noted Resident #82 was alert and confused. No new interventions were initiated to help prevent further falls. The incident report created on 6/9/22 at 6:53 p.m. noted Resident #82 was found on the floor beside the bed and the wall lying on his right side. The incident and investigation report noted staff assessed Resident #82 and transferred him back to bed. The incident and investigation report did not document a timeline of the event and included no witness statements. No new interventions were initiated to help prevent further falls. The incident report created on 6/17/22 at 5:48 p.m. noted Resident #82 was found on the floor in his room in between bed and wheelchair, was lying on his side. Resident #82 was assessed, denied hitting his head, but he was holding his head saying ouch. The resident was sent to the emergency room and returned the same day, everything negative. The incident and investigation did not document a timeline of the event or include any witness statements. No new interventions were initiated to help prevent further falls. The incident report created on 6/19/22 at 1:30 a.m. noted, CNA (Certified Nursing Assistant) called nurse to the room and found resident lying face down beside of the bed, patient said he lost his balance and tried to get back to bed but legs were too weak, so he lowered himself to the floor and put on the call light. The incident and investigation report noted, Resident #82 was assessed by nurse, vital signs taken, assisted back to bed, noted to have 2 small skin tears to left forearm, cleanse and bandage applied. He complained of bilateral hip pain, pain medication was given. The incident and investigation report included no witness statements, no timeline of the event, and no initiation of new interventions to help prevent further falls. The incident report created on 7/4/22 at 2:15 a.m. noted, Nurse heard resident yelling out in the hallway, nurse observed resident sliding out of his bed, he was then observed sitting on the ground. The incident and investigation report noted Resident #82 was assessed and no injuries were noted. Resident #82 denied any new pain but did admit to his chronic pain. Resident #82 was assisted back to bed, and pain medication was given. The resident said he was trying to go to the bathroom. An intervention was added to the fall care plan was to encourage toileting before meals and bedtime. The incident report created on 7/9/22 at 10:00 a.m. noted, CNA notified the nurse that resident was on the floor in the room lying on his left side. Resident #82 was assessed, his brief was wet and changed at this time, vital signs taken, no injuries noted. Resident was described as alert and confused. The incident and investigation report included no witness statements and no timeline of the event. The intervention added to the fall care plan on 7/13/22 was for therapy to place [brand name for non-slip mat] on wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident report created on 7/11/22 at 3:15 a.m. noted staff heard Resident #82 yell, went into room, and found resident on the floor. Resident #82 was assessed, and noted with laceration on the head and skin tear to left arm. The resident said he was trying to get out of bed. The incident and investigation report noted resident was sent to the emergency room (ER) for evaluation. The incident and investigation report had no witness statements and no timeline of the event. Resident #82 returned to the facility on [DATE] with two staples to a head laceration. No new interventions were initiated to help prevent further falls. The incident and investigation report dated 7/15/22 at 12:30 p.m. noted Resident #82 was found lying on the floor next to the window with a skin tear to the hand. The resident said he hit his head on the air conditioning unit, and [CONDITION(S)] (swelling) was noted to his scalp. The incident and investigation report noted nurses assessed Resident #82, assisted him into a wheelchair, cleansed, and dressed the skin tear, and neurological checks were initiated. Resident #82 was sent out to the ER for evaluation. The incident and investigation report had no witness statement. The resident returned to the facility the same day without injuries. New interventions added to the care plan on 7/18/22 (3 days after the fall) included for the resident to be relocated to the memory care unit and ensure staff do not leave unattended in the bathroom. The incident and investigation report dated 7/16/22 at 11:40 a.m. noted the nurse was notified by the resident's wife that the resident needed assistance. When the nurse went in the room, Resident #82 was on the floor. The wife said he started to lose his balance when he was on the toilet, and she lowered him to the floor. The incident and investigation report dated 7/16/22 noted nurse assessed resident no injuries noted, assisted by nurse and CNA to wheelchair. The incident and investigation report had no witness statements. No new intervention initiated until 7/18/22 to ensure staff do not leave unattended when in the bathroom. The incident and investigation report dated 7/30/22 at 4:30 p.m. noted, Wife notified the nurse that the resident was on the floor. The incident and investigation report noted the nurse assessed Resident #82. He complained of left leg and knee pain. The resident said he was walking to the bathroom and tripped over his feet. Resident #82 was sent to ER for evaluation. The incident and investigation report had no witness statements and no timeline of the event. The intervention added to the fall care plan on 7/31/22 was to ensure lights were on for good visibility. The incident and investigation report dated 8/3/22 at 7:17 p.m. noted Resident #82 was found on the floor outside of his bedroom. The incident and investigation report noted Resident #82 was assessed with no injuries observed. The incident and investigation report had no witness statement and no timeline of the event. An intervention added to the fall care plan on 8/4/22 was to evaluate for anti-roll back device to the wheelchair. The incident and investigation report dated 10/18/22 at 11:20 a.m. noted Resident #82 was found sitting on the floor next to the bathroom. The incident and investigation report noted Resident #82 was assessed and had no injuries. The incident and investigation report contained no witness statements. An intervention added to the fall care plan on 10/19/22 was resident has idiosyncratic ways of performing tasks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident and investigation report dated 10/24/22 at 12:37 p.m. showed Resident #82 was found on the floor face down. It was reported to the nurse by Physical Therapy the resident was asking for help to get him to the bed. Resident was unable to say what happened. The incident and investigation noted Resident #82 was assessed, was observed with bleeding to left forearm and bruise to his cheek. Resident #82 was sent out to ER for evaluation. The incident and investigation report dated 10/24/22 noted Resident #82 was alert and confused. Resident #82 returned to the facility on [DATE] at 4:47 p.m. No new interventions were initiated to help prevent further falls. The incident and investigation report dated 10/24/22 at 8:34 p.m. showed Resident #82 was found on the floor laying on his back. The incident and investigation report noted Resident #82 was assessed, complained of a lot of neck pain, and was sent out to ER for evaluation. Resident returned to facility on 10/25/22 at 4:00 p.m. with a cervical collar (provides motion restriction) and a diagnosis of C4 (cervical) fracture. No new interventions were initiated to help prevent further falls. On 11/16/22 at 10:10 a.m., the Administrator verified new interventions were not initiated for multiple falls. She said some of the interventions listed on the fall care plan had already been in place. 2. Review of the clinical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including dislocation of internal right hip prosthesis and unspecified dementia. The plan of care initiated on 12/4/21 identified Resident #9 was at risk for falls and had frequent falls. The interventions included to anticipate and meet the resident's needs, be sure the call light was within reach, and encourage the resident to use it for assistance as needed. Prompt response to all requests for assistance, keep needed items, water, etc., in reach, and making sure personal needs are met, pain, hunger, and toileting needs. The Quarterly Minimum Data Set (MDS) assessment with a reference date of 8/30/22 noted Resident #9's cognition was intact. Resident #9 required extensive assistance of two people for transfers and toileting. The Morse Fall Scale Data Collection with an effective date of 9/3/22 noted Resident #9 was at high risk for falls. Resident #9 had impaired gait, difficulty rising from chair, used chair arms to get up and bounced to rise, grasped furniture, person or aid when ambulating, and could not walk unassisted. The form also noted Resident #9 overestimated or forgot limit. A review of Resident #9's Incident Report and Investigation Report forms revealed Resident #9 sustained 14 unwitnessed falls from 12/4/21 to 11/11/22, including a fall with major injury on 2/11/22. The incident report created on 2/11/22 at 2:31 p.m. noted Resident #9 was found on the floor in his room. The resident said he was going to the bathroom to wash his hands and fell . The incident and investigation report noted Resident #9 was assessed, complained of right hip and leg pain, and was sent out to ER for evaluation. Resident #9 was diagnosed with a dislocation of the right hip. The incident and investigation report noted Resident #9 was alert and confused. The form had no witness statements and no timeline of the event. There were no new interventions initiated to help prevent further falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident report created on 2/27/22 at 6:20 p.m. noted Resident #9 was heard calling for help. Staff went to check and found the resident on the floor. He had been trying to reach the TV controller that fell on the floor. The incident and investigation report noted Resident #9 was assessed, complained of right hip pain, and was sent out to ER for evaluation. The incident and investigation report had no witness statements and no timeline of the event. Interventions put in place on 2/28/22 were to encourage the resident to use the call light and wait for assistance, have his remote close for easy access. Therapy was to screen the resident for the use of a reacher (helps to grab out-of-reach items). A reacher was provided to the resident on 3/2/2022. On 11/15/22 at 7:05 p.m., an observation of Resident #9's room failed to reveal a reacher. Resident #9 could not recall having a reacher. The incident report created on 3/14/22 at 4:00 a.m. showed Resident #9 was found on the floor between the two beds, lying on his back with no reports of pain. The incident and investigation report noted Resident #9 was assessed and no injuries noted. The incident and investigation form had no witness statements. Interventions put in place on 3/15/22 were for staff to ensure the bed was at appropriate height, and staff to offer toileting throughout HS (bedtime) during periods of restlessness. The incident report created on 4/5/22 at 5:50 p.m. noted a CNA found Resident #9 with upper body on the floor and legs over the mattress, called the nurse to assist. The incident and investigation report noted Resident #9 was assessed, vital signs taken, and assisted back to bed, no injuries noted. The incident and investigation report had no witness statements, and no new interventions were initiated to help prevent further falls. The incident report created on 4/7/22 at 3:00 a.m. noted staff found Resident #9 coming off the bed, had thrown the linen on the floor, mattress was halfway out. The incident and investigation report documented Resident #9 was assessed, assisted back to bed, no injuries noted. The incident and investigation had no witness statements, and no new interventions were initiated to help prevent further falls. The incident report created on 6/5/22 at 3:29 p.m. showed a CNA notified the nurse Resident #9 was on the floor. The nurse went to the room and found the resident lying on the right side on the floor. The incident and investigation report noted Resident #9 was assessed, said he was trying to reach the nightstand, slid, and hit his head on the nightstand. Resident #9 was sent out to ER for evaluation and returned to the facility with a negative Computerized Tomography (CT) scan of the head. An intervention added to the fall care plan on 6/8/22 (three days after the fall) was for therapy to screen for bolsters (long cylindrical cushion). The incident report created on 6/22/22 at 2:30 p.m. showed a CNA reported to the nurse Resident #9 was on the floor. The nurse went into the room and found Resident #9 on his back. The resident said he tried to reach for his water on the table and slid. The incident and investigation report dated 6/22/22 noted Resident #9 was assessed, assisted back to bed, and no injuries noted. The incident and investigation report had no witness statements. An intervention added to the fall care plan on 6/23/22 was U/A (urinalysis) sample for a urinary tract infection. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The incident report created on 6/23/22 at 3:00 a.m. showed Resident #9 was found sitting on the floor at a 90-degree angle with his back supported on the bed. Resident #9 said he was trying to get up. The incident report had no witness statements and no new fall interventions. The incident report created on 6/30/22 at 1:55 a.m. showed Resident #9 was found on the floor on the right side, complained of right sided soreness and pain. The nurse administered pain medication. The incident and investigation report noted Resident #9 was assessed, no injuries noted. The care plan had no new interventions. The incident report created on 10/6/22 at 7:33 p.m. noted Resident #9 was on the floor. The nurse went in and found the resident lying on his back next to the bed. The incident and investigation report noted nurse assessed Resident #9 with no visible injuries noted. Resident #9 said he hit his head and was sent to the ER for evaluation. No new interventions were initiated to help prevent further falls. The incident report created on 10/11/22 at 8:30 p.m. noted Resident #9 was found on the floor sitting by the bed. The incident and investigation documented the nurse assessed, and assisted him back to bed, and no injuries noted. The incident and investigation had no witness statement and no timeline of the event. The intervention added to the fall care plan was to continue to follow the care plan. The incident report created on 11/11/22 at 7:20 p.m. showed the resident was found on his back next to the bed by the air conditioning unit. The incident and investigation report noted Resident #9 said he hit his head and was sent to the ER for evaluation. No new interventions were initiated to help prevent further falls. A review of the investigation of the 12 falls revealed documentation the facility determined the root cause of each fall was The resident did not ask for assistance. On 11/16/22 at 10:10 a.m., the Administrator said she had no additional information related to Resident #9's fall investigations. 3. Review of the clinical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, [CONDITION(S)] to the right eye, and [CONDITION(S)] and collapse. The Admission Assessment Minimum Data Set (MDS) with an assessment reference date of 8/20/22 documented that Resident #27's cognition was severely impaired. Resident #27 was totally dependent on the assistance of two people for transfers and extensive assistance of two people for toileting. The plan of care initiated on 8/17/22 identified Resident #27 was at risk for falls. The care plan did not indicate the residents had any falls. The interventions included anticipate and meet resident needs, be sure call light is within reach and encourage to use it for assistance as needed. Prompt response to all requests for assistance, and make sure personal needs are met, pain, hunger, toileting needs, ensure has appropriate assistive devices. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The Morse Fall Scale Data Collection with an effective date of 8/20/22 noted Resident #27 was at high risk for falls. The form noted the resident had impaired gait, difficulty rising from chair, used chair arms to get up and bounced to rise, and grasps furniture, person, or aid when ambulating cannot walk unassisted. The form also noted Resident #27 knows own limits. A review of Resident #27's Incident Report and Investigation Report forms revealed Resident #27 from her admission on 8/17/22 to 9/25/22 had 2 unwitnessed falls including a fall with major injury on 9/25/22. The incident report created on 9/9/22 at 7:44 p.m. noted the CNA notified the nurse that Resident #27 was found on the floor near the bed, said she was trying to get up to turn off the light. The incident and investigation report noted nurses assessed Resident #27, noted a hematoma (pooling of blood outside of the blood vessels) to left side of the head. Resident #27 was sent out to hospital. No new interventions were initiated upon her return to help prevent further falls. The incident report created on 9/25/22 at 5:13 a.m. noted Resident #27 was found lying on the floor on the window side of the bed. The incident and investigation report noted the nurse assessed Resident #27, assisted back to bed, no visible injuries noted at the time. On 9/25/22 at 12:25 p.m., Resident #27 was sent out to the ER and was admitted with a fracture of unspecified part of neck of right femur. Resident #27 returned to the facility on [DATE]. No new interventions were initiated to help prevent further falls. A review of Resident #27's fall investigations for 9/9/2022 and 9/25/22 were started but did not include a timeline of events leading to the unwitnessed falls or staff interviewed to determine the root cause of the falls. Interventions discussed by the interdisciplinary team were not reflected in Resident #27's medical record. On 11/16/22 at 5:03 p.m., the Administrator said she had no additional information related to the resident's fall on 9/25/22. She verified no new interventions were initiated for Resident #27 to help prevent further falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of policies and procedures, and resident and staff interviews, the facility failed to provide care and services consistent with professional standards of practice related to continuous positive airway pressure support for 1 of 2 sampled residents (Resident #16) requiring noninvasive positive-pressure ventilation. The findings included: The facility policy for Bilevel Positive Airway Pressure ([CONDITION(S)]) use documented, Bilevel positive airway pressure ([CONDITION(S)]) is a noninvasive positive-pressure ventilation (NPPV) mode that delivers inspiratory and expiratory positive airway pressures as the patient breathes . NPPV is used to improve oxygenation or ventilation or to prevent airway obstruction during sleep. Implementation. Verify the practitioner's order. Review the patient's medical record for history, indication for [CONDITION(S)] use and any contraindications to [CONDITION(S)]. Confirm the settings by comparing them with the practitioner's order. Confirm that the [CONDITION(S)] device is functioning properly. Apply the patient interface ([CONDITION(S)] mask) to the patient's face, secure the head gear. Monitor the patient's vital signs. Document the procedure . Review of Resident #16's physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/8/22 at 9:58 a.m., Resident #16 was observed in bed. A [CONDITION(S)] machine covered in a plastic bag was observed on the nightstand. Resident #16 said she has to use the machine every night and said no one helped her the night before to put the machine on. She said, If I fall asleep without it on, no one puts it on for me. The resident said she had trouble breathing without the [CONDITION(S)] at night and does not feel as rested if she does not have it on. Resident #16 said she has told the nurse when she wakes up and the machine is not on, but nothing has been done. A review of the Treatment Administration Record (TAR) for October 2022 and November 2022 lacked documentation the [CONDITION(S)] machine was applied as ordered on 10/1/22, 10/2/22, 10/6/22, 10/7/22, 10/15/22, 10/16/22, 10/20/22, 10/21/22, 10/24/22, 11/3/22, and 11/8/22. On 11/9/22 at 4:00 p.m., the Director of Nursing (DON) said the night nurse was responsible to apply [CONDITION(S)] machines/masks as ordered and should document in the electronic record if refused. The DON said she was not aware the [CONDITION(S)] was not being applied for Resident #16.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of policies and procedures, and staff interview, the facility failed to ensure adequate monitoring and justification for continued use of [CONDITION(S)] medications for 3 of 5 residents (Resident #549, #74 and #350) reviewed for unnecessary [CONDITION(S)] medication use. The findings included: The facility's Psychoactive Medication Use and Gradual Dose Reduction policy and procedure revised 10/24/22 revealed, [CONDITION(S)] drug is any drug that affects brain activities associated with mental processes and behaviors . Each psychoactive medication will be given to treat clearly defined targeted conditions and to promote or maintain highest practicable physical, functional, and psychosocial well-being. For PRN [as needed] [CONDITION(S)] medication orders, they must be reevaluated after 14 days. 1. Review of the clinical record for Resident #549 revealed an Admission Minimum Data Set (MDS) assessment with a reference date of 7/29/22 noting the resident scored a 12 on the Brief Interview for Mental Status (a screening tool used to assist with identifying a resident's current cognition) indicating mildly impaired cognition. The MDS documented Resident #549 did not exhibit hallucinations or delusions. The active physician's orders revealed an order dated 9/27/22 to administer [MEDICATION(S)] (antipsychotic) 25 milligrams one tablet at bedtime for [CONDITION(S)]. Review of the Medication Administration Record (MAR) for October 2022 revealed Resident #549 received [MEDICATION(S)] 25 mg daily at bedtime for [CONDITION(S)] and [MEDICATION(S)] 12.5 mg one time a day for agitation. Review of the Consultant Pharmacist notes to the attending physician on 10/28/22 revealed, The resident has an order for [MEDICATION(S)] [[MEDICATION(S)]] 12.5 mg daily for agitation and [MEDICATION(S)] 25 mg at bedtime for [CONDITION(S)]. These are not appropriate indications for this medication. Review of the handwritten physician's order dated 11/7/22 revealed to Discontinue [MEDICATION(S)]. Review of the Medication Administration Record (MAR) for November 2022, revealed documentation [MEDICATION(S)] 12.5 mg was discontinued on 11/7/22 and Resident #549 received [MEDICATION(S)] 25 mg at bedtime on 11/8/22, despite the order dated 11/7/22 to discontinue [MEDICATION(S)]. On 11/9/22 at 9:56 a.m., the Director of Nursing (DON) said [CONDITION(S)] was not a sufficient diagnosis for use of the anti-psychotic, [MEDICATION(S)]. She acknowledged the pharmacy consultant's recommendation on 10/28/22 regarding the use of [MEDICATION(S)] without appropriate diagnoses/conditions. The DON said the physician was probably not aware of the pharmacy consultant's recommendation of 10/28/22 because he had not yet responded to the recommendation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/9/22 at 4:43 p.m., an interview was conducted with the psychiatric practitioner responsible for the psychiatric notes and prescribing [MEDICATION(S)] for Resident #549. She said she is board certified in adult medicine and psychiatric mental health. She said Resident #549 had some issues with [CONDITION(S)] and aggression when she was first admitted , so she prescribed the [MEDICATION(S)]. She said she is familiar with the guidelines for antipsychotics, but [MEDICATION(S)] makes you sleepy and it can be used for [CONDITION(S)]. The prescriber acknowledged [MEDICATION(S)] was an anti-psychotic. 2. Review of the clinical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including depression and anxiety. A physician's order dated 10/21/22 read, [MEDICATION(S)] Tablet 0.5 MG ([MEDICATION(S)]) Give 1 tablet by mouth every 24 hours as needed for agitation/anxiety. Review of the Medication Administration Record (MAR) for October 2022 and November 2022 showed Resident #74 received [MEDICATION(S)] 0.5 mg beyond 14 days, on 10/24/22, 10/25/22, 11/5/22, 11/6/22, 11/7/22, and 11/9/22. The October MAR and November MAR did not contain documentation nursing staff were monitoring Resident #74's behaviors when the resident was administered the [MEDICATION(S)] for agitation and anxiety. Review of the Nursing Progress Notes showed no documentation of behaviors Resident #74 was exhibiting to warrant the use of the [MEDICATION(S)] on 10/24/22, 10/25/22, and 11/9/22. Review of the consultant pharmacist recommendations revealed a note to the attending physician printed on 10/28/22 related to the use of the [MEDICATION(S)] as needed for Resident #74 that read, In accordance with State and Federal Guidelines . orders for [CONDITION(S)] drugs are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the PRN [as needed] order to be extended beyond 14 days. Please Evaluate the resident for the appropriateness of the medication. If it is to be extended, please document the rationale in the residents medical record . The form showed no response from the physician/prescriber's response. On 11/9/22 at approximately 7:00 p.m., the Administrator provided documentation on 11/9/22 the physician responded to the pharmacy consultant's recommendation and ordered to continue the [MEDICATION(S)] for 14 more days. No rationale was documented for continuing the medication. The Administrator verified the form was completed after the request was made for documentation for continuing the as needed [MEDICATION(S)]. 3. Review of the clinical record for Resident #350 revealed a physician's order dated 10/17/22 for [MEDICATION(S)] (antianxiety) 0.25 mg tablet one by mouth every four hours as needed for restlessness/agitation. The order had no stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/9/22 review of the consultant pharmacist recommendations revealed a note to the attending physician printed on 10/28/22 asking to evaluate the resident for the appropriateness of the medication. The note read, In accordance with State and Federal Guidelines . orders for [CONDITION(S)] drugs are limited to 14 days, except when the attending physician or prescribing practitioner believes that it is appropriate for the PRN [as needed] order to be extended beyond 14 days. The clinical record lacked documentation of a physician's response to the consultant pharmacist's recommendation. On 11/9/22 at 6:15 p.m., the DON verified Resident #350's order for [MEDICATION(S)] 0.25 mg as needed had been active for 21 days. She said [CONDITION(S)] medications ordered to be given as needed are limited to 14 days and then reevaluated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility's process for medication administration, resident and staff interviews, the facility failed to safely store medications to prevent unauthorized access in 1 (Transitional Care Unit medication cart) of 1 medication cart on the Transitional Care Unit and 2 (Transitional Care Unit and D wing) of 4 treatment carts observed. The facility also failed to ensure proper storage of medications for 2 (Resident #46 and #95) of 2 residents observed with unsecured medications at the bedside. The findings included: The facility's process (undated) for Medication Administration specified, . Do not leave medications at the patient's bedside. Remain with the patient until all medications, including liquids and nebulizers are administered . Medications carts must be locked when you are not directly in front of it. 1. On 11/7/22 at 10:23 a.m., an [MEDICATION(S)] (relaxes muscles in the airway) inhaler, a [MEDICATION(S)] (steroid) inhaler and a bottle of lubricant eye drops were observed unsecured on the resident's bedside table. The resident said the nurse left them in the room for her to use as needed. Photographic evidence obtained 2. On 11/7/22 at 11:15 a.m., a medication Cart and a treatment Cart were observed unlocked and unattended in the dining area of the Transitional Care Unit (TCU). Several residents were seated at the dining area. The medications were easily accessible to them. No staff member was in the dining area at the time of the observation. On 11/7/22 at approximately 11:20 a.m., Registered Nurse (RN) Staff K walked into the dining area and verified she left the medication and treatment cart, unlocked, unsupervised with medications easily accessible to unauthorized personnel, and residents. RN Staff K said she knew the carts should have been locked when unattended. 3. On 11/7/22 at 1:35 p.m., observed a bottle of [MEDICATION(S)] (antifungal) powder stored unsecured on a shelf in Resident #46's room. Photographic evidence obtained On 11/9/22 at 11:27 a.m., Resident #46 said the nurse left the [MEDICATION(S)] powder in her room. She said she uses it for a yeast infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/22 at 10:00 a.m., Registered Nurse (RN) Unit Manager Staff II she said there should be no medication left in the resident's rooms. 4. On 11/8/22 at 2:10 p.m., a treatment cart was observed unlocked and unattended in the hallway of D wing. The Treatment Cart contained various prescription and over the counter medications. On 11/8/22 at approximately 2:15 p.m., Licensed Practical Nurse (LPN) Staff W verified he left the treatment cart unlocked, and unattended. LPN Staff W said the facility's policy was to keep the cart locked when not in use, and it was his responsibility to lock the cart when left unattended.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident and staff interview, the facility failed to prepare and serve food in a consistency to meet the individual needs for 1 of 5 sampled residents (Resident #250) observed during meals. The findings included: Review of the electronic clinical record for Resident #250 revealed an admitted [DATE] with an order for a regular texture diet. On 11/4/22 the physician issued an order to, Change diet to regular diet, mechanical soft texture for a diagnosis of Poor dentition. On 11/7/22 at 12:25 p.m., Resident #250 was observed having lunch. The meal included a chicken breast and bite size pieces of eggplant. Resident #250 said, I really need a soft diet, I have no teeth. I have an upper denture but not a bottom denture. They bring regular food. Resident #250 said no one has met with her to discuss her dietary needs or preferences. (Photographic evidence obtained) On 11/9/22 at 9:20 a.m., Resident #250 said she was served ribs and potatoes the prior night for dinner but had to spit out the meat because she was unable to chew it. She said she tells staff every day she just can't eat the food. She said she was told to just eat what you can. On 11/9/22 at 3:31 p.m., the Director of Nursing (DON) verified the physician's order for a soft diet was not implemented. She said new physician's orders should be completed within 24 hours.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility policy and procedures review, the facility failed to ensure staff served food in a sanitary manner for 5 of 5 residents (Residents #95, #251, #249, #63, and #46) observed during lunch meal delivery on 1 (Transitional Care Unit) of 4 units observed on 11/7/22. The findings included: The facility's Policy and Procedure for Food Safety and Sanitation dated 2021 specified employees will wash their hands after handling dirty dishes, touching face, hair, other people or surfaces or items with potential for contamination. The facility's Policy and Procedure for Hand washing dated 2021 specified for employees to wash their hands as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks; After engaging in other activities that contaminate hands. On 11/7/22 at 11:15 a.m., Certified Nursing Assistant (CNA) Staff V was observed delivering lunch trays to resident rooms on the Transitional Care Unit. She took a tray to Resident #95's room. CNA Staff V was observed touching the resident's over the bed table as she set up the tray. CNA Staff V did not wash or sanitize her hands after touching potentially contaminated surfaces. CNA Staff V then took a tray to Resident #251's room. She set up the lunch tray was for Resident #251. She touched the resident's table while setting up the tray. She did not wash or sanitize her hands before leaving the room. CNA Staff V continued to deliver meal trays to Resident #249 and #63. Each time CNA Staff V was observed touching potentially contaminated surfaces in Resident #249 and #63's rooms and did not wash or sanitize her hands. CNA Staff V was observed leaving Resident #63's room. She picked up a paper napkin from the floor and disposed of it in the waste basket. She did not wash or sanitize her hands prior to taking the next tray to Resident #46's room. On 11/7/22 at approximately 11:45 a.m., CNA Staff V confirmed she did not wash or sanitize her hands after touching potentially contaminated surfaces in Resident #95, #251, #249, #63, and #46's rooms. She said, We are supposed to always sanitize between residents but sometimes it gets busy. On 11/7/22 at 1:10 p.m., Unit Manager Staff II said staff should be sanitizing their hands between residents.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, the facility's administration failed to use its resources effectively to protect residents' rights to be free from neglect and ensured staff implemented processes and physician's orders to prevent the development and/or worsening of pressure ulcers for 3 (Resident #55, #27, and #74) of 4 residents sampled for development or worsening of pressure ulcers. Resident #27 was dependent on staff for turning and repositioning following a fall and fracture of the right femur. The facility failed to consistently offload the heels of the resident. On 11/4/22, the facility identified an avoidable, infected, advanced stage pressure ulcer of the right heel. On 11/9/22, the wound care physician diagnosed an unstageable pressure ulcer of the right heel with 100% necrotic (dead) tissue requiring a surgical debridement (removal of dead tissue). The facility failed to consistently implement the physician's orders to prevent the worsening of the pressure ulcer. On 11/16/22, the wound care physician documented the pressure ulcer had deteriorated. Resident #55 admitted on [DATE] and was dependent on staff for all activities of daily living, including turning and repositioning. The facility failed to identify, assess, and obtain treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/4/22, the wound care physician diagnosed an unstageable 100% necrotic pressure ulcer to the coccyx requiring surgical debridement. The wound care orders dated 11/4/22 were not implemented until 11/7/22. On 11/8/22, the Licensed Practical Nurse documented an abrasion of the resident's right knee. The area was not assessed or treated until 11/15/22. On 11/16/22, the wound care physician diagnosed a stage 2 (partial thickness) pressure ulcer to the right inner knee. Resident #74 admitted on [DATE] and was at moderate risk for development of pressure ulcer and was dependent on staff for turning and repositioning. The facility failed to consistently offload the resident's heels, turn, and reposition the dependent resident. On 9/14/22, Resident #74 developed an avoidable unstageable pressure ulcer of the right heel requiring surgical debridement. The facility failed to consistently apply the physician ordered treatment and protective dressing to promote the healing of the in-house acquired advanced stage pressure ulcer. The failure of the facility's administration to ensure the ongoing implementation of a process to prevent the development, assess, and treat avoidable pressure ulcers resulted in a determination of isolated (J) Immediate Jeopardy beginning on 11/4/22. The Administrator was notified of the determination of ongoing Immediate Jeopardy on 11/17/22 at 1:17 p.m. The findings included: Cross reference to F600, F686, F867 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nursing Home Administrator's Position Description revised 4/25/22 revealed the position summary was to Plan and direct all day-to-day functions of the Care Center in accordance with applicable company, Federal, State, and local standards to promote that the highest degree of quality is provided to its residents .Plans, develops, organizes, implements, and evaluates the Care Center's programs and activities with strong collaboration with other organizational leaders . Ensures that adequate number of appropriately trained professionals and auxiliary personnel are on duty at all times to meet the needs of the residents. Review of the Director of Nursing's job description dated November 2017 revealed the primary purpose of the position is to plan, budget, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current Federal, State and local standards, guidelines and regulations that govern the facility to ensure that the highest degree of quality of care is maintained at all times. Responsible for ensuring that an adequate level of services is provided to each resident, documented appropriately and regularly evaluated. The facility's Policy and Procedure for the Prevention and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] . to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Nursing: Monitoring of skin integrity. Upon admission, all new residents will have the following orders in place: [brand name] No Sting Barrier Film liquid to bilateral heels every 3 days for 14 days. Offload bilateral heels while in bed. Air mattress for any resident with a Braden Scale of 14 or less. 1. Clinical record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #55 was discharged to an acute care hospital on 10/13/22 and returned to the facility on [DATE]. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (Agency for Health Care Administration form 3008) signed and dated 10/24/22 by a physician revealed a skin assessment noting Resident #55 had a stage 3 pressure injury to the buttock, and a stage 1 (pressure related alteration of intact skin) pressure injury to the right buttock. The facility's Nursing Data Collection-Admission/Readmission Day dated 10/25/22 did not note the presence of the existing pressure ulcer to the buttocks or the coccyx (tailbone). The resident was not able to reposition self while lying in bed or sitting. On 11/2/22 the Nursing Weekly Skin Check completed by a Registered Nurse (RN) noted Resident #55 had a pressure ulcer to the coccyx. The nurse answered No to the question Is this a new skin injury?. The clinical record lacked documentation of treatment to the existing pressure ulcer. On 11/4/22 the wound care physician assessed and documented in a progress note Resident #55 had an unstageable (due to necrosis) pressure ulcer to the coccyx measuring 4.5 centimeters (cm) length by 3.7 cm width with moderate amount of serous exudate. The physician documented performing a surgical excisional debridement to establish the margins of viable tissue. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The physician issued an order to cleanse the coccyx wound, pat dry, apply Santyl (ointment to remove dead tissue), apply Alginate Calcium sheet and cover with boarded gauze dressing daily. There was no documentation the Santyl was applied to the wound as ordered until 11/7/22. The ordered dressing with Alginate Calcium sheet and boarded gauze dressing was not documented as implemented until 11/8/22. On 11/14/22 at 10:45 a.m., Resident #55 was observed in bed, on his back on an air mattress. A soiled dressing dated 11/11/22 was observed to the resident's right inner knee. On 11/14/22 at 10:55 a.m., observation of the resident's right inner knee with RN Staff CC revealed a stage 2 pressure ulcer with copious amount of greenish/brownish malodorous exudate. She said there was no treatment orders for the pressure ulcer to the right inner knee. On 11/16/22 at 4:30 p.m., the wound care physician assessed and diagnosed Resident #55 with a stage 2 pressure ulcer to the right inner knee with redness to the surrounding area. On 11/16/22 the wound care physician wrote in a progress note Resident #55 had a stage 2 partial thickness pressure wound of the right medial knee. The objective was healing. 2. Review of the clinical record revealed Resident #27 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . On 9/25/22, Resident #27 sustained a fall at the facility and was transferred to an acute care hospital for increased right hip pain. Resident #27 returned to the facility on [DATE] with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The Nursing Data Collection-Admission/Readmission form with an effective date of 10/3/22 noted the resident was at risk for skin breakdown. She was not able to reposition herself while lying in bed, or when sitting in a chair or wheelchair. Staff was to assist as needed with the repositioning. The Braden scale (gold standard tool used for identifying pressure ulcer risk) completed on 10/3/22 by a Licensed Practical Nurse noted a score of 14 indicative of moderate risk for pressure ulcer. The Significant Change in Status MDS (Minimum Data Set) assessment with a target date of 10/6/22 noted Resident #27 had severe cognitive impairment. The resident required extensive physical assistance of staff for bed mobility and transfer. The Care Area Assessment noted the resident triggered for pressure ulcer and it was addressed in the care plan. The MDS did not include a turning and repositioning program as part of preventive measures. The physician's orders dated 10/3/22 included an air mattress to the bed for pressure ulcer prevention. Review of the Medication Administration Record (MAR) for October 2022 showed documentation the air mattress was applied on 10/3/22 and discontinued on 10/11/22. The clinical record did not include a rationale for discontinuing the air mattress. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The MAR for October 2022 and November 2022 did not contain documentation the No Sting Barrier Film Liquid was applied to the resident's bilateral heels every three days for 14 days as per facility policy. On 11/9/22 at 7:09 p.m., the DON said she did not know why the mattress was discontinued and it shouldn't have been. The DON also verified the facility failed to implement their policy and procedure and did not obtain an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . The Certified Nursing Assistant (CNA) tasks list for October 2022 and November 2022 had instructions for a turning and repositioning program and encourage the resident to float heels while in bed each shift. On 10/7/22, 10/10/22, 10/22/22, 10/24/22, 10/28/22, 10/30/22, and 11/4/22 the turning and repositioning and encouraging the resident to float heels while in bed were noted as completed only once in a 24-hour period. On 11/4/22 a Licensed Practical Nurse Staff I documented on a nursing weekly skin check Resident #27 had a right heel pressure area, Open blistered area. has odor. On 11/4/22 the physician issued an order for [MEDICAL RECORD OR PHYSICIAN ORDER] . He also ordered to use podus boots (helps in prevention and healing of heel ulcers) to offload heels while in bed. On 11/9/22 from 12:00 p.m. to 2:09 p.m., during multiple random observations, Resident #27 was observed in her room in a wheelchair wearing nonskid socks. Her heels were not offloaded and were pressing into the hard plastic footrests of the wheelchair. Resident #27 was not able to move her right leg upon command. On 11/9/22 at 2:12 p.m., LPN Staff FF said there was no measure to offload Resident #27' heels when she was out of bed. She verified the resident's heels were not offloaded and pressing into the hard plastic footrests of the wheelchair. She said, I questioned it this morning. Her heels are pressing on the footrests. She said not offloading the resident's heels in the wheelchair was a problem. On 11/9/22 at 3:05 p.m., observation of Resident #27's right heel with the wound care physician revealed an advanced stage black, necrotic ulcer with moderate amount of drainage. On 11/9/22 the wound care physician documented in a progress note Resident #27 had an unstageable (due to necrosis) pressure ulcer of the right heel, full thickness of duration greater than 10 days with moderate serous exudate and thick adherent devitalized necrotic tissue covering 100% of the wound. On 11/9/22 at 7:09 p.m., the DON said she completed an investigation when Resident #27 developed the pressure ulcer. She said after looking at all the documentation, she concluded the pressure ulcer was avoidable. She said the facility was using a lot of agency nurses and she has not educated them. She said she didn't know if all nurses were educated on pressure ulcer preventive measures. The DON said she did not look into why the air mattress was discontinued or why preventive measures, including applying the No Sting Barrier Film liquid were not implemented. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/14/22 at 9:30 a.m., Resident #27 was observed on her back in bed. She was not wearing the offloading boots and her heels were pressing onto a folded sheet placed on the air mattress. On 11/14/22 at 9:35 a.m., Agency CNA HH said she was from a staffing agency and was assigned to care for Resident #27. She said she came on duty at 7:00 a.m. but has not had time to make rounds and see her assigned residents. She said she has not received any orientation before starting to work at the facility. She did not know where to get the information to safely care for the residents. She did not know what preventive measures needed to be in place for Resident #27. On 11/14/22 at 9:40 a.m., RN Staff CC said she was assigned to care for Resident #27. RN Staff CC said Resident #27 was supposed to wear offloading boots in and out of the bed. On 11/14/22 at 9:45 a.m., RN Staff CC verified the offloading boots were not in place for the resident and said she didn't know why. On 11/14/22 at 12:00 p.m., Resident #27 remained on her back in bed. Observation of the dressing change with RN Staff CC revealed a dressing to the resident's right heel with a date of 11/11/22. The dressing bore RN Staff CC's initials. She said the dressing was the one she applied to the resident's right heel on 11/11/22. The soiled dressing was saturated with a large amount of malodorous bloody drainage. Review of the MAR showed nurse RN Staff DD signed on 11/12/22 and 11/13/22 he performed the wound care as ordered. On 11/14/22 at 3:15 p.m., RN Staff DD said in a telephone interview he may have made a mistake signing he completed the treatment on 11/12/22 and 11/13/22. He said he was only human and had lot of work to do. On 11/16/22 at 4:20 p.m., the wound care physician said Resident #27's pressure ulcer was probably avoidable. On 11/16/22, the wound care physician wrote deteriorated on the wound progress section for the unstageable full thickness right heel pressure ulcer. On 11/9/22 at 2:50 p.m., the Registered Dietitian said the facility only notified her today (11/9/22) of Resident #27's pressure ulcer. On 11/15/22 at 10:15 a.m., the Registered Dietitian (RD) said it's been a struggle to obtain the wound report to implement adequate nutritional interventions for residents with pressure ulcers. She said she emailed her concerns to the administrative staff on 10/11/22. The RD provided a copy of an email dated 10/11/22 at 3:15 p.m., addressed to the Administrator, the DON, and the Certified Dietary Manager (CDM) that read, Just wanted to let you know I have not received a wound report for several weeks. I am concerned that there may be pressure injuries that have not been addressed. She said the very next day she got a wound report but the next one she received was on 11/9/22. Review of the physician's orders for October 2022 revealed to administer a house shake to Resident #27 three times a day for nutritional supplement as of 10/27/22 and a [brand name for frozen nutritional supplement] two times a day for impaired appetite. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/9/22 at 2:50 p.m., the Registered Dietitian said the nursing staff was supposed to document the percent of the supplement consumed. She said she looks in the clinical record to check if the resident is taking the supplement or not. She also asks the nurse if the resident is taking the supplements. On 11/11/22 RN Staff CC documented on the MAR Resident #27 consumed 100 % of the house shake at 9:00 a.m. and 5:00 p.m., and 50% of the house shake at 1:00 p.m. On 11/14/22 RN Staff CC documented Resident #27 consumed 100% of the house shake at 9:00 a.m. On 11/14/22 at 9:35 a.m., Resident #27's breakfast tray was observed and did not contain a house shake. On 11/14/22 at 12:15 p.m., Resident #27's lunch tray was observed and did not include a frozen nutritional supplement. On 11/14/22 at 12:20 p.m., RN Staff CC said the supplements come on the resident's meal trays. She said she documented the percentage consumed based on what the CNA reported but did not personally see the resident taking the supplements. On 11/14/22 at 12:50 p.m., the Certified Dietary Manager (CDM) provided a list of residents who received supplements on their meal trays. Resident #27 was not included in the list. She said the dietary department did not provide any supplement to Resident #27. On 11/14/22 at 1:05 p.m., Agency CNA EE said the resident did not receive any supplement with her breakfast or lunch meal. RN Staff CC present during the interview said it was a problem and she'll let the DON know about it. 3. Review of the clinical record revealed Resident #74 was admitted on [DATE]. diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The Braden Scale for predicting pressure sore dated 9/17/22 documented the risk score was 14, indicating Resident #74 was at moderate risk for developing a pressure wound. A review of Resident #74's clinical record revealed a care plan initiated on 9/7/22 identifying Resident #74 had a skin concern on both heels. The care plan interventions included to offload heels to decrease pressure. On 9/14/22 the Nurses Weekly Wound Documentation, completed by the Director of Nursing (DON), identified Resident #74 had a new onset, in-house acquired, stage 2 (partial thickness) pressure wound to the right heel measuring 2.0 centimeters (cm) length by 2.0 cm width with 0.2 cm depth, with small amount of serosanguineous exudate. On 10/5/22 the wound care physician assessed and documented in a progress note Resident #74 had an unstageable (due to necrosis) pressure ulcer to the right heel measuring 2.3 centimeters (cm) length by 1.5 cm width with moderate amount of serous exudate. The physician documented performing a surgical excisional debridement (removal of dead tissue) to establish the margins of viable tissue. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound care physician specified to offload pressure to heels. The record showed a physician order dated 11/3/22 to cleanse right heel with Dakin's (strong antiseptic) solution 1/4 strength wet to moist packing, apply border gauze dressing once daily for 16 days. On 11/14/22 at 8:30 a.m., Resident #74 was observed in a wheelchair with grip socks on and her feet and heels were planted firmly on the floor and not offloaded to reduce pressure. There was no dressing noted on the right foot. Licensed Practical Nurse (LPN) Staff AA said she had not completed the scheduled wound care but would do it later in the day. On 11/14/22 at 12:30 p.m., observation of the wound on Resident #74's heels with LPN Staff AA revealed there was no dressing observed on the right heel to cover the resident's wound, exposing the wound to lint from the sock. LPN Staff AA said she had not removed any dressings from the resident's right foot. LPN Staff AA said she had not completed wound care yet and said it was just Dakin's solution to the right heel, no dressing was required; the order was to just apply the solution to the wound. A heel protector was noted on the left foot, and there was none on the right foot. On 11/14/22 at 2:45 p.m., the Director of Nursing (DON) said she was ultimately responsible to make sure the wound care was carried out as ordered by the physician. On 11/15/22 at 8:30 a.m., Resident #74 was observed seated in a wheelchair in the activity room. Her feet were firmly planted on the floor, and she had grip socks on, and her heels were not offloaded to decrease pressure. LPN Staff Q confirmed there was no dressing covering Resident #74's the right heel wound. Review of the Medication Administration Record for November 2022 revealed the wound care with the Dakin's solution was not provided as ordered on 11/4/22, 11/7/22, 11/12/22, and 11/13/22. The reason provided was Dakin's Solution on order. On 11/15/22 at 9:00 a.m., LPN Staff Q said the Dakin's solution was in the medication cart and retrieved it form the cart. LPN Staff Q confirmed the date the Dakin's solution was filled by the pharmacy was 11/7/22. On 11/15/22 at 9:45 a.m., the DON said she was aware the Dakin's solution was delivered by the pharmacy on 11/7/22, and was available, but did not know why the nurse had documented the solution was unavailable. The DON confirmed Resident #74 did not receive the physician ordered wound care on 11/4/22, 11/7/22, 11/12/22, and 11/13/22 and said there was no documentation the physician was notified the wound care was not provided. On 11/15/22 at 10:54 a.m., Unit Manager Registered Nurse Staff T said the wound care to the right heel was done five times on 11/14/22 because Resident #74 removes the dressing. The Unit Manager said the right heel wound was wrapped together with the right shin wound so the resident would not be able to remove the right heel dressing. The Unit Manager confirmed there was no documentation the wound care was provided five times on 11/14/22 and no physician order to wrap the resident's entire right leg and combine the two separate wound dressings. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Unit Manager said the Dakin's solution was pulled from the medication cart because of concerns last week the ordered solution was not the correct dosage. She said once we determined it was correct, it was placed back in the cart. The Unit Manager said she did not know how many days the Dakin's solution was not in the cart and said the nurse just provided standard wound care. The Unit Manager said the nurse just followed the physician order without applying the Dakin's solution, and that was considered standard wound care. The Unit Manager confirmed there was no physician order for [MEDICAL RECORD OR PHYSICIAN ORDER] . On 11/14/22 at 2:40 p.m., the Director of Nursing (DON) said the unit managers and supervisors were responsible to conduct audits to ensure timely and accurate completion of skin checks. On a day-to-day basis the nurses on the unit along with the unit managers were responsible to make sure the care was being provided and supervise the Certified Nursing Assistants (CNAs). The DON said she did not have documentation of the audits performed by the unit managers. On 11/15/22 at 9:25 a.m., RN Unit Manager Staff N said she has been a unit manager at the facility for approximately 10 months. She said her responsibilities are a lot. She has a whole book on responsibilities. They do not include making sure the wound care physician's orders are implemented timely. On 11/15/22 at 10:30 a.m., Unit Manager Staff II said she has been a unit manager at the facility for almost three years. She said there was no specific focus on residents with pressure ulcers. She said she was not responsible to make sure the wound care physician's orders were implemented. She said it was the wound care nurse's responsibility to make sure the orders are entered in the system, and the primary nurse's responsibility to make sure the orders are implemented. On 11/15/22 at 10:55 a.m., RN Staff T said she has been the unit manager for Unit B and C for about two months. She said she rounds her unit as soon as she gets in the building. She makes sure the air mattress is on and inflated properly, heels are up, drinks in front of them. She offered no explanation for the observation on 11/14/22 of Resident #27's not wearing the offloading boots. She said Resident #27 was transferred to her unit on Friday and they should have brought the Kardex to her room. She said she also completes audits for skin checks. She looks over and verifies the accuracy of the skin assessments on the resident. She said she went over all the skin checks from 11/8/22 and 11/11/22. She said the wound care nurse mentioned the area to Resident #55's right inner knee but from the description she wasn't sure what it was. She cleaned it and left it open to air. On 11/15/22 at 3:15 p.m., a review of the Quality Assurance and Performance Improvement (QAPI) program related to pressure ulcers was conducted with the Administrator. She declined for the DON to attend. She said the DON was busy doing other things. She said a skin PIP (Performance Improvement Plan) was introduced in QAPI on 7/13/22. The PIP was developed because they identified skin checks were not done timely and skin issues were not identified timely. They discussed completing a head-to-toe assessment as a baseline. Skin assessments were reviewed to make sure appropriate interventions were in place. She said she did not have information of the findings from the head-to-toe assessments. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator said from what she was told, the skin protocol was reviewed at the time and appropriate interventions were put into place, but she just does not have the documentation to show that. There was no set completion date for the PIP. It was ongoing for three months and then reviewed to determine if an extension was needed. On 8/10/22 the PIP was reviewed. They discussed auditing the new admissions by the wound nurse to make sure appropriate interventions were in place if residents were deemed at risk. She said she could not speak to why this intervention was added. As far as the head-to-toe assessment, she said she did not have documentation it was done, one way or the other. On 9/14/22 the PIP was reviewed again. They reviewed implementation of appropriate interventions. On 9/14/22 they had a total of 10 active wounds. One was facility acquired and it was a vascular issue. The Regional Clinical Manager or designee was going to audit 100% of the skin assessments and skin checks weekly to ensure compliance for the next three months. She said she did not have documentation of how many audits were done and the results of the audits. On 10/19/22 the PIP was reviewed again. It was decided all nursing staff needed to be reeducated on completion of the weekly skin checks. She said she did not have the data or rationale for the decision to reeducate the nurses. As of 10/19/22, the Nurse Managers were also to review the Agency for Health Care Administration form 3008 of all the new admissions to identify any skin issues upon admission for all new admissions. She said she was not certain they reviewed Resident #55's 3008 form when he was admitted on [DATE]. She said she wasn't sure where they document the audits.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to develop and implement effective corrective actions for identified quality deficiencies related to skin assessment, prevention, identification, and treatment of [MEDICAL RECORD OR PHYSICIAN ORDER] Resident #27 and #74 developed an unstageable (advanced stage) pressure ulcer. The facility failed to consistently implement the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Resident #55 was admitted on [DATE] with a pressure ulcer to the coccyx. The facility failed to identify, assess, and treat the pressure ulcer upon admission until 11/7/22. Resident #55 suffered worsening of the pressure ulcer. The facility failed to implement effective corrective actions and monitor results, creating a likelihood of serious harm and impairment to other residents. The facility failure to have an effective Quality Assurance and Performance Improvement (QAPI) program resulted in a determination of isolated (J) Immediate Jeopardy beginning on 11/4/22. The Administrator was notified of the determination of Immediate Jeopardy on 11/17/22 at 1:17 p.m. The findings included: Cross reference to F600, F686 and F835 The facility's Quality Assurance Performance Improvement (QAPI) Plan with an annual update of 4/19/22 noted the purpose of the QAPI plan is to ensure a systematic approach to performance excellence of the organization that includes all stakeholders and is on-going. The Quality Assurance and Performance Improvement plan ensures the organization is always providing surveillance to ensure systems and processes are in place and effective. When there is a change in the metrics/outcomes, the communities will be tracking and trending to identify issues early and avoid adverse events from reaching the individuals they serve. When key issues are identified and/or data indicating potential system breakdown, communities will consider this a proactive opportunity for improvement. Communities will be identifying and addressing the key issues by engaging the stakeholders in the identification of opportunities for improvement, providing a safe environment for reporting issues, and participation in seeking the right improvement interventions. The plan also noted the organization will conduct Performance Improvement Projects (PIP's) that are designed to take a systematic approach to revise and improve care or services in areas identified as needing attention. The facility will conduct PIP's that will lead to changes and guide corrective actions in the systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents living in the community. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	They will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident, and family satisfaction. An important aspect of the PIP is a plan to determine the effectiveness of the performance improvement activities and whether the improvement is sustained. 1. Review of the facility's compliance history revealed on 10/8/21 the facility failed to implement timely effective measures in accordance with professional standards of practice to prevent the development of pressure ulcers for two residents identified at risk for pressure ulcers. 2. Clinical record review revealed Resident #27 was readmitted to the facility on [DATE] after a surgical repair of a right [CONDITION(S)]. The resident was dependent on staff for repositioning. The facility failed to consistently implement preventive measures to prevent the development of an avoidable advanced stage pressure ulcer. On 11/4/22 the facility identified an infected, pressure ulcer of the right heel. On 11/9/22 the wound care physician diagnosed an unstageable right heel pressure ulcer with 100% thick necrotic tissue. The facility failed to consistently implement the daily wound care, offload the area to promote healing. On 11/16/22, the wound care physician documented the wound had deteriorated. 3. Clinical record review revealed Resident #55 was admitted on [DATE] with a stage 3 pressure ulcer to the coccyx and was dependent on staff for all activities of daily living. The facility failed to complete a thorough skin assessment. The pressure ulcer was not identified until 11/4/22, and the physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . The facility also failed to assess, obtain orders, and treat an additional in-house acquired pressure ulcer for Resident #55 identified on 11/8/22 until 11/15/22. 4. Review of the clinical record revealed Resident #74 admitted on [DATE] and was at moderate risk for development of pressure ulcer. Resident #74 was dependent on staff for turning and repositioning. The facility failed to consistently offload the resident's heels, turn, and reposition the dependent resident. On 9/14/22, Resident #74 developed an avoidable unstageable pressure ulcer of the right heel requiring surgical debridement. The facility failed to consistently apply the physician ordered treatment and protective dressing to promote the healing of the in-house acquired advanced stage pressure ulcer. 5. On 11/9/22 review of the facility's wound tracking log revealed the facility had 12 residents with pressure ulcers, 11 of the 12 residents acquired the pressure ulcer at the facility. 6. On 11/14/22 at 2:40 p.m., an interview was conducted with the Director of Nursing (DON) in the presence of the facility Administrator. The DON said since the survey of 10/8/21 that identified noncompliance with development of pressure ulcers, the facility made sure skin assessments were completed to ensure appropriate interventions were in place such as turning and repositioning, air mattress as appropriate. The nurse managers were to review the electronic clinical records daily to ensure all skin issues were addressed appropriately. All nursing staff were educated on pressure ulcer prevention including floating heels, turning, and repositioning. The target date was February 2022, but they were to continue with all interventions and audits. The DON said in July 2022, they developed a PIP because skin concerns were missed on admission. The nurse assigned to round with the wound care physician said, they were doing well. She was accountable to speak with the unit managers if something was not taken care of. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The unit managers and supervisors were responsible to conduct audits to ensure timely and accurate completion of skin checks. On a day-to-day basis, the nurses on the unit, along with the unit managers, were responsible to make sure the care was being provided and supervise the Certified Nursing Assistants (CNAs). The DON said the wound care physician does not attend QAPI meetings. Review of the PIP with a date initiated of 7/8/22 and revised 9/30/22 revealed the problem was the facility failure to identify and manage skin issues, weekly skin checks not completed timely. The goal of the PIP was to ensure all skin issues were identified and managed timely and appropriately. The date expected to be completed was Ongoing. The interventions listed included staff education on pressure ulcer prevention, including floating heels, turning, and repositioning, change of condition, stop and watch, and skin checks. The nurse managers were also to review the Agency for Health Care Administration form 3008 of all the new admissions to identify any skin issues upon admission for all new admissions. On 11/14/22 at 2:40 p.m., at the time of the interview, the DON and the Administrator said they did not have documentation of education or audits completed since the development of the PIP in July 2022. On 11/15/22 at 3:15 p.m., a review of the QAPI program related to pressure ulcers was conducted with the Administrator. She declined for the DON to attend. She said the DON was busy doing other things. She said the skin PIP was introduced in QAPI on 7/13/22. The PIP was developed because they identified skin checks were not done timely and skin issues were not identified timely. They discussed completing a head-to-toe assessment as a baseline. Skin assessments were reviewed to make sure appropriate interventions were in place. She said she did not have information of the findings from the head-to-toe assessments. The Administrator said from what she was told the skin protocol was reviewed at the time and appropriate interventions were put into place, but she just does not have the documentation to show that. There was no set completion date for the PIP. It was ongoing for three months and then reviewed to determine if an extension was needed. On 8/10/22 the PIP was reviewed. They discussed auditing the new admissions by the wound nurse to make sure appropriate interventions were in place if residents were deemed at risk. She said she could not speak to why this intervention was added. As far as the head-to-toe assessment, she said she did not have documentation it was done, one way or the other. On 9/14/22 the PIP was reviewed again. They reviewed implementation of appropriate interventions. On 9/14/22 they had a total of 10 active wounds. One was facility acquired and it was a vascular issue. The Regional Clinical Manager or designee was going to audit 100% of the skin assessments and skin checks weekly to ensure compliance for the next three months. She said she did not have documentation of how many audits were done and the results of the audits. On 10/19/22 the PIP was reviewed again. It was decided all nursing staff needed to be reeducated on completion of the weekly skin checks. She said she did not have the data or rationale for the decision to reeducate the nurses. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As of 10/19/22 the nurse managers were also to review the Agency for Health Care Administration form 3008 of all the new admissions to identify any skin issues upon admission for all new admissions. She said she was not certain they reviewed Resident #55's 3008 form when he was admitted on [DATE]. She said she wasn't sure where they document the audits. The Administrator said she offers the CNAs to attend QAPI, but they don't have any interest. 8. On 11/16/22 at 1:25 p.m., the Area Clinical Manager said she provides support to the nursing home and the nursing home administrator. When she comes to the facility, she meets with the DON and Administrator and to discuss concerns or issues they'd like her to assist with. She said she recommended a PIP for pressure ulcer in July based on a review of the new skin integrity risk management reports. She found skin issues not identified and treatments not done. She said she did not develop the PIP for the pressure ulcers. She makes her recommendations but they're not final. The Administrator and DON are the ones who ultimately decide what they'll end up doing. She did some education after July and would look on her calendar. She said she also completed some audits which she shared on a weekly basis with the DON, the Administrator, the CEO, and the Area Operation Supervisor. Review of the Support Services Report-Clinical reports completed by the Area Clinical Manager showed the week of 7/11/22 the areas of review included, Skin Concerns/Any New Facility Acquired Pressure Ulcer-Any stage. Ensure prevention measures are in place. PIP initiated and brought to QAPI. The week of 7/25/22 the report noted improvements were made. She noted the wound care nurse was not numbering wounds in the weekly wound documentation and would talk to her the following week. Skin assessment had improved but five were overdue for the week. The week of 8/1/22 the report noted the PIP was being worked by the DON. The unit managers were doing weekly skin assessment audits, to be turning in to the DON. The week of 8/15/22 the report noted she needed to work with the wound care nurse on doing electronic wound logs for all departments to access. The paper copy was not being shared with everyone. The Area Clinical Manager also noted the facility needed to start weekly wound meetings and review all wounds weekly to ensure care plans and protocols are in place. She also wrote Skin PIP-no audits in house for me to review. Please continue. The week of 8/22/22 the report noted, Electronic wound log still not being updated correctly. Uncertain if wounds were discussed in Standards of Care. Skin integrity RM (Risk Management) reports: Need to establish process for ensuring treatment is set up for New Skin integrity concerns. 4 of 5 reviewed the RM report stated a treatment was initiated, but there was no treatment put in place. The week of 9/12/22 the report noted, Wound log is not being saved to the G drive for everyone to access. RM reports reviewed for skin still with trouble following through with orders. Weekly skin assessments continue with some incomplete, missing or late. Recommend a pip or process of ensuring that orders get put in place from Risk Management reports. Reviewing Risk management reports in IDT (Interdisciplinary Team) for new skin issues, the nurse indicated that she put a treatment on, which was an appropriate treatment, but an order was not written. Nurse manager is following up but remains a problem. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An undated report noted, There were some pressure ulcers identified that did not have weekly wound documentation. Weekly skin assessments still not 100%. Concerns with wound log not accurate. Reviewed a handful of skin integrity RM reports to see if treatment, care plan and follow up completed as to what the RM report stated. Orders were in place, but I did not see wound tracking for those that were pressure ulcers. One Right buttock wound the weekly wound report said it was Vascular. The report for the week of 10/21/22 noted, [DON] is working on updated wound and skin logs. [DON] is working on long term plan for wound management in the building. Please ensure wounds are discussed weekly in Standards of care. I have not seen audits skin wound PIP status? Continued wound concerns. The report for the week of 10/25/22 noted, At the end of last week, there were 10 Facility acquired Pressure Ulcers at various stages, and a handful to follow up on. I did a whole house review of skin checks: 10 residents were not timely with weekly skin checks, 5 of them had not had a skin check in over a month. The list was sent to [DON] to follow up on last week. I provided all the VOA (Volunteers of America) Wound Skin Protocol and policies to [DON] and [Administrator], which were already on the G drive, but provided again for references. The report for the week of 11/7/22 noted, We reported as a Federal Day 1 for a facility acquired Pressure Ulcer that went without treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] . [DON] is working on having whole house skin audits completed. All the reports noted the responsible person was the DON. 9. On 11/17/22 at 8:23 a.m., the DON said sometimes she would talk to the unit managers about the issues identified in the reports and sometimes she would take care of it herself. The DON had no documentation verifying she addressed the concerns with pressure ulcers noted on the Area Clinical Manager's weekly reports and said, The skin audits were improving.