STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm 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 interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure that a pressure ulcer was assessed and treated timely and according to physician orders for one resident (#10). The deficient practice could lead to deterioration of a resident's medical condition.-Findings include:Resident #10 was admitted to the facility December 25, 2025, with diagnoses of dementia, other acute osteomyelitis of right ankle and foot, sepsis, pressure-induced deep tissue damage of right heel, non-pressure chronic ulcer of skin of other sites, type 2 diabetes mellitus with foot ulcer, Alzheimer's disease, and acquired absence of left great toe.A physician order dated December 25, 2025, included to complete a skin check weekly.A Weekly Skin check and Wound assessment dated [DATE], revealed the resident had the following skin impairments:nephrostomy tube on the right iliac crestskin impairment on the back of the right handsignificant diabetic foot ulcer on the right heel that was incised and debrided in acute carediabetic foot ulcer on the left heelleft great toe former amputation site, and remaining hallux that was an infected wound with osteomyelitis, and wound vac in place.diabetic ulcer on left toe(s)pressure injury on sacrum, with no evidence of further details or measurementsAn Audit Report of the Weekly Skin check and Wound assessment dated [DATE], revealed that a Licensed Practical Nurse (LPN / Staff #30) initially had entered pressure injury on coccyx on December 25, 2025, that was later edited on December 26, 2025, by a registered nurse / Assistant Director of Nursing (RN / ADON / Staff #45) to reveal pressure injury on sacrum.A care plan focus initiated December 25, 2025, revealed Resident #10 had a skin impairment of pressure ulcer to coccyx. Interventions included to administer treatments as ordered and monitor for effectiveness, to have a pressure-relieving mattress, a weekly skin assessment completed by licensed staff, and to monitor / document / report to physician changes in skin status as needed.A Braden Scale assessment dated [DATE], revealed Resident #10 was low risk for development of pressure ulcers.A handwritten paper Treatment Plan and Evaluation of Care document, dated December 26, 2025, and signed by Staff #45, revealed to cleanse with wound cleanser, apply Santyl (prescription enzymatic medication), cover with oil emulsion (adaptic), apply skin prep to periwound and cover with sacral dressing, and if patient refuses full treatment, please apply zinc oxide and cover dressing, to be completed daily. Despite the resident having just admitted to the facility on e day prior, the document also revealed patient has refused daily changes, seems confused, please continue to offer daily wound care. Review of the electronic medical record on January 27, 2026, revealed no evidence that the document was part of the resident's medical record.A paper document titled Formal Wound Assessment, with handwritten log entries, revealed that on December 26, 2025, the resident did not refuse the assessment, and there was no evidence that the resident refused any wound care treatment, and that the treatment objectives included enzymatic debridement and sacral foam cushion protection. The assessment did not include any evidence whether any wound care treatment was completed or not on December 26, 2025. The documentation revealed that on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 27 and 28, 2025, the resident refused a wound assessment, and refused treatment objectives. The documentation revealed that on December 29, 2025, that the wound was not measured, and that the treatment objectives included enzymatic debridement and sacral foam cushion protection, however also included that the resident refused santyl; educated. The document included no evidence of what wound care treatment was provided, if any. Review of the electronic medical record on January 27, 2026, revealed no evidence that the document was part of the resident's medical record.Physician orders dated December 26, 2025, included:- Wound care (Wound Vac): check every 4 hours for proper placement, functioning, and wound vac is upright.- Wound care (Wound Vac): if malfunctions please remove and place hydrogel-soaked gauze and cover area with ABD pad secured with tape, every shift, and notify charge nurse/Director of Nursing (DON)/ Assistant Director of Nursing (ADON).-There was no evidence of physician orders for wound care treatment for the pressure ulcer on the resident's coccyx / sacrum.A Pressure Ulcer Documentation assessment dated [DATE], however created on January 5, 2026 and signed January 6, 2026 by Staff #45, revealed Resident #10 had 1 unstageable pressure ulcer on the sacrum. Measurements were: 4.3 cm x 5.2 cm and depth unable to determine (UTD). The documentation details included Resident #10 was seen for initial assessment of pressure injury to sacral region. Additionally, the resident had diabetic foot ulcers (DFUs) to bilateral lower extremities, and that the sacral pressure wound was obscured thickness with moderate exudate which was serosanguinous in color and non-odorous, and wound bed was 90% slough and 10% granulation tissue, and peri-wound had peeling edges but was otherwise appropriate color for race. The resident experienced 2/10 pain during wound care, and declined daily Santyl (prescription enzymatic medication) at this time, and will continue education.Despite the documentation that the resident declined daily Santyl treatment, there was no evidence in the clinical record of a physician order for Santyl for the sacrum/coccyx wound.Physician orders dated December 27, 2025, included:- Wound care to left foot: cleanse with wound cleanser, pat dry, apply collagen and honey to wound bed followed by oil emulsion dressing. Apply skin prep and cover peri-wound with transparent dressing. Apply green foam followed by more skin prep and transparent dressing. Turn on unit to ensure dressing is on properly. Ensure Vac pressure at 125 mm Hg. Notify DON/ ADON of any changes.- Wound care to right heel: cleanse with wound cleanser, pat dry, paint with iodine. Apply collagen and honey to wound bed and cover with bordered gauze. May frame gauze if needed due to contour of wound area. Notify DON/ ADON of any changes.-There was no evidence of physician orders for wound care treatment to the pressure ulcer on the resident's coccyx / sacrum.A Late Entry History & Physical progress note dated December 26, 2025, however created January 15, 2026, revealed Resident #10 had a pressure ulcer of sacral region, unspecified stage.A Late Entry Wound progress note dated December 26, 2025, however created January 6, 2026, by Staff #45, revealed Resident #10 had a pressure injury to the sacral region which will be charted in the Pressure Ulcer Assessment.A Late Entry Daily Skilled Evaluation dated December 27, 2025, but created December 28, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Daily Skilled Evaluation dated December 28, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Daily Skilled Evaluation dated December 29, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Physician Progress Note dated December 29, 2025, but created January 2, 2026, revealed a list of Resident #10's medical diagnoses, however the list did not include a diagnosis of pressure ulcer of sacrum.A Late Entry Daily Skilled Evaluation dated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 30, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.Despite the documentation of Resident #10 refusing wound care treatment on December 27, 28, 29, and 30, 2025, there was no evidence in the clinical record of education provided to the resident, or that multiple attempts were made, or that the provider was notified that the resident was refusing treatment.An admission minimum data set (MDS) assessment, dated December 31, 2025, revealed Resident #10 had a brief interview for mental status (BIMS) assessment score of 13, indicating intact cognition. Section M - Skin Conditions revealed the resident had no unhealed pressure ulcers/injuries, no venous and arterial ulcers, and no other open lesions other than ulcers, rashes, and cuts. The assessment revealed the resident did have an infection of the foot, a diabetic foot ulcer, and a surgical wound. Regarding treatments, the assessment revealed that Resident #10 did have surgical wound care and application of dressings to feet. However, the documentation revealed the resident did not have pressure ulcer/injury care or applications of non-surgical dressings or ointments/medications other than to feet.A Weekly Skin check and Wound assessment dated [DATE], but created on January 6, 2026 by Staff #45, revealed that Resident #10 had the following skin impairments:nephrostomy tube on the right iliac crestskin impairment on the back of the right handsignificant diabetic foot ulcer on the right heel that was incised and debrided in acute carediabetic foot ulcer on the left heelleft great toe former amputation site, and remaining hallux now infected wound with osteomyelitis, and wound vac in place.diabetic ulcer on left toe(s)pressure injury on sacrum, with no evidence of further details or measurements A Late Entry Wound progress note dated January 2, 2026, but created on January 6, 2026, by Staff #45, revealed documentation for the resident's left foot and right heel wounds. The note also included that the resident also had a pressure injury to the sacrum which would be charted in the Pressure Ulcer Assessment.A Pressure Ulcer Documentation assessment dated [DATE], but created on January 6, 2026, by Staff #45, revealed Resident #10 had 1 unstageable pressure ulcer on the sacrum. Measurements were: 4.3 cm x 5.2 cm and depth unable to determine (UTD). The documentation details included Resident #10 was seen for initial assessment of pressure injury to sacral region. Additionally, the resident had diabetic foot ulcers (DFUs) to bilateral lower extremities, and that the sacral pressure wound was obscured thickness with moderate exudate which was serosanguinous in color and non-odorous, and wound bed was 80% slough and 20% granulation tissue with zinc and sacral foam dressings. Additionally, peri-wound had peeling edges but was otherwise appropriate color for race. The documentation included that the floor nurse spoke with the resident and placed new orders for daily Santyl treatments.The clinical record was reviewed and revealed no evidence of a physician order for zinc for the sacral wound, and additionally no evidence of treatment orders specifying the type and frequency of wound dressing changes for the resident's sacral wound. Despite the documentation that new orders were placed for daily Santyl treatments, there was no evidence in the clinical record that a physician order was placed on January 2, 2026.Review of the resident's medical diagnoses list in the electronic medical record (EMR) revealed a diagnosis of pressure ulcer of sacral region, unspecified stage, was created on January 6, 2026, by Staff #45. There was no evidence of a medical diagnosis for pressure ulcer on the sacrum or coccyx created prior to January 6, 2026.A Late Entry Daily Skilled Evaluation progress note dated January 3, 2026, however created by an LPN (Staff #71) on January 4, 2026, revealed wound care completed today using aseptic technique and prescription medication to wound bed and to see TAR (treatment administration record) and wound notes for details, and that the resident tolerated wound care well. The note did not specify what site of the resident's body the wound care was provided to or which prescription medication was applied to where.A Daily (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skilled Evaluation note dated January 4, 2026, revealed the resident tolerated wound care well, but did not specify what wound care treatment or to which body site.Review of the clinical record revealed no evidence of any physician order for wound care treatment to the resident's coccyx or sacrum from when the resident admitted on [DATE] until January 6, 2026.A physician order dated January 6, 2026, with a start date of January 7, 2026, included for wound care to coccyx: cleanse with wound cleanser, pat dry, apply Santyl to wound bed, followed by oil emulsion dressing, apply skin prep and cover with sacral foam dressing, and to notify DON/ADON of any changes.Review of the Medication Administration Record and Treatment Administration Record (MAR / TAR) for December 2025 revealed no evidence of any wound care treatment provided to the resident's coccyx or sacrum. Review of the MAR / TAR for January 2026 revealed treatment to the resident's coccyx started on January 7, 2026.An interview was conducted with a licensed practical nurse (LPN / Staff #19) on January 27, 2026, at 12:25 p.m. who stated that as a floor nurse, she completes an admission assessment on a new resident that admits to the unit. Staff #19 stated that additionally, a skin assessment and Braden Scale assessment are completed for a resident upon admission and documented in the electronic medical record (EMR), and that all wounds and skin impairments are documented on the skin assessment form. Staff #19 stated that the floor nurses are not supposed to take any measurements of the wounds, and that the wound nurse (Staff #45) is the staff responsible for taking wound measurements.A telephonic interview was conducted with an LPN (Staff #71) on January 27, 2026, at 12:32 p.m., who stated that for a new admission resident, nurses complete a head to toe skin assessment that is documented on the weekly skin assessment form in the EMR. If a resident had a pressure ulcer, then Staff #71 stated a nurse would inform the wound nurse (Staff #45) in order for her to complete further assessment. Regarding Resident #10, Staff #71 stated that he had been the nurse for Resident #10, and that the resident had wounds on his feet, but that he did not believe the resident had any wounds on his sacrum region.A telephonic interview was conducted with an MDS coordinator registered nurse (RN / Staff #90) on January 27, 2026, at 2:09 p.m. who stated that she completes resident assessments that are relevant to the MDS, and that she also reviews data from the EMR in order to complete the MDS assessments for residents. Staff #90 stated that she reviews admission skin assessments from the resident's EMR in order to complete the MDS assessment accurately, and if she has any further questions, she would contact the wound nurse (Staff #45). Staff #90 stated that if the MDS assessment were not completed accurately, then aspects of the resident's care plan or treatment may be missed. The admission MDS assessment for Resident #10 was reviewed, and Staff #90 stated that the assessment included that the resident had osteomyelitis, a diabetic foot ulcer, and a surgical wound, and that the resident did not have any pressure ulcers. The care plan for Resident #10 was reviewed, and Staff #90 stated that a care plan dated December 25, 2025, included that the resident had a pressure ulcer to the coccyx. Staff #90 stated that it looked like the admission MDS assessment had not been completed accurately, and that it looked like the pressure ulcer on the coccyx was missed. Staff #90 reviewed the Resident #10's physician orders, and stated that wound care treatments for the resident's coccyx / sacrum started on January 7, 2026.An interview was conducted with the ADON / RN (Staff #45) on January 27, 2026, at approximately 2:30 p.m. who stated that she performs wound assessments for residents on admission if she is notified via record review or by nursing staff that a resident has a wound that requires assessment, and that she performs weekly wound assessments, and oversees the wound program. Regarding Resident #10, Staff #45 reviewed the clinical record and stated that he had an unstageable pressure ulcer on his sacrum on admission, and that it measured 4.3 x 5.2 centimeters (cm). Staff #45 stated that initially, Resident #10 was ordered daily Santyl wound treatments for his sacrum, and that the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was refusing the wound care. Then, Staff #45 stated over the course of the resident's admission, he became more compliant. Regarding, the Pressure Ulcer Documentation assessment dated [DATE], however created January 5, 2026, Staff #45 stated that it was entered in the medical record late because she got behind in her paperwork. Staff #45 stated that she keeps her own records of the wound assessments that she performs, and that herself and the DON have access to them.An interview was conducted with the Director of Nursing (DON / Staff #66) on January 27, 2026, at approximately 3:00 p.m. who stated that his expectation for floor nurses to assess new admission residents was that multiple types of assessments are completed, and are often dependent on the resident's diagnoses. The DON stated that all new admission residents should have a head to toe skin assessment completed, and recorded in the medical record. Additionally, the DON stated that if a resident had wounds, depending on the type of wound, further assessment and measurements would be completed. The DON stated that a risk to a resident if something was missed on initial assessment would be potentially something could be missed, such as a treatment. Regarding Resident #10, the DON stated that he was not very familiar with the resident, but that he was aware that the resident had wounds. The clinical record was reviewed, and the DON stated that the resident had a pressure ulcer on the coccyx, and feet, and that the resident had a wound vac but could not state where the wound vac was located based on his review of the medical record. The DON also stated that depending on a resident's anatomy, the word coccyx and sacrum could be at times used interchangeably because the regions are so close together on the body. The DON deferred further detailed questions regarding Resident #10's wounds to the ADON / wound nurse (Staff #45).A follow-up interview was conducted with the ADON (Staff #45) on January 27, 2026, at approximately 3:15 p.m. who then provided paper handwritten documentation, including the Treatment Plan and Evaluation of Care document, dated December 26, 2025, and signed by Staff #45, to which she stated was her treatment plan that she recommended for Resident #10. Staff #45 also provided the paper document titled Formal Wound Assessment, which she stated showed that the wound treatment was offered and provided. Staff #45 stated that there was not a physician signature on her treatment plan, and she believed she had told the physician about her treatment recommendation.Another interview was conducted with the DON (Staff #66) on January 27, 2026, at approximately 3:20 p.m. who provided a paper copy of the facility's Standing Wound Orders and Instructions, and stated that the standing wound orders covered both dressing change and debridement, so no other physician order was needed for Resident #10's wound care treatment.Review of the facility's Standing Orders and Instructions for All Patients, signed by a provider, and dated February 27, 2025, included that these wound care treatment plan instructions must be followed by nursing staff to ensure optimal wound healing. Minor modifications or clarifications to treatment plan orders may be made, such as specifying dressing brands, or adjusting dressing change days to align with the facility's dressing supply, staff scheduling, or patient preference. However, unless specified otherwise, the type of dressings used may not be changed in the treatment plan order without provider authorization.Standard Wound Preparation and Cleaning: Unless indicated or instructed otherwise, standard care protocol for ALL wounds includes the following: When possible, schedule dressing changes around shower days. Unless specified otherwise, dressings may be removed, and wounds cleaned in the shower. Nurse may apply lidocaine spray/cream before cleaning/debriding wound for patient comfort. Clean wounds, peri-wounds, and peripheral skin with Hibiclens or similar antiseptic soap, then irrigate with an antimicrobial wound cleanser (e.g., Vashe, Dakins 0.0125%, commercial wound wash, etc.). Paint peri-wound immediately around the wound with iodine or other antiseptic before dressing placement. Use skin prep solution (e.g., benzoin, Mastisol, skin prep, etc.) when applying bordered adhesive dressings. All bordered dressings may (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure that the medical record was complete, accurate, and readily accessible for one resident (#10). The deficient practice could lead to care team members not being aware of a resident's status.-Findings include:Resident #10 was admitted to the facility December 25, 2025, with diagnoses of dementia, other acute osteomyelitis of right ankle and foot, sepsis, pressure-induced deep tissue damage of right heel, non-pressure chronic ulcer of skin of other sites, type 2 diabetes mellitus with foot ulcer, Alzheimer's disease, and acquired absence of left great toe.A physician order dated December 25, 2025, included to complete a skin check weekly.A Weekly Skin check and Wound assessment dated [DATE], revealed the resident had the following skin impairments:nephrostomy tube on the right iliac crestskin impairment on the back of the right handsignificant diabetic foot ulcer on the right heel that was incised and debrided in acute carediabetic foot ulcer on the left heelleft great toe former amputation site, and remaining hallux that was an infected wound with osteomyelitis, and wound vac in place.diabetic ulcer on left toe(s)pressure injury on sacrum, with no evidence of further details or measurementsA care plan focus initiated December 25, 2025, revealed Resident #10 had a skin impairment of pressure ulcer to coccyx. Interventions included to administer treatments as ordered and monitor for effectiveness, to have a pressure-relieving mattress, a weekly skin assessment completed by licensed staff, and to monitor / document / report to physician changes in skin status as needed.A handwritten paper Treatment Plan and Evaluation of Care document, dated December 26, 2025, and signed by Staff #45, revealed to cleanse with wound cleanser, apply Santyl (prescription enzymatic medication), cover with oil emulsion (adaptic), apply skin prep to periwound and cover with sacral dressing, and if patient refuses full treatment, please apply zinc oxide and cover dressing, to be completed daily. Despite the resident having just admitted to the facility on e day prior, the document also revealed patient has refused daily changes, seems confused, please continue to offer daily wound care. Review of the electronic medical record on January 27, 2026, revealed no evidence that the document was part of the resident's medical record.A paper document titled Formal Wound Assessment, with handwritten log entries, revealed that on December 26, 2025, the resident did not refuse the assessment, and there was no evidence that the resident refused any wound care treatment, and that the treatment objectives included enzymatic debridement and sacral foam cushion protection. The assessment did not include any evidence whether any wound care treatment was completed or not on December 26, 2025. The documentation revealed that on December 27 and 28, 2025, the resident refused a wound assessment, and refused treatment objectives. The documentation revealed that on December 29, 2025, that the wound was not measured, and that the treatment objectives included enzymatic debridement and sacral foam cushion protection, however also included that the resident refused santyl; educated. The document included no evidence of what wound care treatment was provided, if any. Review of the electronic medical record on January 27, 2026, revealed no evidence that the document was part of the resident's medical record.Physician orders dated December 26, 2025, included:- Wound care (Wound Vac): check every 4 hours for proper placement, functioning, and wound vac is upright. There was no evidence specifying to what site.- Wound care (Wound Vac): if malfunctions please remove and place hydrogel-soaked gauze and cover area with ABD pad secured with tape, every shift, and notify charge nurse/Director of Nursing (DON)/ Assistant Director of Nursing (ADON). There was no evidence specifying to what site.-There was no evidence of physician orders for wound care treatment for the pressure ulcer on the resident's coccyx / sacrum.A Pressure Ulcer (continued on next page)

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	035277	A. Building B. Wing	01/27/2026

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Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation assessment dated [DATE], however created on January 5, 2026 and signed January 6, 2026 by a registered nurse / Assistant Director of Nursing (RN / ADON / Staff #45), revealed Resident #10 had 1 unstageable pressure ulcer on the sacrum. Measurements were: 4.3 cm x 5.2 cm and depth unable to determine (UTD). The documentation details included Resident #10 was seen for initial assessment of pressure injury to sacral region. Additionally, the resident had diabetic foot ulcers (DFUs) to bilateral lower extremities, and that the sacral pressure wound was obscured thickness with moderate exudate which was serosanguinous in color and non-odorous, and wound bed was 90% slough and 10% granulation tissue, and peri-wound had peeling edges but was otherwise appropriate color for race. The resident experienced 2/10 pain during wound care, and declined daily Santyl (prescription enzymatic medication) at this time, and will continue education.Despite the documentation that the resident declined daily Santyl treatment, there was no evidence in the clinical record of a physician order for Santyl for the sacrum/coccyx wound.Physician orders dated December 27, 2025, included:- Wound care to left foot: cleanse with wound cleanser, pat dry, apply collagen and honey to wound bed followed by oil emulsion dressing. Apply skin prep and cover peri-wound with transparent dressing. Apply green foam followed by more skin prep and transparent dressing. Turn on unit to ensure dressing is on properly. Ensure Vac pressure at 125 mm Hg. Notify DON/ ADON of any changes.- Wound care to right heel: cleanse with wound cleanser, pat dry, paint with iodine. Apply collagen and honey to wound bed and cover with bordered gauze. May frame gauze if needed due to contour of wound area. Notify DON/ ADON of any changes.-There was no evidence of physician orders for wound care treatment to the pressure ulcer on the resident's coccyx / sacrum.A Late Entry History & Physical progress note dated December 26, 2025, however created January 15, 2026, revealed Resident #10 had a pressure ulcer of sacral region, unspecified stage.A Late Entry Wound progress note dated December 26, 2025, however created January 6, 2026, by Staff #45, revealed Resident #10 had a pressure injury to the sacral region which will be charted in the Pressure Ulcer Assessment.A Late Entry Daily Skilled Evaluation dated December 27, 2025, but created December 28, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Daily Skilled Evaluation dated December 28, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Daily Skilled Evaluation dated December 29, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.A Late Entry Physician Progress Note dated December 29, 2025, but created January 2, 2026, revealed a list of Resident #10's medical diagnoses, however the list did not include a diagnosis of pressure ulcer of sacrum.A Late Entry Daily Skilled Evaluation dated December 30, 2025, but created December 31, 2025, revealed Resident #10 refused wound care, but did not specify which wound care treatment was refused, or whether all wound care treatment was refused.Despite the documentation of Resident #10 refusing wound care treatment on December 27, 28, 29, and 30, 2025, there was no evidence in the clinical record of education provided to the resident, or that multiple attempts were made, or that the provider was notified that the resident was refusing treatment.An admission minimum data set (MDS) assessment, dated December 31, 2025, revealed Resident #10 had a brief interview for mental status (BIMS) assessment score of 13, indicating intact cognition. Section M - Skin Conditions revealed the resident had no unhealed pressure ulcers/injuries, no venous and arterial ulcers, and no other open lesions other than ulcers, rashes, and cuts. The assessment revealed the resident did have an infection of the foot, a diabetic foot ulcer, and a surgical wound. Regarding treatments, the assessment revealed (continued on next page)

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