STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	900 Mountain Ranch Road San Andreas, CA 95249

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 - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50716 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) received care to prevent the development of pressure ulcers/injuries (PU/PI - areas of damaged skin caused by staying in one position for too long, usually over an area on the body where a bone is close to the skin's surface (bony prominence)) when: 1. Resident 1 was at risk for developing pressure ulcers and worsening of a shearing wound (a force that causes the skin and underlying tissues to move in opposite directions, often due to pressure and friction) on the coccyx (tailbone). Resident 1's skin assessments and wound documentation were incomplete, the physician was not notified the wound had worsened, and PU preventative measures were not correctly identified and implemented upon admission; and, 2. Resident 2 was at risk of developing pressure ulcers and worsening of a shearing wound on the coccyx and blanchable redness (a temporary reddening of the skin that disappears when pressure is applied) to both heels. Resident 2's skin assessments and wound documentation were incomplete and measures to prevent PU development were not implemented. These failures resulted in Resident 1 having wound pain and required surgical intervention at a hospital with the placement of a wound vacuum (VAC -a medical treatment that uses negative pressure to help severe wounds heal). In addition, these failures resulted in Resident 2 developing a deep tissue injury (DTI - deep skin and tissue loss where the extent of the damage cannot be determined because it is covered by eschar (black dead tissue)) to the left heel and had the potential to result in increased pain, infection (the invasion and growth of germs in the body), and muscle or bone loss. Findings: 1. A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility in Spring 2025 with diagnoses which included but not limited to: sepsis (a life-threatening infection), arthritis (swelling and tenderness where two or more bones meet, causing joint pain and/or stiffness) due to other bacteria (an infection in the joint fluid and tissues caused by bacteria), chronic obstructive pulmonary disease (COPD -a chronic lung disease causing difficulty breathing), and muscle weakness. A review of Resident 1's Minimum Data Set (MDS -an assessment tool), dated 4/22/25, in the section, M -Skin Conditions, indicated, Resident 1 was at risk of developing pressure ulcers. (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 - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/13/25, at 1:19 PM, Resident 1's electronic health record (EHR) was reviewed with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was admitted with two wounds, one on the left hand, and a shearing wound on the coccyx. Resident 1's Admission -Readmission Nursing Evaluation . dated 4/18/25, indicated, .Indicate Pressure Ulcers and/or other wound types .Sacrum [triangular shaped bone in the lower back located between the hip bones] .Type: Pressure [injury to skin and underlying tissue resulting from prolonged pressure on the skin] .Length 1.8 [cm- centimeter -a metric unit of length], Width 0.8 [cm], Depth 0.1 [cm], Stage II [2 -partial-thickness skin loss, presenting as a shallow open wound; wounds are classified into stages to indicate the depth of tissue damage and includes stages 1 through 4 and unstageable (when dead tissue is covering the wound making it unable to determine the depth of the wound)] . LN 1 stated the nurse who completed Resident 1's Admission-Readmission Nursing Evaluation was not a wound nurse. LN 1 stated he updated the description of the wound on the order he entered after he assessed Resident 1's wounds. LN 1 confirmed he entered .Cleanse [clean] shearing wounds to coccyx . to Resident 1's orders on 4/18/25 which changed the type of wound listed on the order from pressure ulcer to shearing wound. LN 1 stated he did not document in a progress note (a written record that documents a resident's health status, treatment progress, and any changes in their condition over time) the measurements, location, and description of what the wound looked like after his initial assessment. LN 1 further stated he needed to get better at documentation, and he tried to make weekly progress notes but stated he missed the charting. LN 1 confirmed Resident 1's BRADEN SCALE [a widely used tool in healthcare to assess and predict a patient's risk for developing pressure ulcers] FOR PREDICTING PRESSURE SORE RISK, dated 4/18/25, indicated, .MOISTURE .Rarely Moist [the degree to which skin is exposed to moisture ranging from rarely moist to constantly moist], .MOBILITY [the ability to move or be moved freely and easily] .Very Limited: Makes occasional slight changes in body or extremity [arms and/or legs] position but unable to make frequent or significant changes independently .[Resident 1 was] AT RISK [risk levels for pressure ulcer development range from at risk, moderate risk, high risk, or very high risk based off of the score obtained from the Braden scale assessment tool] . for pressure ulcers. LN 1 stated he disagreed with Resident 1's initial Braden scale assessment risk level since Resident 1 was fully incontinent of bowel and bladder (involuntary loss of urine or feces), had a high moisture risk, was immobile (not capable of movement), and required assistance to turn or reposition in bed. LN 1 stated Resident 1's Braden Scale assessment should have been assessed as a high risk for pressure ulcer development. LN 1 further stated it was his expectation for Resident 1 to be turned and repositioned every two hours to prevent the wound from worsening. LN 1 explained he completed Resident 1's wound care based on the treatment listed on the treatment administration record (TAR - a document used to track the administration of various treatments, including medications, therapies, and procedures). LN 1 stated he noted on 4/24/25 Resident 1's wound to the coccyx worsened and the wound size increased. LN 1 reviewed Resident 1's Progress Notes, dated 4/24/25, written by LN 1, which indicated, .LATE ENTRY .Provided wound care for resident with shearing wound to coccyx .Wound size went from 3.5x1.5x0.1 [length, width, depth in cm] on admission to 6.2x3x0.1 . discolored sheared skin. Periwound [around the wound] is macerated [softening and breaking down of the skin resulting from prolonged exposure to moisture] .Resident complains of discomfort wound pain 6/10 [pain scale 0-no pain to 10-worse pain] with wound care . LN 1 confirmed that the late entry for the worsening of Resident 1's wound was written in Resident 1's EHR on 5/7/25. LN 1 stated he forgot to document Resident 1 had a worsening condition of the wound on 4/24/25 and confirmed he did not notify the doctor. LN 1 further stated it was facility policy to notify the doctor and to document worsened conditions immediately to obtain new physician orders for wound treatment. Resident 1's EHR was reviewed by LN 1, and he was unable to locate any further documentation regarding Resident 1's worsening wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a follow up interview on 5/13/25 at 2:49 PM, LN 1 stated documentation in a resident's medical record was important because it provided accurate and efficient documentation on what was happening with the resident. LN 1 further explained it was important to document timely and notify the doctor of a change in a resident's medical condition to keep the doctor and care team up to date, and the doctor could give new orders to prevent wounds from getting worse. LN 1 stated the risk to a resident not being turned every two hours (q2h -a patient care practice where a patient is repositioned every two hours) was it increased skin breakdown, decreased circulation (inadequate blood flow through the body's blood vessels), was not good for anyone to stay in one position too long, and for comfort of the resident. LN 1 reviewed Resident 1's medical record but could not find evidence Resident 1 was turned every 2 hours, or where Resident 1 refused to be turned. During a concurrent telephone interview and record review on 5/14/25, at 1:16 PM, LN 4 (a nurse from the hospital Resident 1 was sent from and back out to), confirmed she wrote Resident 1's Progress Note, dated 4/18/25 (day Resident 1 discharged from the hospital and was admitted to the facility) and took photos of the wound to Resident 1's coccyx during her stay at the hospital. LN 4 further stated Resident 1's Progress Note, indicated, .Coccyx continues to have an area of friction [force of rubbing between two surfaces] to left coccyx, wound bed is pink with red frayed [ragged] edges, blanchable erythema [a reddening of the skin that disappears when pressure is applied and returns to normal color when pressure is released], hyperpigmentation [areas of skin that appear darker than the surrounding areas] is noted at gluteal cleft [the deep groove or crease that separates the two buttocks] .skin intact .goals are to .reduce friction and pressure .turn q2hours . LN 4 further stated when Resident 1 returned to the hospital on 4/27/25, Resident 1's wound was re-evaluated and confirmed Resident 1's coccyx had worsened. LN 4 stated the wound covered both sides of Resident 1's buttocks creating an unstageable pressure ulcer with a foul odor (likely indicating infection). LN 4 confirmed Resident 1 required surgical debridement (removal of damaged tissue from a wound) on 5/3/25 and Resident 1 had to have a wound vacuum placed on the coccyx to help close the wound. A review of Resident 1's, Care Plan Report, dated 4/19/25, indicated, . [Resident 1] has skin sheering to her coccyx upon admit .Goal [Resident 1's] skin will show signs of improvement .Interventions/Tasks .Monitor for s/sx [signs and symptoms] of infection .Notify MD [medical doctor] of s/sx of infection . A review of Resident 1's, Nursing Progress Note, dated 4/24/25 (late documentation on 5/7/25), indicated, . LATE ENTRY .Provided wound care for resident with shearing wound to coccyx, increase in size r/t [related to] persistent watery stools. Wound size went from 3.5x1.3x0.1 on admission to 6.2x3x0.1. Wound bed is 100% [percent] granulation [pink or red, fleshy skin growth] with discolored sheared skin. Periwound is macerated. Resident complains of discomforting wound pain 6/10 with wound care . A review of Resident 1's Order Details, order date 4/18/25, indicated, .Cleanse shearing wounds to coccyx with NS [normal saline -salt water], pat dry .every day shift for skin shearing . A review of Resident 1's Order Details, order date 4/18/25, indicated, .Monitor shearing wounds to coccyx for s/s [signs/symptoms] of infection until resolved . A review of Resident 1's Order Details, order date 4/19/25, indicated, .Cleanse shearing wounds to coccyx with NS, pat dry .cover with foam dressing [an absorbent wound covering to promote wound healing] .every day shift for skin shearing AND as needed for soiled, lifting or missing [dressing] . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Nursing Progress Note, dated 4/26/25, indicated, . [Resident 1] transferred to ER [emergency room] . [Resident 1] was having hallucinations [sensing things such as visions, sounds, or smells that seem real but are not] and thinking people were in bed with her, nurse noted grayish appearance . Review of an online version of a published book titled NURSING FUNDAMENTALS SECOND EDITION, dated 2024, in the section 10.5 Braden Scale, indicated, .Each risk factor on the Braden Scale is rated from 1 to 4 based on the client's assessment findings. When using the Braden Scale, start with the first category and review each description listed across the row for each of the ratings from 1 to 4, and choose the one that best describes the client's current status. Continue this process for all rows. Add all six numbers to determine a total score, and then use the total score to determine if the client is at mild, moderate, high, or severe risk for developing a pressure injury. The lower the score, the higher the risk of developing a pressure injury. Additionally, customized nursing interventions are implemented based on the rating in each category. The lower the score, the more aggressive actions are taken to prevent or heal a pressure injury . (https://wtcs.pressbooks.pub/nursingfundamentals/chapter/10-5-braden-scale/) 2. A review of Resident 2's ADMISSION RECORD indicated Resident 2 was admitted to the facility in the Summer of 2022 with diagnoses which included but not limited to: Cerebral Infarction (otherwise known as Ischemic Stroke -the death of brain tissue due to a lack of blood supply), difficulty in walking, muscle weakness, and heart failure (when the heart is unable to pump enough blood to meet the body's needs). A review of Resident 2's Minimum Data Set (MDS -an assessment tool), dated 3/02/25, in the section, M -Skin Conditions, indicated, Resident 2 was at risk of developing pressure ulcers. During a concurrent interview and record review on 5/13/25 at 2 PM, Resident 2's EHR was reviewed with LN 1. LN 1 stated Resident 2's shearing wound to the coccyx was first documented on 3/11/25 and confirmed Resident 2 obtained the wound while residing in the facility. LN 1 confirmed Resident 2 also had blanchable redness (a red or discolored area that turns white or pale when pressed) documented to both the right and left heels on 4/5/25. LN 1 confirmed monitoring of Resident 2's coccyx and heels was placed on the TAR and began on 4/5/25. LN 1 confirmed Resident 2 was immobile, depended on staff for all care, and stated Resident 2 needed to be turned q2h and had heel lift boots (a type of boot or device designed to elevate the heel) applied to both heels to prevent worsening redness and pressure ulcer development. LN 1 further stated the heel lift boots were required anytime Resident 2 was in bed. LN 1 further stated the care plan indicated Resident 2 was to be turned every 2 hours and was incontinent of bladder and bowel. LN 1 further explained it was important that these interventions were implemented to prevent pressure ulcers or other skin wounds from worsening. LN 1 confirmed Resident 2 should be turned every 2 hours by the CNA's (Certified Nursing Assistants). LN 1 confirmed Resident 2's EHR showed no evidence she had been turned every 2 hours per the care plan. During a concurrent interview and record review on 5/13/25 at 2:31 PM, CNA 3 stated the CNA's do not turn residents every 2 hours because they did not have any residents that required it. CNA 3 reviewed Resident 2's EHR and confirmed the care plan for Resident 2 indicated for her to be turned at least every 2 hours, however, CNA 3 stated she would have no way of knowing what was in resident's care plans. CNA 3 further stated she relied on the nurses to tell them, and she stated she had never been told any resident's required being turned or repositioned every 2 hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 5/13/25 at 2:09 PM, with LN 1, in Resident 2's room, Resident 2 was observed lying in bed on her back. LN 1 exposed Resident 2's legs by removing the covers. Resident 2 had on the right sided heel lift boot; however, the left heel was lying on the bed and not in the boot. LN 1 then proceeded with wound care to the left heel. LN 1 removed a foam bandage on Resident 2's left heel. Resident 2's left medial (situated toward the middle of the body) heel where the foam bandage was removed was indented with the bandage and exposed a 2-3 cm dark black puffy circle. LN 1 stated when he last saw the left heel on 5/10/25 it was not like this. LN 1 further stated it was unusual for the wound to turn from just redness to black calling it a deep tissue injury with eschar (dry, leathery, black or brown dead tissue that forms over a wound). LN 1 further explained he was off for the last 2 days and was not notified of any changes, and did not see any documentation in Resident 2's medical record to indicate worsening to the left heel. LN 1 cleansed the wound and replaced the bandage. LN 1 then rolled Resident 2 directly onto her right side exposing her back and buttocks. LN 1 removed the foam bandage covering the wound to Resident 2's coccyx. Resident 2's coccyx had two opened areas actively bleeding and just above on the sacrum was a round opened, and bleeding wound consistent with a Stage 3 pressure ulcer (full-thickness skin loss that extends into the deepest layer of skin) circular in size on a bony prominence, surrounded by non-blanchable redness (a red or discolored area that does not turn white or pale when pressed). LN 1 stated he still believed the wound to the coccyx and sacrum was a shearing wound due to the odd shape and stated it was not a pressure ulcer because it was not circular, but did state the wound was larger. During a concurrent interview and record review on 5/13/25 at 2:49 PM, LN 1 stated the last measurement of the wound was 1.9 x 1.2 cm that he had documented on a written piece of paper that listed each resident with wounds for the week of 4/24/25. LN 1 confirmed there was not any additional written documentation of the wound to Resident 2's coccyx or left heel other than checking off the wound care was completed in the TAR. LN 1 confirmed his documentation was lacking due to time restraints and could be better, but would document the changes he observed today, including getting the wound care clinic involved in treating Resident 2 since the wounds worsened. LN 1 reviewed Resident 2's EHR and stated the only documentation of the skin was done on 5/11/25 on the Long Term Care Weekly Evaluation . form and stated the nurse who completed the evaluation checked the box that indicated, .No New Impairment. Skin clean, dry and intact . LN 1 confirmed the skin was not intact and stated it was his understanding the wounds to the coccyx and left heel were healing and not worsening. During a concurrent interview and record review on 5/13/25 at 2:39 PM, LN 2 stated the expectation for residents who are unable to turn themselves or adjust their own body position in bed was to turn them every 2 hours. LN 2 explained that the CNA's were responsible for this task. Review of Resident 2's, Care Plan Report dated 8/25/22, indicated, . [Resident 2] has an ADL [activities of daily living] performance deficit related to s/p [status post] CVA [Cerebral Vascular Accident; otherwise known as stroke] . [Resident 2] requires substantial/maximal assistance by staff to turn and reposition in bed . In addition, LN 2 confirmed the same care plan report indicated . [Resident 2] was at risk for skin breakdown/pressure injury . [Resident 2] needs assistance to turn/reposition at least every 2 hours, more often as needed . LN 2 stated the residents were turned every two hours because it was a known standard of care. LN 2 further explained she was unable to find evidence in Resident 2's EHR which showed Resident 2 was turned every 2 hours per Resident 2's care plan. LN 2 stated it was important to document the residents turns to help prevent further skin breakdown and it allowed everyone to capture the whole picture of care being provided. LN 2 further stated the risk of not being turned every 2 hours was further skin breakdown or the creation of a new skin wound that could cause pain or infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's Order Details order date 4/5/25, indicated, .Cleanse open area to coccyx with normal saline, pat dry with gauze, apply [brand name bandage] to wound bed, cover with dry dressing .every day shift Change dressing PRN [as needed] if soiled or dislodge . A review of Resident 2's Order details, dated 4/5/2025, indicated, .Monitor left heel blanchable redness for skin breakdown .every shift . A review of Resident 2's Order details, dated 5/13/25, indicated, .Apply skin prep to L [left] heel DTI .every day and evening shift for DTI pressure injury . A review of a facility policy and procedure (P&P) titled, Charting and Documentation, revised 7/17, indicated, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record . The following information is to be documented in the resident medical record .treatments or services performed .changes in the resident's condition .progress toward or changes in the care plan goals . documentation of procedures and treatments will include care-specific details .The date and time the procedure/treatment was provided .The assessment date and/or any unusual findings obtained during the procedure/treatment .How the resident tolerated the procedure/treatment .Notification of family, physician or other staff . A review of a facility P&P titled, Change in a Resident's Condition or Status, revised 11/15, indicated, .Our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical . condition and/or status .A significant change of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .notifications will be made within twenty-four (24) hours of a change . A review of a facility P&P titled, Goals and Objectives, Care Plans, revised 4/09, indicated, .Care plan goals and objectives are defined as the desired outcome for a specific resident problem .When the goals and objectives are not achieved, the resident's clinical record will be documented as to why the results were not achieved .Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved . A review of an undated facility P&P titled, Wound Prevention, indicated, .The purpose of this program is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds .Upon admission .and when a significant change in the resident status occurs, the resident's skin will be evaluated head-to-toe by licensed nurse . Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's Electronic Medical Record (EMR) . A review of an undated facility P&P titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, indicated, . The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers .the nurse shall describe and document/report .full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue .pain assessment . Resident's mobility status .current treatments, including support surfaces . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of an online John Hopkins Medicine article, copyright 2024, titled, Bedsores [pressure ulcers], indicated, .Bedsores can happen when a person is bedridden or otherwise immobile .Bedsores are ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, or wearing a cast for a prolonged time. Bedsores are also called pressure injuries, pressure sores, pressure ulcers, or decubitus ulcers. Bedsores can be a serious problem among frail older adults. They can be related to the quality of care the person receives. If an immobile or bedridden person is not turned, positioned correctly, and given good nutrition and skin care, bedsores can develop .A bedsore develops when blood supply to the skin is cut off for more than 2 to 3 hours. As the skin dies, the bedsore first starts as a red, painful area, which eventually turns purple. Left untreated, the skin can break open and the area can become infected. A bedsore can become deep. It can extend into the muscle and bone. Once a bedsore develops, it is often very slow to heal. Depending on the severity of the bedsore, the person's physical condition, and the presence of other diseases .bedsores can take days, months, or even years to heal . The most severe sores may require a hospital stay to fight infection or surgery may be needed . (https://www.hopkinsmedicine. org/health/conditions-and-diseases/bedsores#:~:text=A%20bedsore%20develops%20when%20blood, A%20bedsore%20can%20become%20deep.) Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) received care to prevent the development of pressure ulcers/injuries (PU/PI - areas of damaged skin caused by staying in one position for too long, usually over an area on the body where a bone is close to the skin's surface (bony prominence)) when: 1. Resident 1 was at risk for developing pressure ulcers and worsening of a shearing wound (a force that causes the skin and underlying tissues to move in opposite directions, often due to pressure and friction) on the coccyx (tailbone). Resident 1's skin assessments and wound documentation were incomplete, the physician was not notified the wound had worsened, and PU preventative measures were not correctly identified and implemented upon admission; and, 2. Resident 2 was at risk of developing pressure ulcers and worsening of a shearing wound on the coccyx and blanchable redness (a temporary reddening of the skin that disappears when pressure is applied) to both heels. Resident 2's skin assessments and wound documentation were incomplete and measures to prevent PU development were not implemented. These failures resulted in Resident 1 having wound pain and required surgical intervention at a hospital with the placement of a wound vacuum (VAC -a medical treatment that uses negative pressure to help severe wounds heal). In addition, these failures resulted in Resident 2 developing a deep tissue injury (DTI - deep skin and tissue loss where the extent of the damage cannot be determined because it is covered by eschar (black dead tissue)) to the left heel and had the potential to result in increased pain, infection (the invasion and growth of germs in the body), and muscle or bone loss. Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	900 Mountain Ranch Road San Andreas, CA 95249

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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 0686 Level of Harm - Actual harm Residents Affected - Few	1. A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility in Spring 2025 with diagnoses which included but not limited to: sepsis (a life-threatening infection), arthritis (swelling and tenderness where two or more bones meet, causing joint pain and/or stiffness) due to other bacteria (an infection in the joint fluid and tissues caused by bacteria), chronic obstructive pulmonary disease (COPD -a chronic lung disease causing difficulty breathing), and muscle weakness. A review of Resident 1's Minimum Data Set (MDS -an assessment tool), dated 4/22/25, in the section, M -Skin Conditions, indicated, Resident 1 was at risk of developing pressure ulcers. During a concurrent interview and record review on 5/13/25, at 1:19 PM, Resident 1's electronic health record (EHR) was reviewed with Licensed Nurse (LN) 1. LN 1 stated Resident 1 was admitted with two wounds, one on the left hand, and a shearing wound on the coccyx. Resident 1's Admission -Readmission Nursing Evaluation . dated 4/18/25, indicated, .Indicate Pressure Ulcers and/or other wound types .Sacrum [triangular shaped bone in the lower back located between the hip bones] .Type: Pressure [injury to skin and underlying tissue resulting from prolonged pressure on the skin] .Length 1.8 [cm- centimeter -a metric unit of length], Width 0.8 [cm], Depth 0.1 [cm], Stage II [2 -partial-thickness skin loss, presenting as a shallow open wound; wounds are classified into stages to indicate the depth of tissue damage and includes stages 1 through 4 and unstageable (when dead tissue is covering the wound making it unable to determine the depth of the wound)] . LN 1 stated the nurse who completed Resident 1's Admission-Readmission Nursing Evaluation was not a wound nurse. LN 1 stated he updated the description of the wound on the order he entered after he assessed Resident 1's wounds. LN 1 confirmed he entered .Cleanse [clean] shearing wounds to coccyx . to Resident 1's orders on 4/18/25 which changed the type of wound listed on the order from pressure ulcer to shearing wound. LN 1 stated he did not document in a progre [TRUNCATED]