STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056198	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kit Carson Nursing & Rehabilitation Center	811 Court Street Jackson, CA 95642

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide quality of care (each resident must receive the necessary care and services to attain or maintain the highest practicable physical well-being) in accordance with professional standards of practice for one of three sampled residents (Resident 1) when,1.The facility staff did not implement in a timely manner the Wound (tissue injury) Doctor's (WD) verbal recommendation on [DATE] to transfer Resident 1 to an acute care hospital for a higher level of care to treat a worsening venous ulcer wound (shallow, slow-healing, or chronic [long term] wounds) on Resident 1's right leg and/or initiate in a timely manner a verbal order on [DATE] from the Medical Director (MD) to arrange a consultation with a vascular surgeon (a highly trained specialist who diagnoses and manages diseases affecting arteries and veins); the expectation of the WD was the recommendation would have been initiated on [DATE] and the MD's expectation was that the verbal order would be initiated within 24 hours.2.The facility did not monitor Resident 1's vital signs and pain level score from [DATE] through [DATE], every shift for 72 hours, after a deterioration of Resident 1's right leg venous ulcer wound was identified on [DATE] (numerical pain scale 0-10; 0=no pain, 1 through 4 [mild pain], 5 through 6 [moderate pain], 7 through 10 [severe pain]). 3. The facility did not provide wound treatment for Resident 1's right leg venous ulcer as directed by the physician.The cumulative effects of these failures have resulted in Resident 1 experiencing poor quality of care (medical care that falls below the reasonable level of competence) and a delay in a higher level of care from [DATE] through [DATE] (6 days) and resulted in Resident 1's death on [DATE] due to cardio-pulmonary arrest (heart and lungs stop working), septic shock (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection), and necrotizing fasciitis of the right leg (a serious infection that kills the body's tissue).Vital signs - measurement of the body's most basic functions such as body temperature, heart rate per minute, respiration rate per minute, and blood pressure.Findings:A review of Resident 1's clinical record titled, admission Record, (a document that contains the resident's demographic information) indicated Resident 1 was admitted to the facility on [DATE] and Resident 1's diagnosis included a non-pressure chronic ulcer of the right lower leg, cellulitis (potentially serious bacterial skin infection), and type 2 diabetes (the body cannot regulate blood sugar and places the resident at a higher risk for infection). The record further indicated Resident 1 did not have the capacity to make her own decisions and had a Responsible Party ([RP]- usually a family member who assists with decision making when a resident cannot make decisions for oneself]). The record indicated Resident 1's code status was full code (the resident requests that all lifesaving measures be implemented in the case of extreme illness).A review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool), dated [DATE], indicated Resident 1 had a Brief Interview for Mental Status score of 4 reflecting severe cognition impairment.(BIMS - 0 through 15-point standardized assessment used to evaluate cognitive function; 0 through 15 = [intact cognition], 8 through 12 [moderate impairment], and 0 through 4 [severe impairment]).A review of Resident 1's clinical record titled, Order Summary, dated [DATE], indicated, Wound evaluation and treatment by [Wound Care Company Name]. The order did not indicate the frequency of the evaluation.A review of Resident 1's clinical record titled, (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 0684 Level of Harm - Actual harm Residents Affected - Few	Weekly Skin Integrity Assessment for Non-Pressure Sore, date of observation was [DATE], signed by the WN on [DATE], indicated, . right lower leg (front), Venous Ulcer - Wound is larger with significant drainage [fluid leaks out of the wound]; measures about 15cm [centimeters, unit of measurement (L=length)] x [by] 5cm [W=width] x 0.4cm [D=depth] post debridement [the medical removal of dead tissue to promote the growth a healthy tissue]. Wound bed [surface of the wound] 50% [percent, amount for every hundred] S [Slough (a yellow, tan, or white, stringy layer of dead tissue)], 50% G [granulation tissue, new vascular tissue - healing surface of the wound], significant drainage, no odor, no s/sx [signs and symptoms] of infection. wound showing improvement . The clinical record does not describe the type of drainage.A review of Resident 1's clinical record titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, date of observation was [DATE], signed by the WN on [DATE], indicated, .Right lower leg (front) Venous Ulcer - wound shows slow improvement and appears healthier; measures about 15cm[L] x5cm[W] x 0.4cm[D] post debridement. Wound bed 30% S,70% G, significant drainage, no odor, no s/sx of infection. wound showing improvement. The clinical record does not describe the type of drainage.A review of Resident 1's clinical record titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, date of observation was [DATE], signed by the WN on [DATE], indicated, . Right lower leg (front) Venous Ulcer - wound is worse. measures [sic] about 15cm[L]x 5cm[W] x 0.4cm[D] post debridement. 100% slough/necrotic [dead, non-viable tissue resulting in lack of blood flow and/or infection] tissue. heavy [sic], drainage, no odor, no s/sx of infection. WOUND MD recommends hospital admission for operative debridement above and below leg amputation [the surgical removal of a limb (arms) or extremity (legs)] . The clinical record does not describe the type of drainage.During an interview on [DATE] at 12:47 PM with the WN, the WN stated as a Registered Nurse (RN) and Wound Care Nurse, her job duties included weekly rounds (a structured process where a medical team [doctors and nurses] assesses the residents' condition, care plans [a document that indicates the resident's problems, goals, and interventions] are updated on the day the condition or event occurred, and the team coordinates their care with other providers) with the Wound Doctor (WD). The WN stated before rounds, the WN updated the WD with any changes to Resident 1's wound. The WN stated after rounds were conducted with the WD, the facility process included the WN updated the Medical Director (MD - Resident 1's primary doctor) about Resident 1's current health status. The WN stated if the WD suggested a new treatment or provided recommendations, the facility process included the WN carried out the order (to execute, fulfill, or perform a command, instruction, or task) given by the WD.During a follow-up concurrent interview and record review on [DATE] at 12:53 PM with the WN, Resident 1's clinical record titled, Progress Notes, dated [DATE], by the WN, was reviewed for the condition of Resident 1's right lower leg wound. The WN stated although Resident 1's Progress Note was entered on [DATE], it was written to reflect the rounds made by the WD and the WN on [DATE]. The Progress Notes, dated [DATE], indicated, Resident was seen and evaluated by [Wound Care Company Name] MD [Medical Doctor, here refer to the WD] for R [right] lower leg ulcer this week. Wound is Worsening. Wound has 100% slough/necrotic tissue .Wound has heavy drainage.Noted resident in excruciating pain.Pain medication was given prior.Resident still appears in very much pain. Wound MD recommends hospital admission for operative debridement above and below R leg amputation . The WN stated the WD assessed Resident 1's wound on [DATE] and recommended Resident 1 to be admitted to the hospital for an operative debridement because her wound was getting worse. The WN stated the Progress Note, dated [DATE] was a note that should have been documented on [DATE]. The WN stated she had not added the phrase, late entry note, because she did not want the documentation to be flagged as a late entry.During an interview on [DATE] at 12:48 PM with the WD, the WD stated he treated Resident 1's right lower leg wound once a week, and he noticed there was little to no improvement, and eventually the wound worsened. The WD stated he spoke with the MD and the WN on [DATE] and the WD informed the MD that the bedside treatment (wound care) was not effective, Resident 1 was getting worse, and needed to go to the hospital to have a surgical wound debridement or amputation of the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	right leg. The WD stated he expressed urgency and serious concern for Resident 1 with the MD and the MD stated he agreed with his recommendation and (MD) would take care of it and he (MD) walked into Resident 1's room. The WD stated after he spoke with the MD and the WN about his concerns he expected Resident 1 would be transferred to the hospital no later than the end of that day on [DATE]. The WD stated he knew if Resident 1 was not sent out to the hospital for a higher level of care, she would develop sepsis.A review of Resident 1's clinical record titled, Care Plan Report, for Resident 1's skin integrity, initiated on [DATE], indicated, . Recommends hospital admission for operative debridement above/lower leg amputation.During an interview on [DATE] at 3:46 PM with the MD, the MD stated on [DATE] the WD notified him of the serious concern he had for the condition of Resident 1's right lower leg venous stasis ulcer (a shallow, slow-healing open sore that develops from long term insufficient blood supply). The MD stated the WD informed him Resident 1's wound was not healing and that he was concerned that the right lower leg might need to be amputated. The MD stated the WD relayed to him that Resident 1's wound had significant vascular compromise, (lack of blood flow) Resident 1 needed to be seen by a vascular surgeon and required hospitalization. The MD stated after speaking with the WD, he (MD) gave a verbal order to the WN on [DATE] for Resident 1 to be seen by a vascular surgeon. The MD stated after he gave the verbal order to the WN he expected that order to be carried out no later than the following day ([DATE]). A review of Resident 1's clinical record titled, Order Summary Report, indicated, . refer to Vascular Surgeon for worsening R [right] lower leg venous ulcer . was entered into Resident 1's clinical record on [DATE].During a telephone interview on [DATE] at 12:20 PM with the RP, the RP stated Resident 1's baseline level was Resident 1 was aware of her surroundings, communicated, and recognized the family upon arrival. The RP stated on [DATE] he noticed Resident 1 was a little more confused than usual and within the week Resident 1's cognition quickly declined. The RP stated when the family visited Resident 1 on [DATE], Resident 1 could not identify the family. The RP stated he never refused to send Resident 1 to the hospital or complained about cost.A review of Resident 1's clinical record titled, Progress Notes, dated [DATE] at 9:50 AM, by the WN indicated, . 79/42 [blood pressure, low],100 [Oxygen saturation percentage, normal], 30 [respirations per minute, high] .99.6 [temperature, high] Resident not responding per baseline [Resident 1's normal status]. Nonverbal to questions. Refused medications. Refused breakfast. Not taking in any fluids. Facial grimacing with moaning. Refused pain medication.A review of Resident 1's clinical record titled, Care Plan Report, dated [DATE], indicated, .Send to [Hospital] for evaluation and treatment. Resident will transfer via emergency services .During a review of Resident 1's [Hospital] record titled, Discharge Summary, dated [DATE] through [DATE], indicated Resident 1 presented to the Emergency Department (ED) on [DATE] at 10:18 AM with confusion, increased heart rate, and low blood pressure due to septic shock related to cellulitis of the right lower extremity. Resident 1's [NAME] Blood Cell Count (WBC-high count indicates infection) was 25 (high, normal range 5-10), lactic acidosis (high production of lactic acid in the blood indicates sepsis, normal range 0.5 to 1.0) was 2.7. A Computed Tomography (CT- diagnostic test) indicated a large soft tissue defect (a significant loss or injury of skin, fat, muscle, or tendon, that cannot be closed simply) on the lateral (side) of the leg with an underlying fluid collection that opened to the skin's surface and extended to the lateral ankle and forefoot (front of the foot) muscles. Resident 1 was admitted to the Intensive Care Unit (ICU- specialized department in the hospital for critically ill patients) and required vasopressor medications (medications to increase blood pressure and sustain life). Resident 1's blood culture (a laboratory test to detect bacteria in the blood) results were positive for multiple bacteria. On [DATE], Resident 1 was placed on comfort measures only (physician orders to keep the resident comfortable through medications and treatments, but no life saving measures are preformed). Resident 1 died on [DATE] related to cardio-pulmonary arrest, septic shock, and necrotizing fasciitis.A review of the facility's Job Description titled, Treatment Nurse, dated 2/2020, indicated, .As Treatment Nurse (LVN [Licensed Vocational Nurse] or RN [Registered Nurse]) you would be responsible for . implementing orders and treatments, . The (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Treatment Nurse . participates in weekly wound team rounds, documents status, insures [sic] notification of physician and family of changes. which will ensure that patient's needs are met in accordance with professional standards of practice through physician orders, center policies and procedures, and federal, state and local guidelines. Major Duties. Initiate requests for consultation or referral. Respond to requests from the resident, physician, or nursing staff.During a concurrent interview and record review on [DATE] at 4:02 PM with the Director of Nurse (DON), the facility's Policy and Procedure (P&P) titled, Medication and Treatment Orders, dated 1/2025, was reviewed. The P&P indicated, . Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last, credentials, the date and the time of the order. The DON stated the WN did not follow this policy because the verbal order that was given by the MD for the vascular surgeon consultation on [DATE] was written on [DATE] (the vascular surgeon consultation was not carried out before Resident 1's transfer to the hospital on [DATE]).2.During an interview on [DATE] at 12:47 PM with the Wound Nurse (WN), the WN stated the job duties of the WN included weekly rounds with the Wound Doctor (WD). The WN stated if there was a change in condition (COC- an acute change in health status which warrants a formal, documented review of the plan of care) with any of the residents, the WN contacted the MD to obtain an order for treatment, if needed.A review of Resident 1's clinical record titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, observation date [DATE], signed by the WN on [DATE], indicated, . Right lower leg (front) Venous Ulcer - wound is worse. measures [sic] about 15cm [L] x5cm [W] x0.4cm [D] post debridement. 100% slough/necrotic tissue. Heavy drainage, no odor, no s/sx of infection. WOUND MD recommends hospital admission for operative debridement above and below leg amputation .During a follow-up concurrent interview and record review on [DATE] at 12:47 PM with the WN, Resident 1's clinical record titled, Progress Notes, dated [DATE], by the WN, was reviewed for the condition of Resident 1's right lower leg venous wound; and Resident 1's Progress Notes, dated [DATE], [DATE], [DATE], and [DATE], were reviewed for the documentation of vital signs and pain level. The WN stated although Resident 1's Progress Note was entered on [DATE], it was written to reflect the rounds made by the WD and the WN on [DATE]. The Progress Notes, dated [DATE] indicated, Resident was seen and evaluated by [Wound Care Company Name] MD [Medical Doctor, in this case the MD was the WD] for R [right] lower leg ulcer this week. Wound is Worsening. Wound has 100% slough/necrotic tissue .Wound has heavy drainage.Noted resident in excruciating pain.Pain medication was given prior. Wound MD [WD] recommends hospital admission for operative debridement above and below R leg amputation . The WN stated on [DATE] Resident 1 had a COC and should have been monitored for this change starting on [DATE]. The WN stated the facility's process for monitoring a COC included obtaining and documenting the affected Resident's vital signs and pain level every shift (a designated work period [duty hours] within a 24-hour cycle, commonly structured as 8, 10, or 12 hours) for 72 hours. The WN reviewed and verified that on [DATE], [DATE], [DATE], and [DATE] there were no progress notes that indicated Resident 1's pain level and the vital signs were monitored each shift. The WN stated this failure placed Resident 1 at risk for further decline in her health status and increased pain.A review of Resident 1's clinical record titled, Progress Notes, dated [DATE] at 9:50 AM, by the WN, indicated, . 79/42 [blood pressure, low],100 [Oxygen saturation percentage, normal], 30 [respirations per minute, high] .99.6 [temperature, high] Resident not responding per baseline [Resident 1's normal status]. Nonverbal to questions. Refused medications. Refused breakfast. Not taking in any fluids. Facial grimacing with moaning. Refused pain medication.During a concurrent interview and record review on [DATE] at 4:12 PM with the DON, Resident 1's record titled, SBAR, [Situation Background Assessment Recommendation- a communication tool used for information exchange during urgent changes in condition] Communication Form, dated [DATE] (date of incident was [DATE]) and Resident 1's Progress Notes, from [DATE] through [DATE], by the WN, were reviewed for 72-hour monitoring of Resident 1's vital signs and pain rating. The SBAR Communication Form, indicated Resident 1's right leg venous ulcer (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	wound measured 15.0 centimeters x 5.0 cm x 0.4 cm. The wound had heavy drainage and was worsening. The wound had 100% slough and necrotic tissue. The document further indicated Resident 1 was in excruciating pain and rated the pain 10 out of 10 (using the numerical pain scale). The DON stated the SBAR Communication Form was dated [DATE], but the COC occurred on [DATE]. The DON stated the late documentation was without proper labeling as a late entry and could have caused confusion to the reader of the progress notes and was not an acceptable practice. The DON stated the WN received the verbal order (an oral directive given by a physician to another health care professional either face to face or via telephone) from the MD on [DATE] for the vascular surgeon consultation but the order was not generated until [DATE]. The DON stated Resident 1 should have been on 72-hour monitoring (vital signs and pain level assessed once per shift for three days) after the COC was identified on [DATE] and they were not. The DON confirmed Resident 1's progress notes did not indicate her vital signs had been taken and/or pain level assessed and documented every shift for three (3) days after the COC was identified on [DATE]. The DON further stated due to Resident 1's complaint of severe pain, the DON's expectations of her staff was the staff should have reached out to the MD or the WD for possible new treatment orders.During a telephone interview on [DATE] at 12:20 PM with the RP, the RP stated Resident 1's baseline level was Resident 1 was aware of her surroundings, communicated and recognized the family upon arrival. The RP stated on [DATE] he noticed Resident 1 was a little more confused than usual and as the week progressed, Resident 1's cognition declined quickly. The RP stated when the family visited Resident 1 on [DATE], Resident 1 could not identify the family. The RP stated Resident 1's wound on her right leg was bleeding from her knee to her ankle and she was in severe pain.During an interview on [DATE] at 12:48 PM with the WD, the WD stated he treated Resident 1's right lower leg venous wound once a week and he noticed there was little to no improvement, and eventually the wound worsened. The WD stated he spoke with the MD and the WN on [DATE] and the WD informed the MD that the bedside treatment (wound care) was not effective, Resident 1 was getting worse and needed to go to the hospital and have a surgical wound debridement or amputation. The WD stated on [DATE], the MD agreed with his strong recommendation that Resident 1 needed a higher level of care to treat the worsening right leg venous ulcer.During an interview on [DATE] at 3:46 PM with the MD, the MD stated on [DATE] the WD notified him of the serious concern he had for the condition of Resident 1's lower leg venous stasis ulcer. The MD stated the WD informed him that Resident 1's wound was not healing and that he was concerned that the right lower leg may need to be amputated. The MD stated he gave a verbal order to the WN on [DATE] for Resident 1 to be seen by a Vascular Surgeon and the WN stated she would initiate the order. The WD stated his expectation was for the verbal order to be entered into Resident 1's medical record on [DATE] or [DATE].During a follow-up interview on [DATE] at 1:40 PM with the DON, the DON stated the WN waited five days to put in the verbal order from the MD for Resident 1 to have a vascular surgeon consultation. The DON stated there were only two attempts made by the facility to get consent from Resident 1's RP for Resident 1 to be seen by a vascular surgeon ([DATE] and on [DATE]). The DON stated the facility should have attempted to get consent from Resident 1's RP daily and the attempts should have all been documented in Resident 1's medical record. The DON stated it was the licensed nurses' responsibility to obtain consent for the vascular surgeon consultation on [DATE].During a follow-up phone interview on [DATE] at 3:02 PM with the WD, the WD stated on [DATE] he spoke with the MD regarding Resident 1's decline in wound healing of the right leg venous ulcer and the need for transfer to a higher level of care. The WD stated his recommendation for Resident 1's transfer to a higher level of care was proactive because he saw the negative direction the wound was heading toward. The WD stated the MD was overall in charge of Resident 1's care, and he provided recommendations regarding the wound. The WD stated his recommendation was strong and clear and the MD agreed with his recommendation. The WD stated Resident 1's chances of survival would have been better if she had been transferred to the hospital when recommended on [DATE].During a follow-up phone interview on [DATE] at 3:14 PM with the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	MD, the MD stated on [DATE] the WD debriefed him on Resident 1's condition and he (MD) agreed with the WD's recommendation that Resident 1 needed to be transferred to a hospital for surgical intervention for the right venous leg ulcer. The MD stated consent for the vascular surgeon consolation should have been obtained by the RP as soon as possible (ASAP).During a phone interview on [DATE] at 4:28 PM, the MD stated he had not assessed Resident 1's right leg venous wound on [DATE] and could not recall the last time he assessed the wound.During a concurrent interview and record review on [DATE] at 4:02 PM with the DON, the facility's P&Ps titled, Change of Condition, dated 1/2025 and the P&P titled, POLICY AND PROCEDURES ON DOCUMENTATIONS, dated 1/2025 were reviewed. The Change of Condition P&P indicated, .All nursing actions/interventions will be documented in the licensed progress notes as soon as possible after resident needs have been met . The licensed nurse responsible for the resident will continue assessment and documentation every shift for seventy-two (72) hours until the condition has stable [sic] . The DON stated the WN did not follow the facility's P&P of COC because the nurse had not initiated a COC when the WD identified Resident 1's wound was getting worse on [DATE]. The DON stated when alert charting (a systematic process of identifying, documenting, and acting upon specific resident safety risks) was initiated on [DATE], the licensed nurses had not completed the alert charting every shift for 72 hours. The DON stated this practice did not meet her expectations and these actions presented the risk of Resident 1's right leg wound and overall health was not monitored properly. The facility's P&P titled, POLICYAND PROCEDURES ON DOCUMENTATIONS, indicated, POLICY it is the policy of the facility to document all pertinent data and information of each resident in their respective medical record.Any change of condition such as incidents, medical problems and the like, shall be reflected with all necessary approaches/interventions appropriate for such problems. It should also include the medications, treatments . The DON stated her staff did not follow this policy and acknowledged there was not an initiation of a COC on [DATE] in Resident 1's clinical record for the change of her right leg venous wound, no diagnostic tests ordered, and no changes in medications. The DON stated the WN did not follow with policy when the documentation for [DATE] was submitted on [DATE] without a label that indicated it was a late entry for [DATE] as well as inconsistencies such as within the note indicating as if the events documented occurred on [DATE] instead of [DATE]. The DON stated this type of documentation caused confusion and could be misleading. The DON stated she expected her staff to accurately document care as was provided.3. A review of Resident 1's clinical record titled, Order Summary Report, dated [DATE], indicated, .TX [treat]: Right lower leg - cleanse with nss [normal saline solution - salt water], pat dry, apply Santyl [ointment used to help the healing of skin ulcers], wrap with soaked Kerlix [gauze bandage used to dress wounds] in Dakins solution [a solution used to clean wounds] .then cover with dry dressing and ACE wrap [a bandage]. Monitor for any change . as needed for chronic ulcer. A review of Resident 1's clinical record titled, Order Summary, dated [DATE], indicated, .Dakins . External [apply to skin] Solution . Apply to R lower leg [for treatment of the right venous ulcer] topically [apply to the skin] Everyday for chronic [long term] ulcer Wound measures: L [length] 15.0cm x W [width] 5.0cm x D [depth] 0.4cm .A review of Resident 1's clinical record titled, Order Summary, dated [DATE], indicated, .Santyl [a prescription medication used to remove dead tissue] for chronic skin ulcers External Ointment . Apply to Right Lower Leg [right leg venous ulcer] topically for chronic ulcer L15cm x W 5cm x D 0.4cm wraped [sic] with soaked Kerlix with Dakins solution . The Order did not indicate the frequency of applying the ointment.During an interview on [DATE] at 12:48 PM with the WD, the WD stated after he treated Resident 1's right lower leg wound every week he noticed there was little to no improvement and eventually the wound worsened. The WD stated a couple weeks prior to Resident 1's transfer to the hospital on [DATE], the WD spoke with the DON that he was concerned the WN was not changing Resident 1's right leg venous ulcer dressing daily. The WD stated he had also spoken with the DON and nursing supervisor three to four weeks prior to [DATE] and questioned the quality of wound care Resident 1 received. The WD stated the wound care was not done well as evidenced by when he (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	removed the dressing weekly and assessed the wound, the dressing was dry and hard to remove and stuck to the wound.During a concurrent interview and record review on [DATE] at 4:12 PM with the DON, Resident 1's record titled, SBAR Communication Form, dated [DATE] (date of incident was [DATE]) and Resident 1's Progress Notes, by the WN, from [DATE] through [DATE] were reviewed for 72-hour monitoring of Resident 1's vital signs and pain level. The SBAR Communication Form, indicated Resident 1's right leg venous ulcer wound had 100% slough and necrotic tissue. The document further indicated Resident 1 was in excruciating pain and rated the pain 10 out of 10 (worst pain possible using the 0 through 10 numerical pain scale). The DON stated due to Resident 1's complaint of severe pain, the DON's expectations of her staff were to reach out to the MD or the WD for possible new treatment orders.During a follow up concurrent interview and record review on [DATE] at 4:02 PM with the DON, Resident 1's Treatment Administration Record, (TAR- a document where nursing staff document completed physician treatment orders) dated 2/2026 through 3/2026 and the facility's P&P titled, Wound Care, dated 1/2025 were reviewed. Resident 1's Treatment Administration Record, indicated Resident 1 had not received Dakin Solution treatment to her right lower leg venous statis ulcer on [DATE], [DATE], [DATE], and [DATE]. The DON verified the missing treatments and stated the risk for Resident 1 not receiving the ordered wound care was a deterioration in the wound and overall health for Resident 1. The DON stated she expected her staff to accurately document care as was provided.The P&P titled, Wound Care, dated 1/2025, indicated, .The following information should be recorded in the resident's medical record: 1. The type of wound care given, 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any changes in the resident's condition.6. All assessment data (i.e. [example], wound bed color, size, drainage, odor, pain, etc. [and the rest]) Obtained when inspecting the wound. Weekly by the wound nurse/designee. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. The DON stated the WN did not follow this policy because none of the required documentation listed on the P&P were documented in Resident 1's clinical record when the COC was first noticed on [DATE]. The DON stated Resident 1 was at risk for not receiving continuity of care (the process by which patients receive ongoing, coordinated, and comprehensive care from a consistent healthcare team over time), which could have contributed to the condition of Resident 1's right leg venous ulcer worsening.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician (Medical Director, MD) took an effective role in overseeing, supervising, and assessing one of three sampled residents (Resident 1's) medical care when the MD did not assess Resident 1's right leg venous stasis ulcer (a slow-healing, open sore on the lower leg or ankle caused by poor blood circulation) after a change in condition was identified on [DATE], follow the Wound Doctor's (WD) recommendation on [DATE] that Resident 1 should be transferred to an acute care hospital for a higher level of care, or follow up in a timely manner on his own verbal order given on [DATE] for Resident 1 to be seen by a vascular surgeon (a doctor who specializes in treating diseases of the blood vessels throughout the entire body). These failures caused a delay for a consult with a vascular surgeon for debridement (the medical process of removing dead, damaged, or infected tissue from a wound to help it heal faster) and/or surgical amputation (the surgical removal of all or part of a limb or extremity) of the right lower leg, which could have contributed to Resident 1's development of sepsis (a life threatening medical emergency related to overwhelming infection), and ultimately her death. Findings:A review of Resident 1's clinical record titled, admission Record, (a document that contains the resident's demographic information) indicated Resident 1 was admitted to the facility on [DATE] and Resident 1's diagnosis included a non-pressure chronic ulcer of the right lower leg, cellulitis (potentially serious bacterial skin infection), and type 2 diabetes (the body cannot regulate blood sugar and places the resident at a higher risk for infection). The record further indicated Resident 1 did not have the capacity to make her own decisions and had a Responsible Party ([RP]- usually a family member who assists with decision making when a resident cannot make decisions for oneself]). The record indicated Resident 1's code status was full code (the resident requests that all lifesaving measures be implemented in the case of extreme illness).A review of Resident 1's Minimum Data Set, (MDS, a standardized assessment tool) dated [DATE], indicated Resident 1 had a Brief Interview for Mental Status score of 4 reflecting severe cognition impairment. (BIMS - 0 through 15-point standardized assessment used to evaluate cognitive function; 0 through 15 = [intact cognition], 8 through 12 [moderate impairment], and 0 through 4 [severe impairment]).A review of Resident 1's clinical record titled, Order Summary, dated [DATE], indicated, Wound evaluation and treatment by [Wound Care Company Name]. The order did not indicate the frequency of the evaluation.A review of Resident 1's clinical record titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, date of observation was [DATE], signed by the WN on [DATE], indicated, . right lower leg (front), Venous Ulcer - Wound is larger with significant drainage [fluid leaks out of the wound]; measures about 15cm [centimeters, unit of measurement (L=length)] x [by] 5cm [W=width] x 0.4cm [D=depth] post debridement [the medical removal of dead tissue to promote the growth a healthy tissue]. Wound bed [surface of the wound] 50%[percent, amount for every hundred] S [Slough (a yellow, tan, or white, stringy layer of dead tissue)], 50% G [granulation tissue, new vascular tissue - healing surface of the wound], significant drainage, no odor, no s/sx [signs and symptoms] infection. wound showing improvement . A review of Resident 1's clinical record titled, Weekly Skin Integrity Assessment for Non-Pressure Sore, date of observation was [DATE], signed by the WN on [DATE], indicated, . Right lower leg (front) Venous Ulcer - wound is worse. measures [sic] about 15cm[L]x 5cm[W] x 0.4cm[D] post debridement. 100% slough/necrotic [dead, non-viable tissue resulting in lack of blood flow and/or infection] tissue. Heavy [sic], drainage, no odor, no s/sx of infection. WOUND MD recommends hospital admission for operative debridement above and below leg amputation [the surgical removal of a limb (arms) or extremity (legs)] .During an interview on [DATE] at 12:47 PM with the Wound Nurse (WN), the WN stated before rounds (a structured process where a medical team [doctors and nurses] assesses the residents' condition), the WN updated the WD with any changes to Resident 1's wound. The WN stated after rounds were conducted with the WD, the facility process included the WN updated the Medical (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director (MD - Resident 1's primary doctor) about Resident 1's current health status. During a follow-up concurrent interview and record review on [DATE] at 12:53 PM with the WN, Resident 1's clinical record titled, Progress Notes, dated [DATE], by the WN, was reviewed for the condition of Resident 1's right lower leg wound. The WN stated although Resident 1's Progress Note was entered on [DATE], it was written to reflect the rounds made by the WD and the WN on [DATE]. The Progress Notes, dated [DATE], indicated, Resident was seen and evaluated by [Wound Care Company Name] MD [Medical Doctor, here refer to the WD] for R [right] lower leg ulcer this week. Wound is Worsening. Wound has 100% slough/necrotic tissue .Wound has heavy drainage.Noted resident in excruciating pain.Pain medication was given prior.Resident still appears in very much pain. Wound MD recommends hospital admission for operative debridement above and below R leg amputation . The WN stated the WD assessed Resident 1's wound on [DATE] and recommended Resident 1 to be admitted to the hospital for an operative debridement because her wound was getting worse. The WN stated the Progress Note, dated [DATE] was a note that should have been documented on [DATE]. The WN stated she had not added the phrase, late entry note, because she did not want the documentation to be flagged as a late entry. A review of Resident 1's clinical record titled, Care Plan Report, for Resident 1's skin integrity, initiated on [DATE], indicated, . Recommends hospital admission for operative debridement above/lower leg amputation. [the recommendation was given by the WD on [DATE]].A review of Resident 1's clinical record titled, Order Summary Report, dated [DATE], indicated, . refer to Vascular Surgeon for worsening R [right] lower leg venous ulcer . [the verbal order for given by the MD on [DATE]].A review of Resident 1's clinical record titled, Progress Notes, dated [DATE] at 4:14 PM by the WN, indicated, . Spoke with [MD] regarding the WOUND MD's [WD] recommendation to send resident to the hospital for operative debridement/leg amputation. [MD] suggested to talk [sic] to RP and offer either referral to vascular surgeon as medical measure to treat the left leg wound or place the resident on hospice care [focus on pain management at the end of life].[RP] came in and spoke with social service. Per ss [social services], . [RP] decided to have a consult to vascular surgeon for [Resident 1] .During a telephone interview on [DATE] at 12:20 PM with the RP, the RP stated Resident 1's baseline level was Resident 1 was aware of her surroundings, communicated, and recognized the family upon arrival. The RP stated on [DATE] he noticed Resident 1 was a little more confused than usual and within the week Resident 1's cognition quickly declined. The RP stated when the family visited Resident 1 on [DATE], Resident 1 could not identify the family. The RP stated he never refused to send Resident 1 to the hospital or complained about cost. During an interview on [DATE] at 12:48 PM with the WD, the WD stated he treated Resident 1's right lower leg wound once a week, and he noticed there was little to no improvement, and eventually the wound worsened. The WD stated he spoke with the MD and the WN on [DATE] and the WD informed the MD that the bedside treatment (wound care) was not effective, Resident 1 was getting worse, and needed to go to the hospital to have a surgical wound debridement or amputation of the right leg. The WD stated he expressed urgency and serious concern for Resident 1 with the MD and the MD stated he agreed with his recommendation and (MD) would take care of it and he (MD) walked into Resident 1's room. The WD stated after he spoke with the MD and the WN about his concerns he expected Resident 1 would be transferred to the hospital no later than the end of that day on [DATE]. The WD stated he knew if Resident 1 was not sent out to the hospital for a higher level of care, she would develop sepsis.During an interview on [DATE] at 3:46 PM with the MD, the MD stated on [DATE] the WD notified him of the serious concern he had for the condition of Resident 1's lower leg venous stasis ulcer (a shallow, slow-healing open sore that develops from long term insufficient blood supply). The MD stated the WD informed him Resident 1's wound was not healing and that he was concerned that the right lower leg might need to be amputated. The MD stated the WD relayed to him that Resident 1's wound had significant vascular compromise (lack of blood flow), Resident 1 needed to be seen by a vascular surgeon and required hospitalization. The MD stated after speaking with the WD, he (MD) gave a verbal order to the WN on [DATE] for Resident 1 (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be seen by a vascular surgeon. The MD stated after he gave the verbal order to the WN, he expected the order to be carried out no later than the following day ([DATE]). When the Department asked if five days was an acceptable amount of time to put in the verbal order for a vascular consult, the MD stated, I can't answer that. The MD stated he did not send Resident 1 to the hospital on [DATE] because he did not feel it was urgent. The MD stated he had not reviewed any of the WD notes on the historical and current status of Resident 1's right leg ulcer wound and was not aware of the level of deterioration that had been documented over time. The MD stated the facility was waiting for the Responsible Party (RP, a designated person, often a family member who assists the resident with decision making matters) to give consent (permission) for Resident 1 to be seen by a vascular consultant. During a follow-up interview on [DATE] at 1:40 PM with the DON, the DON stated five days went by from when the MD gave the verbal order for Resident 1 to have a vascular consultation to when it was entered into Resident 1's medical record. The DON stated there were only two attempts made by the facility to get consent from Resident 1's RP for Resident 1 to be seen by a vascular surgeon. The DON stated the facility should have attempted to get consent from Resident 1's RP daily and the attempts should have all been documented.During a follow-up phone interview on [DATE] at 3:02 PM with the WD, the WD stated on [DATE] he spoke with the MD of Resident 1's decline in wound healing of the right leg venous ulcer and the need for transfer to a higher level of care. The WD stated his recommendation for transfer was proactive because he saw the negative direction the wound was heading toward. The WD stated the MD was overall in charge of Resident 1's care, and he provided recommendations regarding the wound. The WD stated his recommendation was strong and clear and the MD agreed with his recommendation. The WD stated Resident 1's chances of survival would have been better if she had been transferred to the hospital when recommended.During a follow up telephone phone interview on [DATE] at 4:28 PM with the MD, the MD stated on [DATE] he and the WD had a conversation about the condition of Resident 1's right venous leg wound. The MD stated he (MD) did not assess Resident 1's right leg ulcer wound after the WD's recommendation was given. The MD stated he was unable to remember the last time he assessed the wound and had not gone out of his way to observe the wound himself due to the facility having a wound team. A review of Resident 1's clinical record titled, Progress Notes, dated [DATE] at 9:50 AM, by the WN indicated, . 79/42 [blood pressure, low],100 [Oxygen saturation percentage, normal], 30 [respirations per minute, high] .99.6 [temperature, high] Resident not responding per baseline [Resident 1's normal status]. Nonverbal to questions. Refused medications. Refused breakfast. Not taking in any fluids. Facial grimacing with moaning. Refused pain medication.During a review of Resident 1's [Hospital] record titled, Discharge Summary, dated [DATE] through [DATE], indicated Resident 1 presented to the Emergency Department (ED) on [DATE] at 10:18 AM with confusion, increased heart rate, and low blood pressure due to septic shock related to cellulitis of the right lower extremity. Resident 1's [NAME] Blood Cell Count (WBC-high count indicates infection) was 25 (high, normal range 5-10), lactic acidosis (high production of lactic acid in the blood indicates sepsis, normal range 0.5 to 1.0) was 2.7. A Computed Tomography (CT- diagnostic test) indicated a large soft tissue defect on the lateral (side) of the leg with an underlying fluid collection that opened to the skin's surface and extended to the lateral ankle and forefoot (front of the foot) muscles. Resident 1 was admitted to the Intensive Care Unit (ICU- specialized department in the hospital for critically ill patients) and required vasopressor medications (medications to increase blood pressure and sustain life). Resident 1's blood culture (a laboratory test to detect bacteria in the blood) results were positive for multiple bacteria. On [DATE], Resident 1 was placed on comfort measures only (physician orders to keep the resident comfortable through medications and treatments, but no life saving measures are performed). Resident 1 died on [DATE] related to cardio-pulmonary arrest, septic shock, and necrotizing fasciitis.During a review of a facility provided document titled, .DUTIES AND RESPONSIBILITIES OF A MEDICAL DIRECTOR, dated 2/2014 indicated, .Coordinate medical care in the facility to insure the adequacy and appropriateness of the medical services provided, be familiar with policies and (continued on next page)

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