

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Heritage Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21414 S. Vermont Avenue Torrance, CA 90502	
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 observation, interview, and record review, the facility failed to ensure one of one sampled residents, (Resident 139) who was admitted with intact skin integrity (undamaged skin) did not develop a blood blister (fluid-filled pocket that forms when small blood vessels break under the skin, usually caused by pinching, crushing, or rubbing) on the left calf that deteriorated to a deep tissue injury ([DTI] (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) and later progressed to a Stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon [a tough cord of fibrous tissue that connects a muscle to a bone], ligament, cartilage, or bone) pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to: 1. Ensure a change of condition (COC a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) evaluation was completed when Resident 139 developed a left calf blood blister on 2/20/2026, that progressed to a DTI on 3/3/2026 and later progressed to a Stage 4 pressure injury on 5/26/2026. 2. Ensure an Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meeting was conducted to evaluate and address the progression of Resident 139's left calf wound from a blood blister to a DTI and later to a Stage 4 pressure injury with exposed tendon, and the development of gangrene (death of body tissue caused by a loss of blood flow or a severe bacterial infection) of Resident 139's left toes. 3. Ensure the licensed staff obtained a timely referral to a vascular specialist (specialty doctor who diagnoses and treats problems in the blood vessels) and promptly notified the appropriate healthcare provider, when Resident 139's left calf wound deteriorated from a blood blister to a DTI and to a Stage 4 pressure injury with exposed tendon accompanied by gangrene of the left toes. 4. Ensure the Registered Dietician (RD) was informed of Resident 139's worsening left calf wound condition to assess the nutritional status and provide the necessary recommendations to support wound healing. 5. Ensure the licensed staff accurately assessed, monitored and documented Resident 139's left lower extremity capillary refill (a medical test that measures how many seconds it takes for color to return to a skin or nail area after it is pressed and turns white) and pedal pulse (heartbeat-like throb felt in the foot) and timely communicated abnormal findings to Resident 139's physician for further evaluation. These failures resulted in delayed recognition and intervention for Resident 139's worsening vascular compromise (a reduction or stoppage of blood flow to a specific tissue) , resulting in progression of the left calf wound from a blood blister which measured eight (8) centimeter (cm-unit of measurement) by three (3) cm to a deep tissue injury and eventually to a Stage 4 pressure injury with exposed tendon which measured 13 cm by 7 cm by 0.2 cm., development of gangrene of the left toes, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056308
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F 0684 Level of Harm - Actual harm Residents Affected - Few	hospitalization, and a vascular surgeon's recommendation for a left above the knee amputation (a surgical procedure to remove the leg above the knee joint due to poor blood flow).Findings:During a review of Resident 139's admission Record, the admission Record indicated Resident 139 was admitted to facility on 3/1/2023 and readmitted on [DATE]. The admission Record indicated a diagnoses including malignant neoplasm (cancer) of the right breast, atherosclerotic heart disease (heart condition where fatty plaque builds up in the heart's arteries), long term use of anticoagulant (taking blood-thinning medications for an extended or indefinite period) and mild protein calorie malnutrition (nutritional deficient caused by eating too few proteins and calories).During a record review of Resident 139's Care Plan, titled High risk to further develop pressure ulcer dated 12/15/2023, the Care Plan interventions included to use an alternate pressure mattress (APM- used to prevent and treat pressure injury), check skin for presence of sores, breakdown/impairment, cleanse after each episode of incontinence (accidental loss of bladder or bowel control), dietary to assess nutritional needs to maintain good skin integrity, offload (remove or reduce weight and pressure from a specific part of the body) feet when in bed or in wheelchair, and turn and position at least every two hours, and as needed.During a review of Resident 139's Minimum Data Set (MDS - a resident assessment tool), dated 3/29/2024, the MDS indicated Resident 139 had moderate cognitive impairment (decline in thinking, memory, and reasoning that interferes with complex daily activities) and was dependent (helper does all the effort and the resident does none of the effort to complete the activity) with self-care activities, such as bathing, toileting, and dressing, and was dependent in functional abilities, such as going from a sitting to a lying position. The MDS further indicated Resident 139 was at risk of developing pressure injuries, and had no Stage 4 pressure injury, or DTI. The MDS also indicated Resident 139 had no venous (veins-carries blood from the body to the heart) and arterial (artery- carries blood from the heart to the rest of the body) ulcers (open wound on the lower legs and feet caused by poor blood circulation) and no foot problems.During a review of Resident 139's COC Evaluation, dated 2/20/2026, the COC Evaluation indicated, Resident 139 was noted with an eight (8) cm by three (3) cm closed blood blister on the left posterior (back) calf. Charge Nurse (CN) assessed and noted with 8 cm by 3 cm closed blood blister on left posterior calf.During a review of Resident 139's Skin Issues Progress Note, dated 2/24/2026, the Skin Issues Progress Note indicated, Resident 139 had an open blood blister on her left posterior calf, measuring eight (8) cm by three (3) cm by 0.1 cm, which was acquired in-house. The Skin Issues Progress Note indicated that the NP was consulted regarding Resident 139's open blood blister and new treatment was ordered. According to the Skin Progress Note the treatment consisted of cleansing with chlorhexidine (wound cleanser), autolytic debridement (wound-care method that uses the body's own moisture and enzymes to soften and liquefy dead or damaged tissue), and dressing with hydrogel (wound dressing) and foam. The Skin Issues Progress Note also indicated that Treatment Nurse (TN) 1 recommended an arterial and venous (AV) doppler ultrasound (a test that uses sound waves to check blood flow in the legs and arms) for Resident 139's left leg to the primary care provider (PCP), but the PCP declined.During a record review of Resident 139's Care Plan titled Impaired skin integrity related to left posterior calf open blood blister-reclassified as an unstageable wound dated 2/24/2026, the Care Plan included interventions to administer treatment as ordered, provide good infection control during treatment, left posterior leg calf wound: report any edema (swelling), erythema (redness), discharge, fluctuance (wavy impulse felt when pressing), or odor., monitor capillary refill on left foot., monitor for signs of infection as redness, drainage, and increased temperature, monitor pedal pulse on left foot., notify medical doctor (MD) of the progress, and offload the left posterior lower extremity at all times.During a review of Resident 139's Nurse Practitioner (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	blood supply or a severe bacterial infection) on her toes. During a concurrent interview and record review on 7/23/2026 at 4:55 p.m. with TN 1, Resident 139's Treatment Administration Record (TAR), dated 6/2026-7/2026 was reviewed. The TAR indicated Resident 139 had a present pedal pulse on her left foot from 6/1/2026 to 6/30/2026 and from 7/1/2026 to 7/24/2026. The TAR indicated Resident 139 had a capillary refill of less than 3 seconds (adequate peripheral perfusion [delivery of oxygen-rich blood to small blood vessels in outer body parts, such as toes, fingers, and skin]) on the left foot during those same time periods. TN 1 stated she checked Resident 139's capillary refill on her left toes. She did not respond when asked how she checked capillary refill when Resident 139 had gangrenous toes. TN 1 stated the COC and IDT meeting were not completed when Resident 139's left calf wound progressed from a blood blister to a Stage 4 pressure injury. She stated the COC should have been initiated to inform the nurses and the family about the condition of Resident 139's wound. TN 1 stated that conducting an IDT meeting was important to assess the plan of care and revise it accordingly. TN 1 stated she did not ask Resident 139's primary care physician (PCP) for another vascular consult even after the wound progressed to Stage 4. TN 1 stated she had recommended an AV doppler to Resident 139's PCP on 2/24/2026, but the physician declined the recommendation. TN 1 stated she did not ask the PCP again for the AV doppler after 2/24/2026, even after Resident 139's wound progressed to Stage 4 and gangrene left toes. TN 1 stated she did not escalate to the Director of Nursing (DON) when NP 1 declined the recommendation to obtain an AV doppler. During an interview on 7/23/2026 at 5:55 p.m. with the Director of Nursing (DON), the DON stated the COC and IDT should have been initiated when Resident 139's left calf wound progressed from a blood blister to a DTI and eventually to a Stage 4 pressure injury. He stated the COC should have reflected the wound status and included notification of the attending physician, responsible party, and dietician. He stated the COC served as a guide to inform the physician of the problem and required clear documentation of who was notified, what the physician said, including notification of the family member and what was communicated. He stated that if documentation was not completed, then the notification was not done. The DON stated the IDT should have discussed the condition of the wound and the actions needed to address the deterioration. The DON stated the IDT should have met to address the changes in the residents' wound, document the deterioration, and update the treatment plan to determine whether to continue or modify the current interventions. The DON stated the reason nurses check pedal pulses and capillary refill was to monitor whether the resident's leg circulation was worsening. He stated the capillary refill documentation was not accurate because the resident had gangrenous toes, which made capillary refill assessment invalid. During a concurrent observation and interview on 7/23/2026 at 6:06 p.m. with Registered Nurse Supervisor (RNS) 2 in Resident 139's room, Resident 139's second, third and fourth (2nd, 3rd, and 4th) digits (toes) were black. RNS 2 checked Resident 139's pedal pulse on the left foot and stated, Resident 139 had no pedal pulse on the left foot. Two (2) Health Facilities Evaluator Nurses (HFENs - licensed registered nurse who inspects, investigates, and evaluates healthcare facilities) verified pedal pulse on left foot and pedal pulse was absent. RNS 2 stated, she was unable to check capillary refill on Resident 139's left foot because there were no blood flow and Resident 139's toes were necrotic (black). During a concurrent observation and interview on 7/23/2026 at 6:32 p.m., with RNS 2 in Resident 139's room, RNS 2 checked the pedal pulse on Resident 139's right foot. RNS 2 stated, the pedal pulse on Resident 139's right foot was faint. Two (2) HFENs verified that the pedal pulse on right foot was faint. During a review of Resident 139's Emergency Department (ED) to Hospital-admission Record, dated 7/25/2026, indicated Resident 139 was diagnosed with peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), left leg ischemic limb pain (severe ache or burning caused by a (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	lack of blood flow to the left leg), and gangrene of the left toe. The Emergency Department (ED) to Hospital-admission Record indicated the left lower extremity was warm with delayed capillary refill, and posterior tibial and dorsalis pedis pulses were not dopplerable (able to measured, detected, or imaged pulse using doppler technology). The record indicated that the only surgical option for Resident 139 was an AKA. During a review of Resident 139's Vascular Surgery Consultation dated 7/25/2026, the Vascular Surgery Consultation indicated the reason for the evaluation was peripheral artery disease (PAD-common circulatory problem where narrowed arteries reduce blood flow to the limbs) and gangrene of the left toes. The note indicated the vascular surgeon was unable to palpate the left popliteal (back of the knee) or pedal pulses and stated it was unclear how long the condition had been present. The note indicated the vascular surgeon spoke with Resident 139's family member and explained that the only surgical option was a left AKA. During a review of the facility's undated policy and procedures (P&P) titled, Change in a Resident's Condition or Status, the policy and procedure indicated, ?A significant change of condition is a decline or improvement in that resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting) . The Nurse Supervisor/Charge Nurse will record in the resident's medical record relative to the changes in the resident's medical/mental condition or status. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted.'. During a review of the facility's undated policy and procedures (P&P) titled, Care Planning - Interdisciplinary Team, indicated, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. During a review of the facility's undated, policy and procedures (P&P) titled, Care Plans - Comprehensive, indicated, The comprehensive care plan is based on a thorough assessment. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. During a review of the facility's undated, policy and procedures (P&P) titled, Charting and Documentation, indicated, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Documentation of procedures and treatments shall include care-specific details and shall include a minimum: . The assessment data/and/or any unusual findings obtained during the procedure/treatment. During a review of the facility's undated, policy and procedures (P&P) titled, Pressure Ulcer Treatment, indicated, Pressure ulcer treatment requires a comprehensive approach, including: . Managing systemic issues (edema (swelling), venous insufficiency [a long-term condition where leg veins fail to send blood back to the heart], etc.), maximizing the potential for healing.		

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NAME OF PROVIDER OR SUPPLIER Heritage Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21414 S. Vermont Avenue Torrance, CA 90502	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was accurately completed and obtained from the resident and/or responsible party for three of three sampled resident (Resident 35, 45, and 139). The facility failed to: 1. Ensure Resident's 35's informed consent for psychotropic medication (a drug that changes brain function and results in alterations in perception, mood, consciousness, or behavior) was signed by the physician. 2. Ensure Resident 45's informed consent for psychotropic medication contained the correct medical diagnosis. These failures violated the residents' right to make an informed decision regarding the use of psychoactive medications. 3. Ensure Nurse Practitioner (NP-advanced practice registered nurse who provides specialty healthcare services) 1 informed Resident 139's family member and obtained an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) before performing sharp wound debridement (surgical procedure to remove non-viable [dead] tissue) on (3/24/2026, 4/7/2026, 4/21/2026, 4/28/2026, 5/7/2026, 5/19/2026, and 5/26/2026) to Resident 139's left calf wound. This failure resulted in Resident 139 undergoing an invasive procedure (medical treatment that requires breaking the skin or inserting instruments into the body) without the resident's representative being informed of the purpose of the debridement, its risks, benefits, and alternatives, preventing the resident's representative from making an informed medical decision on the resident's behalf. Findings: 1. During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including depression (constant sadness, low energy, and loss of interest in life) and vascular dementia (a progressive state of decline in mental abilities) with severe agitation (a state of severe restlessness, jumpiness, and inner tension where a person cannot relax or stay still). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 6/5/2026, the MDS indicated Resident 35's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 35 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 35's Psychotherapeutic Drug Informed Consent Form dated 6/10/2026, indicated an informed consent for Depakote Sprinkles (medicine used to treat mood disorders) 125 milligrams (mgs- a unit of measurement), once daily with no indication, was obtained from the resident representative on 6/10/2026, and signed by the licensed vocational nurse (LVN). The Psychotherapeutic Drug Informed Consent Form did not include the physician's signature. During a review of Resident 35's Physician Order Summary Report dated 6/18/2026, the Physician Order indicated an order for Depakote Sprinkles 125 mgs twice a day for mood swing (sudden, (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extreme, or rapid change in a resident's emotional state, shifting quickly between feelings like happiness, sadness, anger, or irritability), agitation, and restlessness. During a review of Resident 35's Physician Order Summary Report dated 6/18/2026 indicated an order for Ativan (medication to treat anxiety {feelings of worry, nervousness, and fear about what might happen in the future}) 0.5 mgs, every 12 hours as needed for anxiety manifested by restlessness or irritability. During a review of Resident 35's Psychotherapeutic Drug Informed Consent Form dated 6/18/2026, the Psychotherapeutic Drug Informed Consent Form indicated an informed consent for Ativan 0.5 mgs, every 12 hours as needed for anxiety was obtained from the resident representative on 6/18/2026, signed by the LVN. The Psychotherapeutic Drug Informed Consent Form did not include the physician's signature. 2.During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including dementia and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 45's Physician Order Summary Report dated 2/19/2026 indicated an order for Olanzapine (a medication to calm and rebalance brain activity)) 2.5 mgs one tablet in the morning for atypical psychosis manifested by visual hallucinations (seeing things that are not actually there). During a review of Resident 45's Psychotherapeutic Drug Informed Consent Form dated 2/19/2026, indicated an informed consent for Olanzapine 2.5 mgs every morning for schizophrenia (a mental illness that is characterized by disturbances in thought) was obtained from the resident representative on 2/19/2026, signed by the LVN. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 8's cognition was severely impaired. The MDS indicated Resident 45 required maximal assistance with ADLs. During a concurrent interview and record review on 7/22/2026 at 11:26 a.m. with Registered Nurse Supervisor (RNS) 1, the Psychotherapeutic Drug Informed Consent Forms were reviewed. RNS 1 stated Resident 45's Psychotherapeutic Drug Informed Consent Forms were inaccurate because neither form contained a physician's signature. RNS 1 stated it was important for the physician to sign the informed consent to confirm the physician was aware the resident or resident representative agreed to and consented to the prescribed medication. During a concurrent interview and record review on 7/22/2026 at 2:18 p.m. with RNS 1, Resident 45's Psychotherapeutic Drug Informed Consent Form was reviewed. RNS 1 stated the form was inaccurate because Resident 45 did not have a diagnosis of schizophrenia. RNS 1 stated an incorrect diagnosis on the informed consent form placed the resident and the resident's representative at risk of being improperly informed, which could affect their rights. RNS 1 stated informed consent forms must be completed accurately to ensure the resident and the resident representative were fully aware of the treatment being provided. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/2026 at 2:24 p.m., with the Director of Nursing (DON), the DON stated the Psychotherapeutic Drug Informed Consent Form should be signed by the physician immediately to confirm it was ordered for the resident and if it was not signed, the form would be invalid. The DON stated Psychotherapeutic Drug Informed Consent Form should have the correct diagnosis documented because the treatment should match the resident's diagnosis. During a review of the facility's Psychotherapeutic Drug Informed Consent Form Instruction Sheet, dated 12/2025, the Psychotherapeutic Drug Informed Consent Form Instruction Sheet indicated, The prescriber is required to read and sign. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use and Consent, undated, the P&P indicated, .the staff and practitioner will review an individual's current medication regimen, to identify whether there is a clear indication for treating that individual with the medications. 3. During a review of Resident 139's admission Record, the admission Record indicated Resident 139 was admitted to facility on 3/1/2023 and readmitted on [DATE]. The admission Record indicated a diagnoses including malignant neoplasm (cancer) of the right breast, atherosclerotic heart disease (heart condition where fatty plaque builds up in the heart's arteries), long term use of anticoagulant (taking blood-thinning medications for an extended or indefinite period) and mild protein calorie malnutrition (nutritional deficient caused by eating too few proteins and calories). During a review of Resident 139's Annual History and Physical (H&P), dated 5/6/2026, the H&P indicated, Resident 139 was diagnosed with major vascular neurocognitive disorder (severe decline in thinking skills caused by reduced blood flow to the brain) and moderate protein calorie malnutrition (mid-level nutritional deficient caused by eating too few proteins and calories). The H&P indicated, Resident 139 did not have decision making capacity. During a review of Resident 139's MDS dated [DATE], the MDS indicated Resident 139 had moderate cognitive impairment and was dependent on self-care activities, such as bathing, toileting, and dressing, and was dependent on functional abilities, such as going from sitting to lying position. The MDS indicated, Resident 139, was frequently incontinent (lacking voluntary control over urination or defecation) of bowel and bladder. The MDS indicated Resident 139 had an unhealed Stage 4 pressure injury and had no venous and arterial ulcers and no foot problems. During a concurrent observation and interview on 7/22/2026 at 12:01 p.m., with Treatment Nurse (TN 1) in Resident 139's room, Resident 139 was observed with a left calf wound that was red and moist with yellowish-white drainage, and exposed tendon. TN 1 stated, Resident 139 developed the wound because Resident 139 crossed her legs. During a concurrent interview and record review on 7/22/2026 at 2:15 p.m. with TN 1, Resident 139's Skin Issue Progress Notes, dated 2/24/2026 to 7/20/2026, was reviewed. The Skin Issue Progress Notes indicated Resident 139 had received multiple debridement sessions on her left calf wound on 3/24/2026, 4/7/2026, 4/21/2026, 4/28/2026, 5/7/2026, 5/19/2026, and 5/26/2026. TN 1 stated, Resident 139's left calf wound started as a popped blood blister on 2/24/2026, progressed to (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unstageable pressure injury on 4/28/2026, and advanced into a Stage 4 pressure injury on 6/11/2026. During a record review of the Wound Care Nurse Practitioner's Progress Notes, dated 3/3/2026 to 7/20/2026, the Progress Notes indicated the Resident 139 received bedside sharp wound debridement on the left calf wound on 3/24/2026, 4/7/2026, 4/21/2026, 4/28/2026, 5/7/2026, 5/19/2026, and 5/26/2026. During an interview on 7/23/2026 at 4:14 p.m. with TN 1, TN 1 stated she was present when the Wound Care Nurse Practitioner (WCNP) was doing the wound debridement. TN 1 stated, debridement was an invasive procedure (any medical procedure that enters the body, either by breaking the skin or by inserting instruments into the body). TN 1 stated, an informed consent was not obtained prior to debridement of Resident 139's left calf wound and an informed consent should have been done for Resident 139's debridement. During a concurrent interview and record review on 7/23/2026 at 4:44 p.m. with the Assistant Director of Nursing (ADON), Resident 139's consents were reviewed. The ADON stated, Resident 139 does not have an informed consent for wound debridement. The ADON stated, Resident 139 required an informed consent to be completed prior to wound debridement. The ADON stated, the informed consent ensures the residents' right to receive information about the proposed care and to accept or refuse care before it was provided. During an interview on 7/23/2026 at 5:35 p.m. with FM 2, FM 2 stated she did not provide informed consent for Resident 139's debridement procedure. FM 2 stated her brother did not provide informed consent for Resident 139's debridement procedure either. During an interview on 7/23/2026 at 5:55 p.m. with the DON, the DON stated the Nurse Practitioner should obtain consent from the family representative before performing sharp wound debridement, as it was an invasive medical procedure. The DON stated the NP should explain the purpose of the procedure, its risks and benefits, and any alternative options. During a review of the facility's policy and procedures (P&P), there was no P&P on informed consent for invasive procedures. Cross reference F684.		