STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106150	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-North Tampa, LLC	18940 Sunlake Blvd Lutz, FL 33558

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46234 Based on interviews and record review, the facility failed to complete an investigation for a fracture of unknown origin for one resident (#1) out of thirteen sampled residents. Findings included: Review of Admission Records showed Resident #1 was admitted from the hospital on 9/17/24 with diagnoses including urinary tract infection, vascular dementia, gout, muscle weakness, and history of transient ischemic attack, and cerebral infarction without residual deficits. Review of Resident #1's Admission Observation, dated 9/17/24, showed an assessment of his musculoskeletal system revealed no contractures, paralysis or flaccidity, extremity weakness, history of joint replacement, weight bearing limitation, requirement of assistive devices, or amputations/prosthetics. The assessment also showed no impairment for functional limitation in range of motion for lower extremities. Review of Resident #1's Physical Therapy (PT) Evaluation, dated 9/17/24, showed a musculoskeletal system assessment of the resident's lower extremity range of motion within functional limits (WFL). Review of Resident #1's Progress Notes revealed a note, dated 9/23/24, showed the following: X-ray to left ordered d/t [due to] c/o [complaints of] pain and discomfort, result received and communicated with doctor, result showed fracture to left head femur, received orders to send patient to hospital, skin assessment completed, no bruises or swelling noted to left hip area, no discomfort reported during assessment when palpating area . patient c/o pain when admitted to this facility from hospital while admitting nurse was assessing patient. Review of imaging results, dated 9/23/24, showed acute fracture of the femoral neck with mild adduction of the femoral head in the acetabular fossa with soft tissue swelling. Review of Resident#1's hospital records showed a computerized tomography (CT) scan of the abdomen/pelvis with contrast was completed on 9/13/24. The results showed no discrete abnormality to explain patient's symptoms. The hospital physical exam on 9/13/24 showed extremities moves all, normal range of motion and musculoskeletal: normal inspection, painless range of motion. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 10/18/24 at 2:40 p.m. with Staff A, Registered Nurse (RN). He said at the time of Resident #1's fracture he was the interim Director of Nursing (DON), covering for the Risk Manager while she was on orientation, covering for the Nursing Home Administrator (NHA) while he was out of town, and completing his normal nursing duties on a medication cart. He said the resident's x-ray showed Resident #1 had a hip fracture, and he went out to the hospital. He said the resident had not had any falls at the facility. Staff A said no interviews were done and he did not talk to staff; We did not investigate it. He said after the resident went out, he had been told the resident had three falls at his ALF prior to going to the hospital and his subsequent admission to this facility. Staff A said he had not seen the hospital CT results (from his hospital stay prior to admission at this facility) in the resident's record, that showed no fractures, at the time or he would have gone further and investigated the fracture. Review of an article titled Hip Joint, reviewed 1/20/23, explained a hip joint is a connection between the legs and torso. The hip joint is made up of the femur and pelvis. (https://my.clevelandclinic.org/health/body/24675-hip-joint accessed on 10/26/24) Review of an article titled Diagnosing Hip and Pelvic Fractures, undated, showed a CT scan examines a fracture pattern or assess the extend of damage in the hip joint. A CT scan uses x-rays and a computer to create two- and three-dimensional pictures of the hip and pelvic bones, enabling doctors to examine a fracture from many different angles. (https://nyulangone.org/conditions/hip-pelvic-fractures/diagnosis accessed on 10/26/24) Review of a facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation or Property, revised 10/27/2020, did not include any information related to investigating. An interview was conducted on 10/18/24 at 1:30 p.m. with the DON about a policy related to investigating and she said, All I have is what I gave you.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to ensure surgical wounds were monitored for signs of infection and surgical sutures were removed per physician orders for two residents (#1 and #7) of three residents sampled for wound care. Findings included: 1. Review of Resident #1's entry record, dated 9/17/24, revealed the resident was admitted on [DATE]. The Minimum Data Set (MDS) records revealed the resident was admitted on [DATE], discharged on [DATE], and readmitted on [DATE]. Further review of the clinical record revealed the resident was hospitalized from 10/2/24 to 10/11/24. Review of Resident #1's MDS discharge assessment, dated 9/23/24, revealed the resident had a fall in the last month prior to admission, had a fall in the prior 2-6 months to admission, and did not have a fracture related to a fall in the 6 months prior to admission. The assessment showed the resident's primary medical condition was Medically Complex Conditions. Review of Resident #1's MDS scheduled 5-day assessment, dated 9/29/24, revealed the resident's primary diagnosis was Fractures and Other Multiple Trauma and secondary diagnoses included hip fracture and non-Alzheimer's dementia. The assessment revealed the resident's fracture history in the 6 months prior to admission was unable to determine. Review of Resident #1's Medication Administration Record (MAR), from 9/17/24 to 10/17/24, revealed a physician order instructing staff to obtain a portable left hip x-ray, 2 views, due to (d/t) pain, portable service necessary d/t generalized weakness and pain. The documentation showed the one-time x-ray was completed on 9/23/24. Review of the Agency for Healthcare Administration (AHCA) form 5000-3008 revealed the facility had received the resident from an acute care facility, dated 9/27/24, showed Resident #1's primary diagnosis was hip fracture. The 3008 form revealed the resident had a left (L) hip surgical site and left ankle skin tear. Review of Resident #1's Admission Observation Detail List Report, dated 9/27/24 at 3:06 p.m., and completed on 9/29/24 at 3:12 p.m. by Staff F, Licensed Practical Nurse (LPN), showed the resident arrived at the facility on a stretcher requiring a manual lift assist from stretcher to new surface. The observation showed extremities were observed for any pain, swelling, weakness, stiffness, warmth, tenderness, loss of sensation, change in color, or impaired function and the resident had no functional limitation in Range of Motion to either upper or lower extremity. The admission observation report showed the resident did not have any abrasions, bruising, burns, dermatitis, skin graft, skin tear, surgical incision (or) ulcer. The staff documented there was no alteration in skin or any skin/ulcer/injury treatments. Review of Resident #1's progress note, dated 9/27/24 at 7:06 p.m., showed the resident had been readmitted to the facility status post (s/p) total left hip arthroplasty. The note did not reveal the skin condition of the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Restraint-Adaptive Equipment assessment, dated 9/28/24 at 3:28 a.m., completed by Staff B, LPN, revealed the staff documented the resident did not have a history of hip fracture. Review of a Focused Observation completed by Staff E, LPN on 9/28/24 at 4:03 a.m., showed the shift charting included mental/neuro, cardiovascular, genitourinary (GU), musculoskeletal, and pain observations. The charting did not include an assessment of Resident #1's skin. Review of Resident #1's Nutrition Assessment, completed on 9/28/24 at 8:47 p.m., showed the resident was admitted to the facility following a hip fracture (fx). Review of Resident #1's progress note, dated 9/29/24 at 1:38 p.m., revealed the staff member had assessed the resident's left femur surgical site, the old dressing was removed, no drainage or redness was noted, and 19 staples were noted. The note revealed dressings were noted to the left lower extremity and left heels. Review of Resident #1's skin note written by Staff C, Registered Nurse (RN), dated 10/2/24, revealed the resident had bruising, skin tear/abrasion, rash/dermatitis, and a left hip surgical incision with 19 staples present. The note showed the resident had a left leg skin tear, scabs on bilateral legs, discoloration both arms, scrotum redness, shift of penis redness, left buttock deep tissue injury (DTI), (and) right buttock open area. Review of Resident #1's progress note, dated 10/11/24 at 11:50 p.m. written by Staff B, LPN, revealed the resident had arrived to the facility accompanied by 2 transporters and the left femur surgical site was observed with 19 staples, no redness, and no abnormal drainage. The note revealed the resident had shearing to the buttock which was cleaned and dressing applied, an old dressing to left heel was removed and the area was cleaned with an application of a new dressing. Review of Resident #1's re-admit observation report, dated 10/12/24 at 3:45 a.m., written by Staff B, LPN, showed the resident had an alteration in skin identified as an abrasion to the sacrum/coccyx area with application of non-surgical dressing and application of dressings to feet. The report did not include the resident's left hip surgical incision previously noted (10/2/24). Review of Resident #1's skin note, written by Staff C RN, dated 10/14/24 at 1:42 p.m. the staff had observed a surgical incision with 15 staples and the skin surrounding the incision was normal color. The observation did not reveal any progress note had been included. Review of a Wound Care vendor note, dated 10/14/24, showed the provider had been consulted for a Stage III pressure wound to left ischium, Stage III pressure wound to coccyx, arterial wounds to the left heel, digit 1 and 2 of left foot, dorsal proximal of left foot, left lower lateral leg, and post-operative left hip with 15 staples. The vendor recommended cleansing the digits on left foot, left dorsal proximal foot, left lower lateral leg, and left post-operative wound with normal saline/wound cleanser, skin prep peri wound and leave open to air. Review of Resident #1's Focused Observation report, written by Staff D, LPN, dated 10/15/24 at 5:21 p.m., revealed the resident had no alteration in skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's progress note, dated 10/16/24, showed staff contacted a provider for an order to remove staples from left hip. The provider notified the staff that the contacted provider did not provide the surgery for the resident and after reviewing the hospital records the correct surgeon was notified. Review of Resident #1's progress note, dated 10/16/24 at 3:19 p.m. revealed 15 staples were removed from the left hip incision. Review of Resident #1's Medication Administration Record (MAR) did not reveal the staff were monitoring the left hip incision for signs/symptoms of infection. The MAR contained an order dated 10/16/24 instructing staff to remove staples from left hip and the documentation revealed Staff C had completed the order. During an interview on 10/18/24 at 1:35 p.m. Staff A, RN reported surgical incisions were monitored, It's usually an order. The staff member reviewed an unsampled resident and reported staff sign off monitoring (of the incisions) on the MAR and per the order the physician was to be notified if any issues. Staff A reported the electronic dashboard tells staff what areas to focus charting on. The staff member stated skin assessments are done weekly on everybody in the building, and the skin was actually looked at if the staff member was doing the assessment. Staff A stated the Wound Care Nurse (Staff C) does skin assessments however if the WCN was not available the day shift nurse was responsible for odd number rooms and the night shift nurse was responsible for the even numbers. An interview was conducted on 10/18/24 at 4:48 p.m. with the Director of Nursing (DON). The DON stated if there wasn't any orders (for staple/suture removal) staff should reach out (to physician) sooner then later, and to contact them within 10 to 14 days. She stated she would expect the incision to be monitored until after the staples were removed. Review of Resident #1's MAR showed staff were not monitoring the left hip surgical incision from the return of the resident on 9/27/24 until transfer to hospital on 10/2/24, then from return on 10/12/24 until Staff C assessed the area on 10/14/24. The facility documentation revealed staff were inconsistent with accurately assessing/observing the resident's skin. 2. Review of Resident #7's Entry Minimum Data Set (MDS) assessment showed the resident was admitted on [DATE]. The Admission MDS, dated [DATE] revealed the resident had a history of falls in the last month prior to admission, 2-6 months prior to admission, and had a fracture related to a fall in the 6 months prior to admission. Review of Resident #7's progress note, dated 5/1/24 at 5:31 p.m., showed the resident was admitted with three (3) different incision related to a right femur fracture. The resident was alert and oriented times 3. Review of Resident #7's late entry progress note, dated 5/15/24 at 6:58 a.m., revealed the resident had returned from a Orthopedic appointment with new orders which included an advisement not to apply any cream or ointments to legs to allow wounds to heal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Orthopedic vendor's note, dated 5/15/24 at 11:40 a.m., revealed Resident #7 was a post-operative hip new patient related to a 4/27/24 right femur fracture. The note revealed the patient reported experiencing pain which was explained as a normal part of the healing process as the fracture was still healing. The radiograph's showed the rod placement was in good position with no complications and was lined up nicely. Review of the Weekly Skin Check note, dated 5/22/24 at 4:56 a.m., showed there was no alteration in Resident #7's skin, then continued to document the presence of a right hip surgical incision. The note did not describe the appearance of the surgical incision of the number of staples present. Review of Resident #7's shift charting, dated 5/23/24 at 3:28 a.m., revealed the skin was warm, dry, normal color, no petechiae, normal turgor, and no alterations in the skin. Review of Resident #7's shift charting, dated 5/24/24 at 2:41 a.m., revealed the skin was warm, dry, normal color, no petechiae, normal turgor, and no alterations in the skin. Review of Resident #7's progress note, dated 5/25/24 at 6:34 p.m., showed the resident voiced Some discomfort to right lower extremity to surgical site. The area had some light redness to the stitch's insertion site, warm to touch and some mild and tolerable discomfort. The on-call provider was notified and staff were awaiting a call back. Review of Resident #7's shift charting note, dated 5/26/24 at 1:20 a.m., revealed the resident's skin was warm, dry, normal color, no petechiae, normal skin turgor, and no alterations in the skin. Review of Resident #7's progress note, dated 5/27/24 at 2:36 p.m., showed the resident's right lower extremity's post operative site was assessed with slight erythema note to site circa sutures. The note revealed a call was placed to the surgeon and was awaiting a call back related to obtaining an order to remove sutures. Review of a Skin note, dated 5/29/24 at 3:54 a.m., showed there was no alteration(s) in skin and the area for documentation if a surgical incision was present, the appearance of the incision and number of staples was blank, without documentation. Review of a late entry note, dated 5/29/24 at 4:08 p.m., (recorded as a late entry on 6/4/24), showed the nurse removed sutures from both surgical sites to right lower extremity. The wound was well-approximated, no pain or erythema was noted. Review of the Shift Charting note, dated 6/1/24 at 2:07 a.m., showed Resident #7's skin was warm, dry, normal color, with no petechiae, normal turgor, and without alterations. Review of the Focused Observation note, dated 6/1/24 at 11:51 a.m., showed Resident #7's skin was warm, dry, normal color and turgor, without petechiae, and skin intact at this time. Review of the Focused Observation note, dated 6/4/24 at 1:00 a.m., showed Resident #7's skin was warm, dry, normal color and turgor, without petechiae, and there were no alterations in skin. Review of the Focused Observation note, dated 6/4/24 at 3:43 p.m., showed the weekly focus observation did not include assessment of Resident #7's skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Daily Focused Observation, dated 6/5/24 at 2:54 a.m., revealed the resident's skin was warm, dry, normal color and turgor, without petechiae, and with no skin alterations. Review of Resident #7's Daily Focused Observation, dated 6/8/24 at 2:00 a.m., revealed the resident's skin was warm, dry, normal color and turgor, without petechiae, and with no skin alterations. Review of Resident #7's Weekly Skin note, dated 6/10/24 at 8:50 a.m., Staff C, Registered Nurse (RN) documented there was no alteration in skin, a surgical incision was present on the right hip, edges of the incision were well-approximated, sutures were present, and the skin surrounding the incision was of normal color. Review of Resident #7's progress note, dated 6/10/24 at 9:11 a.m., showed the resident Noted with four sutures to right hip upper incision. Lower incision sutures removed, and incision healed. A call placed to MD for orders to remove sutures. Awaiting return call, son at bedside and is aware. A note on 6/10/24 at 1:19 p. m. revealed Staff C received orders to remove sutures from right hip incision. Review of the General Administration History, dated 5/1 - 5/31/24, showed Resident #7's skin was checked by the nurse once a week during the 7 p.m. to 7 a.m. shift. Review of the Treatment Administration History, dated 5/1-5/31/24, revealed an order, started and ended on 5/4/24 to Keep dressing to right hip in place until post-op day 7, remove and leave open to air. A review of the General, Treatment, and Medication Administration History's, dated 5/1 - 5/31/24, did not show staff had monitored Resident #7's surgical site on a daily basis. Review of the Wound Management section of Resident #7's clinical record did not reveal the resident had either an active or healed surgical incision. Review of Resident #7's care plan revealed the resident was at risk for skin breakdown related to (r/t) assistance needed for mobility and transfers, pain and pain meds, use of antiplatelet medication and comorbidities. Patient (Pt.) admitted with surgical incision to Right (R) hip. An interview was conducted on 10/18/24 at 4:30 p.m. with the Director of Nursing (DON). The DON stated the facility did have a full-time wound care nurse, confirmed as Staff C. The DON reported Staff C does work full-time but not 100% as the Wound Care Nurse, the staff member has been working at fulfilling floor positions, sometimes has to work the cart. The DON defined an alteration in skin as Alteration is not natural, skin is no longer intact, it's altered, or appearance has changed and confirmed a surgical incision would be considered an alteration until it was resolved. The DON stated the expectation for how staff are to document a skin assessment was for staff to visualize the skin and the facility was doing weekly skin assessments on residents generally done with all care depending on the care and minimally weekly. The DON stated the admitting nurse should document any skin issues, all visualized and sometimes surgeons will give directions not to remove dressings until seen but nurses should document it exists and normally the resident has orders from the hospital to follow up, in event there's no order for surgical follow up staff are to contact the physician or the medical director. The DON reported nurses are to know when to monitor a surgical incision when it's determined they have a site and they should order to monitor the site or reinforce the dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy - Documentation of Skin and Wound Care, revised 6/14/24, revealed the following: It is the policy of the healthcare center to complete documentation that reflects the current resident status as related to skin/ wound care. Documentation will provide current and timely documentation when resident's condition related to skin/ wound care, accurate information on resident's status as it pertains to skin/ wound care, record care rendered and interventions in place and provide a detailed history of wound assessments that have occurred in the health care center. The scope of this policy applies to all {Facility Name}providing wound care. Documentation regarding wound observations and care should be completed: - On pressure ulcers, venous insufficiency/ stasis ulcers, arterial ischemic ulcers, diabetic wounds, and any other chronic or complex wounds (weekly). - Upon admission or readmission of residents. - I'm skin tears, rashes, etc. (weekly) in narrative notes kept with the treatment assessment record (ETAR). - Whenever there is an unexpected change in condition of the wound. - As needed, per clinical judgment. The Admission skin assessment reflects current skin condition, noting wounds, areas of skin compromise, etc. at the time of admission. Wound Manager is to be completed at admission on any noted skin conditions. The Weekly Documentation off treatments will be completed on wound manager in the EHR and focus observation to include skin observation. At least every seven days a comprehensive nursing assessment is completed by a registered nurse that includes a review of the current plan of care, current wound status (based on assessment and review of all documentation), and the patient/resident's response to the treatment plan. The policy includes necessary documentation as follows: - The anatomical location of existing wound should be documented. - Clean the wound per physician orders. - Assay round for older and document presence of order in the narrative. - Describe the surrounding tissue. Describe using intact, dry, macerated, erythema, edema, hard (indurated), fluctuance, and others should be described in the narrative. - Document any signs or symptoms of infection in the narrative. - Describe how the wound is responding to the current treatment. Describe using new (first assessment of the wound), improving, declining, or stable.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observations, record review, and interviews, the facility failed to provide sufficient nursing staff to meet the needs of three residents (#8, #9, & #13) out of seven sampled residents related to answering call lights timely and provide activities of daily living. Findings included: On 10/17/24 at 10:06 a.m., an interview was conducted with Resident #9. Resident #9 stated, The call bell has not worked since I got here (almost a week). It's been terrible. Finally, the facility provided me with this little bell (a round metal table bell, with the activating lever in the top middle of the bell) after I told them no one was assisting me but still no one comes when I ring it. I'm not sure what I would do if I fell or something. I don't really feel that safe. Although, the therapy is great! That is why I stay. Review of Resident #9's medical record revealed an admitted [DATE]. Review of Resident #9's Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form 3008 revealed primary diagnosis of Urinary Tract Infection with other co-morbidities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating cognition was fully intact. Review of Care Plan revealed need for assistance due to impaired mobility. On 10/17/24 at 10:10 a.m., an interview was conducted with Resident #13 and Resident #13's representative. Resident #13 stated not bothering to push the light as no one would come, my representative stays with me and assists me. If my representative wasn't here, I don't know what I would do. Resident #13 and representative stated both have told the Director of Nursing (DON) but nothing changed. Review of Resident #13's medical record revealed an admitted [DATE], with a primary diagnosis of Left hip hemiarthroplasty (hip replacement) due to a left femur neck fracture. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition was fully intact. On 10/17/24 at 10:36 a.m. and 1:10 p.m., an interview was conducted with Resident #8's resident representative in Resident #8's room. The call light available is the normal round control with a red button on top, Resident #8, does not have the ability to press the button on the top of the control. Resident #8's representative has requested a different device that Resident #8 could just place their hand on. Resident #8's representative states no one listens. Resident #8's representative stated the call light stopped working for her. Resident #8's representative stated the facility gave Resident #8 a bell (a round metal table bell, with the activating lever in the top middle of the bell). Although they did not answer prior when the call light did work. Resident #8's representative stated, I would have to go out in the hallway and track people down, so I decided to just change him myself. I have to do this a lot; I don't mind helping but it worries me that he won't get care if I am not here. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's medical record revealed an admitted [DATE], with a primary diagnosis of traumatic subdural hemorrhage without loss of consciousness and other co-morbidities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 00, resident was unable to participate in assessment. On 10/17/24 at 1:05 p.m. the call light to room [ROOM NUMBER] was observed to go on, at 1:25 p.m. a therapist was observed entering the room. Review of the grievance logs from September 2024 to 10/16/2024 showed eleven total grievances under the nursing department during this time. Of those eleven, six were sampled, the concerns were all related to residents in need of assistance and not receiving. A grievance on 9/19/24, revealed a resident was not receiving assistance with hearing aids. Under the section steps taken to investigate: an order was put in place for hearing aid assistance. A grievance on 9/20/24, revealed a resident had to verbally call out for help, no one assists with tray set or elevating resident's head to eat, not brushing resident's teeth, resident had to call grandson for assistance. Another grievance, dated 9/25/24, revealed a resident stated you need to burn this place down, people here they don't care. Today, I needed to call my daughter to ask for help. No-one came to change me until after she got her at 1:45 p.m., this happens all of the time. Review of grievance, dated 10/2/24, revealed: resident was taken to therapy without being changed from her pajamas and without her adult brief being changed and after rehab taken to the beauty salon to get her hair done. Family member continues to state, I changed her. A grievance on 10/15/24 revealed concerns about cold food, activities of daily living care, and oxygen placement. Another grievance placed on 10/15/24, revealed a concern regarding care {State agency name} came into the facility to investigate. An interview was conducted with Staff H, Certified Nursing Assistant (CNA) on 10/17/24 at 1:50 p.m. Staff H, CNA stated not knowing about any different type of bells for call lights and did not know to look for call light function. Staff H stated, The building is huge, and we have difficulty getting to everyone - sometimes the assignment sheets are out but usually you have no idea - we try really hard to get to everyone - but with the layout it is almost impossible. An interview was conducted with Staff J, CNA on 10/17/24 at 2:00 p.m. Staff J, CNA stated, not knowing about call light malfunction or bells. Staff J, CNA stated, Staffing is challenging - I don't want to say anymore - afraid to get fired. An interview was conducted with Staff K, CNA on 10/17/24 at 3:30 p.m. Staff K, CNA stated, not knowing about any bells, I see some in resident rooms but not sure why they are in the rooms. Staff K, CNA stated, The physical layout is hard for us to get around to all the rooms - not enough eyes to accomplish everything. An interview was conducted with Staff L, CNA on 10/17/24 at 3:45 p.m. Staff L, CNA stated, It's hard working with all the residents we are assigned, usually we can't get everything done. An interview was conducted with Staff N, CNA on 10/17/24 at 3:50 p.m. Staff N, CNA stated, not knowing anything about bells and it's hard to get to all your residents assigned with the physical plant. (continued on next page)

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	106150	A. Building B. Wing	10/18/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff M, CNA on 10/17/24 at 4:00 p.m. Staff M, CNA stated not knowing about bells or that the call lights are not working. Staff M, CNA stated the evening shift was really hard due to more residents than during the day, and Getting to everyone especially after dinner is almost impossible. On 10/17/24 at 4:10 PM an observation of call lights was conducted. Resident #9 rang physical ring bell for help two separate times. No staff was observed in the hall. At 4:18 PM Resident #9 rang physical ring bell again, 3 staff members were observed in the hall outside of her room. Observed none of the staff answering her call light. At 4:21 PM an interview with Resident #9 was conducted. She stated she was ringing her physical ring bell, and verified ringing it 2 separate times for help. Resident #9 stated they normally don't answer the ring bell since the call light has stopped working. On 10/18/24 at 10:00 AM an interview with Resident #11 was conducted. She stated she recently fell , she was trying to get up to go to the bathroom. She stated she did not call for help because she is tired of waiting for help and never getting it. She continued to say she always waits for a long time regardless of what time of day, it is all the time. An interview was conducted with the Staffing Coordinator (SC) on 10/18/24 at 10:30 a.m. The SC stated the facility determines staffing based on the census. The SC stated never being instructed to alter staffing for any other reasons. During an interview on 10/18/24 at 2:40 p.m. Staff A, Registered Nurse (RN) explained being the interim Director of Nursing (DON) prior to the current DON arriving. Staff A, RN stated staffing is based on census. During an interview on 10/18/24 at 2:40 p.m. the Director of Nursing (DON) stated staffing is based on the census. Review of the facility's Policy titled Staffing with a revised date of 6/1/2017 showed: Policy: at all times, the center will have as many partners on duty as may be needed to properly safeguard the health, safety and welfare of the residents, and provide unhurried assistance to residents according to each one's individualized plan of care. The minimum staffing pattern observed shall be as follows: *At least one Administrator, on site Manager, or designated responsible staff person at least [AGE] years of age will be on the premises 24 hours per day. *Residents shall not be left unsupervised. A minimum on site staff to resident ratio shall be: . *Staff, such as cooks and maintenance staff who do not receive ongoing direct care training and whose job duties do not routinely involve the oversight or delivery of direct personal care to the residents, will not be counted toward these minimum staffing ratios. *Residents must be supervised consistent with their needs. *An accurate staffing plan that takes into account the specific needs of the residents and monthly work schedules for all partners, including relief workers, showing planned and actual coverage for each day and night, shall be developed and maintained. Any needed changes in the schedule and relief workers used will be indicated on the schedule at the time of the change so the change can be identified. The completed staff schedules shall be maintained for a minimum of one year. sufficient staff time shall be available to assure that each resident: * receives treatments, medications and diets as prescribed.* receives proper care to prevent decubitus ulcers and contractures.* Is kept comfortable and clean.* Is treated with dignity, kindness, consideration, and respect.* Is protected from injury and infection.* Is given prompt, unhurried assistance.* Is given assistance, if needed, with daily hygiene including baths and oral care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51097

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on interview and record review, the facility failed to ensure competent nursing care staff, related to care of one unresponsive Resident (#10), and wound monitoring for two Residents (#1 and #7) was provided out of thirteen resident sampled. Findings included: 1. Review of Admission Records showed Resident #10 was admitted on [DATE] with diagnoses including fracture of right femur, subsequent encounter for closed fracture with routine healing. Review of Resident #10's Admission Observation, dated [DATE], showed the resident was oriented, generally to person, place and time, understands and had clear comprehension, intact memory and clear, organized thinking. Review of Resident #10's care plan showed she had an Activities of Daily Living (ADL) decline related to a recent hospitalization due to fall with right hip fracture and surgical repair. Interventions included 1-person assist for transfer/toileting. Resident #10 also had a care plan for being a fall risk related to assistance being required for mobility and transfers, pain and pain medication, history of fall with fracture and comorbidities including hypertension and coronary artery disease. Interventions included assist for toileting and transfers as needed and place call light within reach. Review of Resident #10's progress note, dated [DATE] at 3:37 a.m., showed the following note written by Staff G, Licensed Practical Nurse (LPN): Around 3 AM CNA [Certified Nursing Assistant] alerted writer that resident was on the floor. Resident was observed on floor and resident was unable to articulate how she ended up on the floor. Resident responsive, Initiated head to toe assessment, Initiated neuro check. assessed resident's body and head, No bleeding or bruises noted; helped resident into wheelchair and went to grab vital machine, came back resident was unresponsive. Called a code, Initiated call to 911 and writer got RN and other LPN on duty to help initiate CPR. Called emergency contact on file: [family member name] and let him know EMS would be transporting resident to [hospital name]. Called on- call: [Nurse Practitioner name] to let them know resident is unresponsive and is being taken to hospital. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 10:56 a.m. with a family member of Resident #10. The family member said they would love to know what happened to the resident. They said Resident #10 was admitted to the facility a little over a week before this incident for rehabilitation after a hip replacement. The family member said Resident #10 had not yet stood up or walked on her own after the surgery. They said they were told the resident got out of bed and walked toward the bathroom and that is where staff found her on the floor. The family member said prior to surgery the resident had been completely independent. The family member said a point of contention on the resident's first day at the facility was staff not answering the call bell. The family member said the resident had to go to the bathroom, she turned her call light on, and it took 45 minutes for staff to come help causing the resident to soil herself. They said the resident was so embarrassed she cried. The family member said they spoke to the nurse about their concerns that first day. The family member said Resident #10 told them about having another accident a couple of days later because she was not able to get someone to help her to the bathroom in time. The family member said two days before the accident the resident was excited because the physical therapist was helping her build confidence, and the resident had set a goal to move to a chair on her own by the end of that week. The family member said the resident had been scared to get out of bed on her own. The family member said the day prior to the accident another family member visited the resident. That family member said they had to go get a nurse to help the resident because she pushed her call bell, and no one had come. An interview was conducted on [DATE] at 12:54 p.m. with Staff G, LPN. She confirmed she was the nurse that cared for Resident #10 on the night shift running from [DATE] until the morning of [DATE]. Staff G said this was the first shift she had with the resident and didn't know her well, but she had spoken clearly, was easy to understand and was not mumbling. She said the resident was a little anxious about the hurricane coming. Staff G said early in the shift Resident #10 had requested pain medication due to her hip hurting, and she received medication. Staff G said the Certified Nursing Assistant (CNA) came to the nurses' station around 3:00 a.m. to let her know Resident #10 had fallen. Staff G said she went to the resident's room and called her name. She said the resident was lying on the floor by the bathroom on her left side. Staff G said the resident was mumbling but incomprehensible. Staff G said she asked the resident if staff could pick her up and put her in bed and the resident said no. Staff G said Resident #10 was gasping with her breathing and mumbling. Staff G said she did a quick head-to-toe assessment and didn't see any injuries or bleeding. Staff G said she asked the resident if they could pick her up and put her in the chair and she said yes. Staff G said she and the CNA picked the resident up and put her in the chair. Staff G said she then left the resident and CNA in the room while she got the vital signs machine and when she returned the resident was unresponsive but still breathing. Staff G said she went to get the vital signs machine herself because the resident's room was close to the nurses' station and she could grab it quickly. Staff G said when she found the resident unresponsive, she went to get Staff H, Registered Nurse (RN) from another unit. Staff G said they moved Resident #10 to the bed, and she no longer had a pulse and staff initiated cardiopulmonary resuscitation (CPR). Staff G said CPR continued until emergency medical services (EMS) arrived and took over. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 4:31 p.m. Staff P, LPN. Staff P said he was assigned to care for the ,d+[DATE] unit on the morning Resident #10 was found unresponsive. He said Staff G came to his unit and said she had a resident in a wheelchair that is unresponsive. She informed him she had left the room to get the vital signs machine after the resident had a fall and when she came back Resident #10 was unresponsive. He said he was in the middle of something with a resident, he finished what he was doing and went to the 300 unit. He said it took him probably ,d+[DATE] min's to get to Resident #10's room. Staff P said when he arrived in the room with Staff G, the resident was still sitting in the wheelchair; the Certified Nursing assistant (CNA) was present. He said he checked the resident's pulse and her pupils. He said the resident was then transferred to her bed and staff initiated CPR. Staff P said he went and got the crash cart. During CPR he said the automated external defibrillator (AED) was attached to the resident and asked them to stop a few times and he believed it delivered a shock. He said no one documented on the code form during or after the event. Staff P said if he found a resident unresponsive or incomprehensible he would look at the code status and start CPR if needed. Staff P said he would not leave the resident's room without a nurse there. An interview was conducted on [DATE] at 6:05 p.m. with the Director of Nursing (DON). She said if a resident had a fall and was mumbling and gasping, she should have been left on the floor and 911 called. She said her expectation would be for the nurse to stay with the resident and not leave the room to get equipment or go to another unit to get a nurse. The DON reviewed staff statements and confirmed Staff G wrote in her statement she left the unit to go get Staff P. An interview was conducted on [DATE] 1:30 p.m. with the DON. She said the facility did not have a policy and procedure for falls but the staff had competencies to complete. A sample list of these competencies was provided. Review of the documents showed there were competencies related to wound care and skin assessments, but there were no competencies related to resident falls; only fall prevention. 2. Review of Resident #1's entry record, dated [DATE], revealed the resident was admitted on [DATE]. The Minimum Data Set (MDS) records revealed the resident was admitted on [DATE], discharged on [DATE], and readmitted on [DATE]. Further review of the clinical record revealed the resident was hospitalized from [DATE] to [DATE]. Review of Resident #1's MDS discharge assessment, dated [DATE], revealed the resident had a fall in the last month prior to admission, had a fall in the prior ,d+[DATE] months to admission, and did not have a fracture related to a fall in the 6 months prior to admission. The assessment showed the resident's primary medical condition was Medically Complex Conditions. Review of Resident #1's MDS scheduled 5-day assessment, dated [DATE], revealed the resident's primary diagnosis was Fractures and Other Multiple Trauma and secondary diagnoses included hip fracture and non-Alzheimer's dementia. The assessment revealed the resident's fracture history in the 6 months prior to admission was unable to determine. Review of Resident #1's Medication Administration Record (MAR), from [DATE] to [DATE], revealed a physician order instructing staff to obtain a portable left hip x-ray, 2 views, due to (d/t) pain, portable service necessary d/t generalized weakness and pain. The documentation showed the one-time x-ray was completed on [DATE]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Agency for Healthcare Administration (AHCA) form ,d+[DATE] revealed the facility had received the resident from an acute care facility, dated [DATE], showed Resident #1's primary diagnosis was hip fracture. The 3008 form revealed the resident had a left (L) hip surgical site and left ankle skin tear. Review of Resident #1's Admission Observation Detail List Report, dated [DATE] at 3:06 p.m., and completed on [DATE] at 3:12 p.m. by Staff F, Licensed Practical Nurse (LPN), showed the resident arrived at the facility on a stretcher requiring a manual lift assist from stretcher to new surface. The observation showed extremities were observed for any pain, swelling, weakness, stiffness, warmth, tenderness, loss of sensation, change in color, or impaired function and the resident had no functional limitation in Range of Motion to either upper or lower extremity. The admission observation report showed the resident did not have any abrasions, bruising, burns, dermatitis, skin graft, skin tear, surgical incision (or) ulcer. The staff documented there was no alteration in skin or any skin/ulcer/injury treatments. Review of Resident #1's progress note, dated [DATE] at 7:06 p.m., showed the resident had been readmitted to the facility status post (s/p) total left hip arthroplasty. The note did not reveal the skin condition of the resident. Review of Resident #1's Restraint-Adaptive Equipment assessment, dated [DATE] at 3:28 a.m., completed by Staff B, LPN, revealed the staff documented the resident did not have a history of hip fracture. Review of a Focused Observation completed by Staff E, LPN on [DATE] at 4:03 a.m., showed the shift charting included mental/neuro, cardiovascular, genitourinary (GU), musculoskeletal, and pain observations. The charting did not include an assessment of Resident #1's skin. Review of Resident #1's Nutrition Assessment, completed on [DATE] at 8:47 p.m., showed the resident was admitted to the facility following a hip fracture (fx). Review of Resident #1's progress note, dated [DATE] at 1:38 p.m., revealed the staff member had assessed the resident's left femur surgical site, the old dressing was removed, no drainage or redness was noted, and 19 staples were noted. The note revealed dressings were noted to the left lower extremity and left heels. Review of Resident #1's skin note written by Staff C, Registered Nurse (RN), dated [DATE], revealed the resident had bruising, skin tear/abrasion, rash/dermatitis, and a left hip surgical incision with 19 staples present. The note showed the resident had a left leg skin tear, scabs on bilateral legs, discoloration both arms, scrotum redness, shift of penis redness, left buttock deep tissue injury (DTI), (and) right buttock open area. Review of Resident #1's progress note, dated [DATE] at 11:50 p.m. written by Staff B, LPN, revealed the resident had arrived to the facility accompanied by 2 transporters and the left femur surgical site was observed with 19 staples, no redness, and no abnormal drainage. The note revealed the resident had shearing to the buttock which was cleaned and dressing applied, an old dressing to left heel was removed and the area was cleaned with an application of a new dressing. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's re-admit observation report, dated [DATE] at 3:45 a.m., written by Staff B, LPN, showed the resident had an alteration in skin identified as an abrasion to the sacrum/coccyx area with application of non-surgical dressing and application of dressings to feet. The report did not include the resident's left hip surgical incision previously noted ([DATE]). Review of Resident #1's skin note, written by Staff C RN, dated [DATE] at 1:42 p.m. the staff had observed a surgical incision with 15 staples and the skin surrounding the incision was normal color. The observation did not reveal any progress note had been included. Review of a Wound Care vendor note, dated [DATE], showed the provider had been consulted for a Stage III pressure wound to left ischium, Stage III pressure wound to coccyx, arterial wounds to the left heel, digit 1 and 2 of left foot, dorsal proximal of left foot, left lower lateral leg, and post-operative left hip with 15 staples. The vendor recommended cleansing the digits on left foot, left dorsal proximal foot, left lower lateral leg, and left post-operative wound with normal saline/wound cleanser, skin prep peri wound and leave open to air. Review of Resident #1's Focused Observation report, written by Staff D, LPN, dated [DATE] at 5:21 p.m., revealed the resident had no alteration in skin. Review of Resident #1's progress note, dated [DATE], showed staff contacted a provider for an order to remove staples from left hip. The provider notified the staff that the contacted provider did not provide the surgery for the resident and after reviewing the hospital records the correct surgeon was notified. Review of Resident #1's progress note, dated [DATE] at 3:19 p.m. revealed 15 staples were removed from the left hip incision. Review of Resident #1's Medication Administration Record (MAR) did not reveal the staff were monitoring the left hip incision for signs/symptoms of infection. The MAR contained an order dated [DATE] instructing staff to remove staples from left hip and the documentation revealed Staff C had completed the order. During an interview on [DATE] at 1:35 p.m. Staff A, RN reported surgical incisions were monitored, It's usually an order. The staff member reviewed an unsampled resident and reported staff sign off monitoring (of the incisions) on the MAR and per the order the physician was to be notified if any issues. Staff A reported the electronic dashboard tells staff what areas to focus charting on. The staff member stated skin assessments are done weekly on everybody in the building, and the skin was actually looked at if the staff member was doing the assessment. Staff A stated the Wound Care Nurse (Staff C) does skin assessments however if the WCN was not available the day shift nurse was responsible for odd number rooms and the night shift nurse was responsible for the even numbers. An interview was conducted on [DATE] at 4:48 p.m. with the Director of Nursing (DON). The DON stated if there wasn't any orders (for staple/suture removal) staff should reach out (to physician) sooner then later, and to contact them within 10 to 14 days. She stated she would expect the incision to be monitored until after the staples were removed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's MAR showed staff were not monitoring the left hip surgical incision from the return of the resident on [DATE] until transfer to hospital on [DATE], then from return on [DATE] until Staff C assessed the area on [DATE]. The facility documentation revealed staff were inconsistent with accurately assessing/observing the resident's skin. 3. Review of Resident #7's Entry Minimum Data Set (MDS) assessment showed the resident was admitted on [DATE]. The Admission MDS, dated [DATE] revealed the resident had a history of falls in the last month prior to admission, ,d+[DATE] months prior to admission, and had a fracture related to a fall in the 6 months prior to admission. Review of Resident #7's progress note, dated [DATE] at 5:31 p.m., showed the resident was admitted with three (3) different incision related to a right femur fracture. The resident was alert and oriented times 3. Review of Resident #7's late entry progress note, dated [DATE] at 6:58 a.m., revealed the resident had returned from a Orthopedic appointment with new orders which included an advisement not to apply any cream or ointments to legs to allow wounds to heal. Review of the Orthopedic vendor's note, dated [DATE] at 11:40 a.m., revealed Resident #7 was a post-operative hip new patient related to a [DATE] right femur fracture. The note revealed the patient reported experiencing pain which was explained as a normal part of the healing process as the fracture was still healing. The radiograph's showed the rod placement was in good position with no complications and was lined up nicely. Review of the Weekly Skin Check note, dated [DATE] at 4:56 a.m., showed there was no alteration in Resident #7's skin, then continued to document the presence of a right hip surgical incision. The note did not describe the appearance of the surgical incision of the number of staples present. Review of Resident #7's shift charting, dated [DATE] at 3:28 a.m., revealed the skin was warm, dry, normal color, no petechiae, normal turgor, and no alterations in the skin. Review of Resident #7's shift charting, dated [DATE] at 2:41 a.m., revealed the skin was warm, dry, normal color, no petechiae, normal turgor, and no alterations in the skin. Review of Resident #7's progress note, dated [DATE] at 6:34 p.m., showed the resident voiced Some discomfort to right lower extremity to surgical site. The area had some light redness to the stitch's insertion site, warm to touch and some mild and tolerable discomfort. The on-call provider was notified and staff were awaiting a call back. Review of Resident #7's shift charting note, dated [DATE] at 1:20 a.m., revealed the resident's skin was warm, dry, normal color, no petechiae, normal skin turgor, and no alterations in the skin. Review of Resident #7's progress note, dated [DATE] at 2:36 p.m., showed the resident's right lower extremity's post operative site was assessed with slight erythema note to site circa sutures. The note revealed a call was placed to the surgeon and was awaiting a call back related to obtaining an order to remove sutures. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Skin note, dated [DATE] at 3:54 a.m., showed there was no alteration(s) in skin and the area for documentation if a surgical incision was present, the appearance of the incision and number of staples was blank, without documentation. Review of a late entry note, dated [DATE] at 4:08 p.m., (recorded as a late entry on [DATE]), showed the nurse removed sutures from both surgical sites to right lower extremity. The wound was well-approximated, no pain or erythema was noted. Review of the Shift Charting note, dated [DATE] at 2:07 a.m., showed Resident #7's skin was warm, dry, normal color, with no petechiae, normal turgor, and without alterations. Review of the Focused Observation note, dated [DATE] at 11:51 a.m., showed Resident #7's skin was warm, dry, normal color and turgor, without petechiae, and skin intact at this time. Review of the Focused Observation note, dated [DATE] at 1:00 a.m., showed Resident #7's skin was warm, dry, normal color and turgor, without petechiae, and there were no alterations in skin. Review of the Focused Observation note, dated [DATE] at 3:43 p.m., showed the weekly focus observation did not include assessment of Resident #7's skin. Review of Resident #7's Daily Focused Observation, dated [DATE] at 2:54 a.m., revealed the resident's skin was warm, dry, normal color and turgor, without petechiae, and with no skin alterations. Review of Resident #7's Daily Focused Observation, dated [DATE] at 2:00 a.m., revealed the resident's skin was warm, dry, normal color and turgor, without petechiae, and with no skin alterations. Review of Resident #7's Weekly Skin note, dated [DATE] at 8:50 a.m., Staff C, Registered Nurse (RN) documented there was no alteration in skin, a surgical incision was present on the right hip, edges of the incision were well-approximated, sutures were present, and the skin surrounding the incision was of normal color. Review of Resident #7's progress note, dated [DATE] at 9:11 a.m., showed the resident Noted with four sutures to right hip upper incision. Lower incision sutures removed, and incision healed. A call placed to MD for orders to remove sutures. Awaiting return call, son at bedside and is aware. A note on [DATE] at 1:19 p. m. revealed Staff C received orders to remove sutures from right hip incision. Review of the General Administration History, dated ,d+[DATE] - [DATE], showed Resident #7's skin was checked by the nurse once a week during the 7 p.m. to 7 a.m. shift. Review of the Treatment Administration History, dated ,d+[DATE]-[DATE], revealed an order, started and ended on [DATE] to Keep dressing to right hip in place until post-op day 7, remove and leave open to air. A review of the General, Treatment, and Medication Administration History's, dated ,d+[DATE] - [DATE], did not show staff had monitored Resident #7's surgical site on a daily basis. Review of the Wound Management section of Resident #7's clinical record did not reveal the resident had either an active or healed surgical incision. (continued on next page)

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	106150	A. Building B. Wing	10/18/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's care plan revealed the resident was at risk for skin breakdown related to (r/t) assistance needed for mobility and transfers, pain and pain meds, use of antiplatelet medication and comorbidities. Patient (Pt.) admitted with surgical incision to Right (R) hip. An interview was conducted on [DATE] at 4:30 p.m. with the Director of Nursing (DON). The DON stated the facility did have a full-time wound care nurse, confirmed as Staff C. The DON reported Staff C does work full-time but not 100% as the Wound Care Nurse, the staff member has been working at fulfilling floor positions, sometimes has to work the cart. The DON defined an alteration in skin as Alteration is not natural, skin is no longer intact, it's altered, or appearance has changed and confirmed a surgical incision would be considered an alteration until it was resolved. The DON stated the expectation for how staff are to document a skin assessment was for staff to visualize the skin and the facility was doing weekly skin assessments on residents generally done with all care depending on the care and minimally weekly. The DON stated the admitting nurse should document any skin issues, all visualized and sometimes surgeons will give directions not to remove dressings until seen but nurses should document it exists and normally the resident has orders from the hospital to follow up, in event there's no order for surgical follow up staff are to contact the physician or the medical director. The DON reported nurses are to know when to monitor a surgical incision when it's determined they have a site and they should order to monitor the site or reinforce the dressing. Review of the policy - Documentation of Skin and Wound Care, revised [DATE], revealed the following: It is the policy of the healthcare center to complete documentation that reflects the current resident status as related to skin/ wound care. Documentation will provide current and timely documentation when resident's condition related to skin/ wound care, accurate information on resident's status as it pertains to skin/ wound care, record care rendered and interventions in place and provide a detailed history of wound assessments that have occurred in the health care center. The scope of this policy applies to all {Facility Name}providing wound care. Documentation regarding wound observations and care should be completed: - On pressure ulcers, venous insufficiency/ stasis ulcers, arterial ischemic ulcers, diabetic wounds, and any other chronic or complex wounds (weekly). - Upon admission or readmission of residents. - I'm skin tears, rashes, etc. (weekly) in narrative notes kept with the treatment assessment record (ETAR). - Whenever there is an unexpected change in condition of the wound. - As needed, per clinical judgment. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission skin assessment reflects current skin condition, noting wounds, areas of skin compromise, etc. at the time of admission. Wound Manager is to be completed at admission on any noted skin conditions. The Weekly Documentation off treatments will be completed on wound manager in the EHR and focus observation to include skin observation. At least every seven days a comprehensive nursing assessment is completed by a registered nurse that includes a review of the current plan of care, current wound status (based on assessment and review of all documentation), and the patient/resident's response to the treatment plan. The policy includes necessary documentation as follows: - The anatomical location of existing wound should be documented. - Clean the wound per physician orders. - Assay round for older and document presence of order in the narrative. - Describe the surrounding tissue. Describe using intact, dry, macerated, erythema, edema, hard (indurated), fluctuance, and others should be described in the narrative. - Document any signs or symptoms of infection in the narrative. - Describe how the wound is responding to the current treatment. Describe using new (first assessment of the wound), improving, declining, or stable.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48223 Based on observations, record review, and interviews, the facility failed to maintain a functioning nurse call system to respond to resident needs during two days (10/17/24, 10/18/24) of two days observed during survey. Findings included: On 10/17/24 at 10:06 a.m., an interview and observation was conducted with Resident #9. Resident #9 stated, The call bell has not worked since I got here (almost a week). It's been terrible. Finally, the facility provided me with this little bell (a round metal table bell, with the activating lever in the top middle of the bell) after I told them no one was assisting me but still no one comes when I ring it. A table bell was observed on the resident's nightstand. On 10/17/24 at 10:36 a.m. and 1:10 p.m., an interview and observation was conducted with Resident #8's resident representative in Resident #8's room. Resident #8's representative stated that the call light stopped working for her. Resident #8's representative stated the facility gave Resident #8 a bell (a round metal table bell, with the activating lever in the top middle of the bell). Although they did not answer prior when the call light did work. A table bell was observed on the resident's nightstand. During an interview on 10/17/24 at 10:30 a.m. the Director of Nursing (DON) and Nursing Home Administrator (NHA) stated all the building systems were fully functional. During an interview on 10/17/24 at 11:30 a.m. the DON stated the facility was aware of the call lights not functioning for a few rooms, she did not understand the question being asked earlier regarding the building system's functioning. During an interview on 10/17/24 at 4:00 p.m. with the NHA and DON, the NHA stated a vendor was coming out on Wednesday as the generator is hard on call light systems. The NHA presented a document titled Logbook Documentation dated 10/17/24 at 2:17 p.m., which revealed the following: Nurse Call System Checks - 10/2/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Fail; 300 Nurse Call Pass. - 10/8/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Pass; 300 Nurse Call Pass. - 10/14/24 showed: 100/200 Nurse call - NA; 400/500 Nurse Call - Fail; 300 Nurse Call Fail. Comments: rooms [ROOM NUMBERS] 515 are not working. Called IT for service. 320, 321 not working (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 4:30 p.m. with the Director of Maintenance (DOM). The DOM stated the facility became aware of two resident rooms call lights not functioning. The DOM stated, an email was sent earlier in the month to the companies IT department, as this is who arranges for repair of the system, although the DOM has not had a reply. The DOM stated on 10/3/24 he became aware rooms [ROOM NUMBERS] were not working. The DOM issued table bells to the Administrator in Training (AIT) for placement in the resident rooms that were not functioning. The DOM stated a complete facility audit (room by room) was not completed. He stated, I did a few rooms every day, a sampling. Usually, this type of audit is only completed monthly, but I have been doing one weekly. But no not all rooms are tested . An interview was conducted with the AIT on 10/17/24 at 4:37 p.m. The AIT confirmed handing out the table bells to the resident rooms that were not functioning. Confirmed explaining the table bells to the resident/resident families and the nurse responsible for those particular rooms. The AIT confirmed not speaking to any other staff members. On 10/17/24 at 4:35 p.m., a resident was heard yelling help from room [ROOM NUMBER]. An unknown nurse was observed standing across the hall from room when this writer and Staff C, Registered Nurse (RN) entered room [ROOM NUMBER]. The unknown resident did not voice any needs when asked and closed eyes. Staff C was asked to press the call light button for the bed and confirmed the call light was not working. The observation did not reveal a hand bell was available for the resident to use. Staff C left the room and informed the unknown nurse that the call light in room [ROOM NUMBER] was not working and it needed to be reported. On 10/17/24 at 4:40 p.m.Staff C confirmed a hand bell was not observed in room [ROOM NUMBER] and the staff member was getting the resident one. An interview was conducted with Staff A, Registered Nurse (RN) on 10/17/24 at 4:45 p.m. Staff A, RN stated, I have been telling administration for weeks now what call lights are not working. The facility ran out of bells, so not everyone has a table bell. I know 502, 504, 518, 513, 515 off the top of my head are not working. I told my staff about the table bells but not other units. An interview was conducted on 10/18/24 at 9:44 a.m. with Staff O, Maintenance Assistant (MA). Staff O, MA stated, not being responsible for the call light audits. Although I was requested to complete some audits yesterday (10/17/24). During a follow-up interview and observation on 10/18/24 at 9:50 a.m. with the DOM. The DOM explained when completing call light room audits, by entering a resident room, pressing the call button, ensuring the wall system is activated, exiting the room and ensuring the light is on above the door. This process is repeated with resident bathroom light. The audit process is in the computer system to be checked on a monthly basis. The DOM changed this to a weekly check. The check occurs of a random sample of rooms in each hall, not all rooms. The DOM entered the facility computer, pulled up the Logbook Documentation for the nurse call system. During this demonstration the DOM pulled up the log book for the week 10/2/24 and changed the document from Fail to Pass. The DOM stated that was an error. The NHA presented a document titled Logbook Documentation, dated 10/17/24 at 4:51 p.m. which revealed the following: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse Call System Checks 10/17 2166: 217, 312, 317,318, 319, 320, 321, 322, 502, 504, 508,509,510, 518 - 10/2/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Pass; 300 Nurse Call Pass. - 10/8/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Pass; 300 Nurse Call Pass. - 10/14/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Fail; 300 Nurse Call Fail. - 10/15/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Fail; 300 Nurse Call Fail. - 10/16/24 showed: 100/200 Nurse call - Pass; 400/500 Nurse Call - Fail; 300 Nurse Call Fail. Comments: rooms [ROOM NUMBERS] 515 are not working. Called IT for service. 320, 321 not working as of 10/14. 508, 509 as of 10/15. 510 as of 10/16. 518, 318, 319, 312, 322, 217, 216 as 10/17. Note: The above was significantly changed from the prior documentation received. During an interview on 10/18/24 at 5:34 p.m. with the Nursing Home Administrator (NHA) and AIT, the NHA stated the vendor was contacted on 10/2/2024 for repair of the call system. The facility was only required to ensure residents had way to notify staff of need for assistance and the facility provided them with table bells, which meets the requirement. The NHA stated, Being quite busy due to the fact two hurricanes had occurred in a short time. We contacted our vendor. The NHA stated on 10/18/24 at 1:30 p.m. the facility did not have a policy and procedure for Equipment Repair and Maintenance. 37999