

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Cascadia of Boise		STREET ADDRESS, CITY, STATE, ZIP CODE  6000 W Denton St Boise, ID 83704	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306</b></p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed develop a comprehensive resident-centered care plan. This was true for 1 of 21 residents (Resident #18) whose care plans were reviewed. This failure placed Resident #18 at risk of unmet care needs when he did not have a care plan for pneumonitis. Findings include:</p> <p>Review of the facility's Care Plans policy, dated 10/15/22 revealed, A comprehensive care plan is developed consistent with the residents' specific conditions, risks, needs, behaviors, cultural expectations, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident's response to the interventions or changes in the resident's condition .</p> <p>Resident #18 was admitted to the facility on [DATE], with multiple diagnoses including paraplegia (paralysis of the legs and lower body) and diabetes mellitus.</p> <p>A quarterly MDS assessment, dated 5/24/24, documented Resident #18 was cognitively intact.</p> <p>A physician's order dated 5/23/24 documented the following laboratory request for Resident #18: complete blood count (CBC), comprehensive metabolic panel (CMP), and urinalysis (UA) with culture and sensitivity (C&amp;S)</p> <p>A physician's assistant progress notes dated 5/23/24 documented Resident #18 had a diagnosis of pneumonitis versus urinary tract infection.</p> <p>Resident #18's record documented his UA result was negative for urinary tract infection.</p> <p>A nursing progress notes dated 5/23/23 documented Resident #18 had fever, elevated heart rate, and cough. An order was received for Resident #18 to receive intravenous fluids and Rocephin (antibiotic).</p> <p>Review of Resident #18's care plan revealed no documentation concerning these orders.</p> <p>During an interview on 8/6/24 at 4:12 PM, the MDS Nurse confirmed that a care plan should had been developed to reflect these new orders for Resident #18.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/24 at 4:12 PM, the DON confirmed that a care plan should have been updated with the change of condition on 5/23/24 when Resident #18 presented with a fever, cough and elevated heart rate.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on record review, policy review and interview, it was determined the facility failed to ensure medication orders were written accurately per current standards of practice. This was true for 2 of 21 residents (#52 and #710) whose physician's orders were reviewed. This failure created the potential for residents to receive the wrong dosage or receive the medication via the wrong route. Findings include:</p> <p>The facility's Eight Rights of Medication Administration policy, undated documented the following: right resident, right medication, right dose (confirm the appropriateness of the dose using a current drug reference), right route (confirm that the resident can take or receive the medication by the ordered route), right time, right documentation, right reason and right response.</p> <p>1. Resident #71 was admitted to the facility on [DATE] with multiple diagnoses including tracheostomy (a surgically created hole in the windpipe for breathing), dementia, and gastrostomy (presence of surgical opening into the stomach for nutritional support).</p> <p>An admission MDS assessment dated [DATE], documented Resident #71 had a short term and long-term memory problems and severely impaired in decision making.</p> <p>Review of Resident #71's Physician Orders dated [DATE], documented Resident #71 was to received Depakote sprinkles 125 milligrams four capsules by mouth two times a day for seizures.</p> <p>Review of Resident #71's care plan dated [DATE], documented Resident #71 was NPO [nothing by mouth] and medications were administered in liquid or crushed forms and given by gravity as ordered by the physician.</p> <p>During an interview on [DATE] at 4:33 PM, LPN #1 stated, I gave the medication like I do all of his other meds [medicines], per the peg [percutaneous endoscopic gastronomy tube, feeding tube inserted through the skin into the stomach] tube. When asked if LPN #1 clarified the route in which the order stated the medication was to be given, LPN #1 stated, No, I didn't but I should have.</p> <p>During an interview on [DATE] at 4:35 PM, RCM #1 stated, He [Resident #71] doesn't get his meds [medicines] by mouth. The RCM #1 stated the process that was followed once a physician places the order in the computer, the order was flagged as Pending. The nurse would then confirm the order. RCM #1 stated, I check the dosage, time route and what it is used for . When asked if the route was correct for the ordered medication Depakote Sprinkles, RCM #1 stated, No, I will have to fix this right now.</p> <p>During an interview on [DATE] at 4:53 PM, the DON, The nurse is to check the order prior to giving the medication to make sure it is the right drug, the right dose, the right route and the right time. If it is wrong, the nurse is to clarify the order with the doctor.</p> <p>50981</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2a. The facility's policy titled, Oral Medication Administration, dated [DATE], included instructions for staff preparing medications to validate the medication order against the medication packaging and confirm correct dose.</p> <p>Resident #52 was admitted to the facility on [DATE] with multiple diagnoses including fibromyalgia (a disorder characterized by widespread pain accompanied by fatigue, sleep, memory, and mood issues), dysphasia (inability to use or understand language), and had an abnormal gait (a walking abnormality) and problems with mobility.</p> <p>A laboratory result dated [DATE], documented Resident #52 had a low level of Vit D.</p> <p>An order dated [DATE], was received to give Resident #52 cholecalciferol 2,000 mg three times a day for 8 weeks.</p> <p>Resident #52's MAR dated [DATE] through [DATE] documented Resident #52 received cholecalciferol 2,000 mg three times a day.</p> <p>On [DATE] at 8:07 AM, LPN #3 administered one tablet of D3 50mcg/2,000 IU to Resident #52.</p> <p>On [DATE] at 10:26 AM, LPN #3 stated she gave Resident #52 one tablet of Vit D, and it was ordered three times a day. When asked what the order for Resident #52's Vit D was, LPN #3 then reviewed the order and stated it was 2,000 mg TID. LPN #3 then stated she did not give Resident #52 the right amount of Vit D because she only gave one tablet of Vit D 50 mcg. LPN #3 stated, I think it was an entry error. LPN #3 then asked the DON who was just exiting a resident's room. The DON looked at the order and stated, Let me go clarify that.</p> <p>On [DATE] at 10:40 AM, the DON stated Resident #52 received the right dose of Vit D which was 50mcg/2000 IU and not 2000 mg of Vit D. The DON stated the dose was entered wrong in the computer. The DON stated she expect the nurse to contact the physician for clarification if they noticed any discrepancy in the physician's order.</p> <p>On [DATE] at 4:05 PM during a follow-up interview, the DON stated the [DATE] physician's order written for Vit D administration for 8 weeks was expired and Resident #52 should not have continued to receive this order.</p> <p>b. The facility's policy titled, Pharmacist Consultation, dated [DATE], documented the responsibility of the pharmacist to conduct monthly medication regimen review (MRR) for each resident in the facility, including whether the medication dose, frequency, route of administration, and duration are consistent with the resident's condition, manufacturers recommendation, and applicable standards of practice.</p> <p>The May, June and [DATE] MRR, did not include recommendation from the pharmacist regarding Resident #52's medications.</p> <p>On [DATE] at 10:41 AM, during a phone interview, the pharmacist stated he conducted the MRR for the facility once a month and during the review he would check the physician's orders for every resident. The pharmacist stated he should have caught the 2,000 mg dosage of Vit D. He stated it was an oversight.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on observations, staff interviews, and record review, it was determined the facility failed to ensure physician's order was followed regarding dressing changes for 1 of 2 residents (Resident #84). This failure created the potential for infection to spread to Resident #84's open areas to his left arm if it was not covered as ordered by the physician. Findings include:</p> <p>Resident #84 was admitted to the facility on [DATE] with multiple diagnoses including stroke, acute respiratory failure with hypoxia (low level of oxygen in the body tissues), and left hemiparesis (weakness) and hemiplegia (paralysis).</p> <p>An admission MDS assessment dated [DATE], documented Resident #84 was severely cognitively impaired.</p> <p>A Physician Order dated 8/6/24, directed staff to cleanse Resident #84's open rash to his left arm with wound cleanser, cover with boarder gauze and change two times a week and as needed.</p> <p>Resident #84's care plan dated 8/7/24, documented Resident #84 had a rash on his left arm. Interventions included: avoid scratching and keep hands and body parts from excessive moisture, monitor skin rashes for increased spread or signs of infection, seek medical attention if skin becomes bloody or infected, and try to identify skin allergies and avoid them.</p> <p>On 8/7/24 at 11:30 AM and 1:49 PM, Resident #84 did not have a dressing on his left arm. At 1:49 PM, RCM #1 accompanied surveyor to Resident #84's room and confirmed Resident #84 had no dressing present to his left arm.</p> <p>During an interview on 8/7/24 at 2:00 PM, LPN # 2 confirmed Resident #84 was to have a dressing to the left arm, and it was to be changed two times a week and as needed. When asked if the dressing came off, was the dressing to be redressed, LPN #2 stated, Yes. LPN #2 then accompanied the surveyor to Resident #84's room and confirmed Resident #84 did not have a dressing on the left arm.</p> <p>During an interview on 8/7/24 at 4:12 PM, the DON stated if Resident #84's dressing to his left arm came off, it was to be redressed.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on staff interview, and record review, it was determined the facility failed to obtain physician ordered laboratory testing. This was true for 1 of 21 residents (Resident #18) whose records were reviewed. This failure created the potential for a physician to inaccurately diagnose and/or treat a resident appropriately due to lack of information.</p> <p>Findings include:</p> <p>Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including paraplegia (paralysis of the lower limbs below the navel) and cerebral palsy (CP is caused by abnormal brain development or damage to the developing brain that affects a person's ability to control their muscles). Resident #18 did not have any cognitive deficiencies and could make his own medical decisions.</p> <p>Resident #18's record contained physician orders, dated 5/23/24, for 3 laboratory tests:</p> <ol style="list-style-type: none"> <li>1. Complete Blood Count (a CBC examines the number and types of cells in a person's blood);</li> <li>2. Comprehensive Metabolic Panel (a CMP measures 14 substances in a person's blood to provide information about multiple body systems);</li> <li>3. Urinalysis with Culture and Sensitivity (a UA with C&amp;S checks for bacteria in a person's urine that could cause infection).</li> </ol> <p>Resident #18's record contained laboratory testing results for the ordered CBC and UA with C&amp;S. Results for the CMP were not able to be located in his record.</p> <p>On 8/6/24 at 11:45 AM, the RCM stated the facility used a form to document if laboratory test results were pending, and the form was discussed at their morning clinical meeting. During the discussion, the team would ensure laboratory test results were followed-up on.</p> <p>On 8/6/24 at 2:25 PM, the DON stated she was not aware they had not received results of the CMP laboratory test for Resident #18 and contacted the lab to follow-up. She added, the lab reported the sample of blood for the CMP was collected in the wrong blood sample tube required for this type of blood test and the test was not able to be conducted. The DON stated the facility had not followed-up on ensuring the blood test was completed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25225</p> <p>Based on staff interview, record review, and facility policy review, it was determined the facility failed to have accurate and complete clinical records for 2 of 21 residents (Resident's #33 and #84) whose clinical records were reviewed.</p> <ol style="list-style-type: none"> <li>1. Resident #33's record did not contain information related to the discontinuation of an antibiotic; and</li> <li>2. Resident #84's record documented a dressing change had been completed when it had not been.</li> </ol> <p>These failures created the potential to cause failures in communication amongst the interdisciplinary team</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #33 was readmitted to the facility on [DATE] with multiple diagnoses including calculus of the ureter (mineral deposits lodged in the tubes that connect the kidneys to the bladder), urosepsis with Methicillin Resistant Staphylococcus Aureus infection (an extreme inflammatory response to a urinary tract infection caused by MRSA that spreads to the kidneys).</li> </ol> <p>Resident #33's record contained a physician order from an infectious disease physician, dated 7/25/24, instructing he receive daptomycin 350 mg (an antibiotic), intravenously (IV), for 42 days, through 8/10/24 due to MRSA urosepsis. The order documented instructions to not stop or change the use of daptomycin without consulting the infectious disease physician.</p> <p>On 7/30/24 at 11:41 AM, a progress note written by the DON, documented Resident #33 was diagnosed with pneumonic consolidation (a condition in which lung tissue fills with liquid instead of air) in the base of his right lung. The DON documented the infectious disease physician was consulted and ordered azithromycin (an antibiotic). The progress note did not document information regarding the order for daptomycin.</p> <p>Resident #33's record documented the order for daptomycin was discontinued on 8/3/24. Documentation the infectious disease physician had discontinued the daptomycin could not be located in the record.</p> <p>On 8/6/24 at 4:40 PM, the DON stated, on 7/30/24, when she spoke with the infectious disease physician and they ordered the azithromycin, they gave instructions to discontinue the daptomycin after 48 hours, and that's my error, and she should have documented the order.</p> <p>28306</p> <ol style="list-style-type: none"> <li>2. The facility's policy titled, Documentation of Resident Health Status Needs and Services, dated 10/14/22, documented directions to document services provided after the encounter has concluded and do not document in advance or prior to providing treatments.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #84 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (lack of oxygen in the blood and body tissues), hypertension, heart disease, and stroke. Resident #84 was severely cognitively impaired.</p> <p>Resident #84's record contained a physician order, dated 8/6/24, that directed staff to cleanse the open rash on his left arm with wound cleanser, cover with bordered gauze, and change two times per week and as needed.</p> <p>On 8/7/24 at 11:30 AM, Resident #84 was observed in his room, he did not have a dressing on his left arm.</p> <p>On 8/7/24 at 1:28 PM, LPN #2 documented in a progress note, [Rash on left arm] was cleaned, and foam dressings applied. No other new skin issues noted at this time.</p> <p>On 8/7/24 at 1:49 PM, the Resident Care Manager (RCM) observed Resident #84 and stated he did not have a dressing present on his left arm.</p> <p>On 8/7/24 at 2:20 PM, LPN #2 stated, I got this messed up in my head. I did not do his [dressing] today.</p> <p>On 8/7/24 at 2:24 PM, the RCM stated the nursing notes should reflect the care the nurse gives to the resident.</p> <p>On 8/7/24 at 4:12 PM, the DON stated, she expected the nurses to perform treatments as ordered and to document after the treatment was provided, not prior.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28306</p> <p>Based on observation, staff interview, record review, and nursing competency review, it was determined the facility failed to observe infection control guidelines during a wound care dressing change for 1 of 2 residents, (Resident #71) whose wound care was observed. This failure placed the resident at increased risk of contracting an infection in their wound. Findings include:</p> <p>Resident #71 was admitted to the facility on [DATE] with multiple diagnoses including acute and chronic respiratory failure with hypoxia (lack of oxygen in the blood and body tissues), dementia, and a stage 4 pressure ulcer (localized damage to the skin and underlying soft tissue, usually over a bony prominence, as a result of intense and prolonged pressure, a stage 4 pressure ulcer has full thickness tissue loss exposing bone, tendon, or muscle) on his sacral region (the area located between the lower back and the tailbone). Resident #71 was dependent on a gastric tube (g-tube) for all of his nutrition, hydration, and medications, and he had a tracheostomy (a surgically created opening in the windpipe that provides an alternative airway for breathing).</p> <p>Resident #71's record contained a physician order from 7/24/24 directing staff to, cleanse and place wet to dry and cover, daily to the wound on his right buttock.</p> <p>Resident #71's care plan, dated 7/15/24, documented he had a stage 4 pressure injury to his right buttock present on admission. His care plan documented he used a pressure relieving mattress and directed staff to administer medications and treatments as ordered, assess/record/monitor wound healing, and report improvements and declines to the medical director.</p> <p>Lippincott's nursing standards of practice for basic wound cleaning, dated 12/2008, directed, For an open wound, such as a pressure ulcer, gently wipe in concentric circles, starting directly over the wound and moving outward.</p> <p>The facility's undated skills competency titled, Clean Dressing Change, documented when cleaning a wound, staff should clean from center of wound to the edge.</p> <p>On 8/7/24 at 8:20 AM, LPN #1 was observed cleaning Resident #71's wound bed by patting the wound with gauze, moving without pattern, patting from areas outside the wound then inside the wound bed, increasing the risk of bringing contaminants from Resident #71's skin into the wound bed.</p> <p>On 8/7/24 at 10:33 AM, LPN #1 stated, The dirty to the cleanest. I don't remember how I cleaned it.</p> <p>On 8/7/24 at 10:45 AM, the DON stated, the nurse should clean the wound from the inside of the wound to the outer region of a wound.</p> <p>On 8/7/24 at 11:01 AM, the Staff Development Coordinator/Infection Preventionist (SDC/IP) stated the nurses were to clean the wound in a circular motion from the inside out of the wound bed to prevent bringing bacteria into the wound.</p>		