STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thornton Terrace Health Campus	188 Thornton Rd Hanover, IN 47243

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure the kitchen equipment was clean, sanitary and the removal of expired food items during 3 of 3 kitchen observations. This deficient practice had the potential to affect 45 of 45 residents who received meals in the facility.Findings include:1. During an observation of the kitchen, on 9/03/25 at 9:25 a.m., the following concerns were identified:-On the floor between the fryer and stove were food debris and a bug trap. There was a yellowish-brown greasy substance running down the right side of the stove. -There were three brown colored burnt areas on the back panel behind each burner of the stove top.-The drip pan under the stove top had a foil liner that was 100% covered with a tan substance and food debris.-The grill top to the left of the stove had a black build-up on the griddle irons.-The drip pan under the grill had a torn foil liner with a half inch of a brown liquid substance with a heavy coverage of food debris.-Dried food debris was observed on a large, slotted spoon hanging from the overhead rack, over the steam table. 2. During a return observation to the kitchen, on 9/4/25 at 9:26 a.m., the Dietary Manager indicated the char burner grill was used yesterday, so it was cleaned and the drip pan was cleaned. The foil was new. She indicated the stove top burners were cleaned every other day. The following concerns were still identified:-The drip pan under the stove top was the same with grease and food debris present. -The grease down the side of the stove was still visible.-The food debris and grease was still present on the floor between the stove and the fryer. -The burnt areas to the back panel of the stove top burners was still present. 3. During an observation, on 9/3/25 at 11:07 a.m., of the salads being assembled there were concerns. The open bag of shredded lettuce had an expiration date of 9/1/25 printed on the bag. [NAME] 13 opened the bag and started to place it on the plates. When asked what the expiration date on the lettuce was, she had trouble finding it. Once found, she indicated it was two days past the expiration date. She entered the walk-in refrigerator and obtained another bag of lettuce with an expiration date of 9/9/25. The four bags of salad greens next to the shredded lettuce was brown in color and had an expiration date of 8/28/25. During an interview, on 9/3/25 at 9:30 a.m., the Dietary Manager indicated the food company delivered on Tuesdays and Fridays. She only had issues with running out of produce sometimes. She could obtain the produce from a local store just down the highway, if she needed to, though.During an interview, on 9/3/25 at 11:13 a.m., the Dietary Manager indicated all staff should be monitoring the expiration dates of the foods. She will take photos of the dates on the salad mix and send them back to the food company for a refund, since it was delivered on Tuesday.The kitchen cleaning schedule, indicated the following:-The PM [NAME] Daily Cleaning List included: Wipe all tables and equipment down, Skim and wipe down the fryer, and Empty grease trap.-The AM [NAME] Daily Cleaning List included: Clean work area after each task. The Cleaning Schedules lacked documentation of emptying and cleaning the drip pans under the stove or grill; and cleaning the sides of the stove or the back panel.The Food Labeling and Dating Policy, dated 4/26/22, included, but was not limited to, . Any food item must have a received-on label/received on date, and or a label that indicates the production date and the use by date for the product. 3.1-21(i)(3)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident had an order to self administer medications related to medications left at the bedside for 1 of 4 residents reviewed for self-administration of medication. (Resident 31)Findings include:An observation, on 9/3/25 at 10:01 a.m., indicated Resident 31 had multiple medications in a medicine cup sitting on the resident's bedside table. No staff members were present or near the resident's room. The medications were due between 8:00 a.m. and 10:00 a.m. There was an open inhaler sitting next to the medicine cup on the bedside table. The resident was asleep and did not observe the medications sitting next to her breakfast bowls. During an interview, on 9/3/25 at 10:03 a.m., Licensed Practical Nurse (LPN) 9 looked at the orders and indicated there was no order for the resident for self-administration. She indicated the following medications were in the medication cup on the resident's bedside table: Tart cherry supplement; Potassium; metoprolol; Hair, Skin, and Nails vitamins; Lysine; Allopurinol; Norvasc; Bumetanide (Bumex); Fenofibrate; Iron; Omeprazole; Sertraline; Tramadol; Vitamin D3; and Wellbutrin, Inhaler. The record for Resident 31 was reviewed on 9/5/25 at 12:28 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, chronic diastolic congestive heart failure, type 2 diabetes mellitus with hyperglycemia, severe morbid obesity due to excess calories, obstructive sleep apnea, restless leg syndrome, hypothyroidism, depression, deficiency of the B group vitamins, cardiac murmur, carpal tunnel syndrome of the bilateral upper limbs, dry eye syndrome of bilateral lacrimal glands, muscle weakness, age-related osteoporosis, a lack of coordination, difficulty in walking, long term use of insulin, dependence on enabling machines and devices, a history of falling, dysphagia, metabolic encephalopathy, anemia, cognitive communication deficit, and abnormal posture. The care plan, dated 2/26/24 and revised 7/25/25, indicated the resident had an impairment in functional status. The interventions, dated 2/26/24, indicated staff were to encourage the resident to be as independent as safely possible, administer medications per physician's order, provide assistance as needed with self-care and mobility functional tasks. The physician's order, dated 2/26/24, indicated staff were to administer the Resident's 5 milligrams (mg) of amlodipine (Norvasc) daily between 6:00 a.m. and 10:00 a.m., for hypertension. The physician's order, dated 2/26/24, indicated staff were to administer the resident's 40 mg of omeprazole delayed release daily between 6:00 a.m. and 10:00 a.m. for GERD. The Quarterly Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was cognitively intact. The physician's order, dated 3/7/24, indicated staff were to administer the resident's 186 mg of Hair, Skin and Nails Advanced Multivitamin daily between 6:00 a.m. and 10:00 a.m. for hair and nail growth. The physician's order, dated 3/21/24, indicated staff were to administer the resident's 2 mg of bumetanide twice daily between 6:00 a.m. and 10:00 a.m. Then between 6:00 p.m. and 10:00 p.m., for congestive heart failure (CHF). The care plan, dated 5/23/24 and revised 7/25/25, indicated the resident had a diagnosis of attention deficit disorder. The interventions, dated 5/23/24, indicated staff were to administer medication as ordered. The care plan, dated 5/29/24 and revised 7/25/25, indicated the resident demonstrated a slight hearing loss. The interventions, dated 5/29/24, indicated staff were to communicate with the resident in a clear, concise manner, and increase the volume to ensure the resident received the message. The physician's order, dated 5/31/24, indicated staff were to administer the resident's 50 mg of tramadol three times daily between 6:00 a.m. and 10:00 a.m., then between 11:00 a.m. and 1:30 p.m., then between 6:00 p.m. and 10:00 p.m., for moderate pain. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 300 mg of allopurinol daily between 6:00 a.m. and 10 a.m., for gout. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 200 mg of sertraline daily between 6:00 p.m. and 10:00 p.m., for depression. The physician's order, dated 8/14/24, indicated staff were to administer the resident one puff of 100-25 mcg of Breo Ellipta (fluticasone furoate-vilanterol) blister with device; daily between 6:00 a.m. and 10:00 a.m., for chronic obstructive pulmonary disease (COPD). Please (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have the resident rinse their mouth out after each use to prevent thrush. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 1,000 mg of lysine daily between 6:00 a.m. and 10:00 a.m. for a supplement. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 50 mg of metoprolol twice daily between 6:00 a.m. and 10:00 a.m., then 6:00 p.m. and 10:00 p.m., for hypertension. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 10 milliequivalents (meq) of potassium extended release three times daily between 6:00 a.m. and 10:00 a.m., then between 11:00 a.m. and 1:30 p.m., then between 6:00 p.m. and 10:00 p.m., for hypokalemia. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 8.6 mg of senna [OTC] daily between 6:00 a.m. and 10:00 a.m., for bowel mobility. The physician's order, dated 8/14/24, indicated staff were to administer the resident's 30-250-75-75-20 mg of Tart Cherry (vitamin C-sweet cherry-celery-grape) twice daily between 6:00 a.m., then between 6:00 p.m. and 10:00 p.m., for gout. The physician's order, dated 8/22/24, indicated staff were to administer the resident's 325 mg of ferrous sulfate (iron) daily between 6:00 a.m. and 10:00 a.m., for a supplement. The physician's order, dated 9/7/24, indicated staff were to administer the resident's 25 mcg of Vitamin D3 (cholecalciferol-vitamin D3) daily between 6:00 a.m. and 10:00 a.m. The physician's order, dated 11/21/24, indicated staff were to administer the resident's 54 mg of fenofibrate daily between 6:00 a.m. and 10:00 a.m., for hypertriglyceridemia. The physician's order, dated 2/20/25, indicated staff were to administer the resident's 4 mg of ropinirole twice daily between 6:00 a.m. and 10:00 a.m., then between 6:00 p.m. and 10:00 p.m., for RLS. The physician's order, dated 3/6/25, indicated staff were to administer the resident's 150 mg of Wellbutrin extended release daily between 6:00 a.m. and 10:00 a.m. for depression. The Social Service note, dated 3/18/25 at 5:30 p.m., indicated a family member called, expressing concerns about phone conversations with the resident indicating the resident returned a phone call to him and the call was not going well. She was combative in conversation and had constant negative comments. The resident was getting upset with multiple family members often, and the family was concerned whether the new antidepressant was a good match or not. The Social Service note, dated 4/1/25 at 11:26 a.m., indicated Social Service and the Psychiatric Nurse Practitioner (NP) met for a behavioral management meeting. The resident was last seen by the psychiatric provider on 4/1/25. The resident was prescribed Sertraline, Trazadone, and Wellbutrin, per order. The mood behavior episodes were consistent with depression episodes. The resident was recently started on a new Wellbutrin dose on 3/6/25, and resident's family member indicated an improvement in the resident's overall mood this week. The recommendation was to hold on course on the current medication regimen. The physician's order, dated 8/21/25 indicated the resident should take the medications one at a time in a pureed carrier, three times daily between 6:00 a.m. and 2:00 p.m., then between 2:00 p.m. and 10:00 p.m., and between 10:00 p.m. and 6:00 a.m. The physician's order, dated 5/6/25, indicated the resident had episodes of the following swallowing issues: Dysphagia example of coughing or choking during meals or medication pass, loss of liquids or solids from the mouth when eating or drinking, holding food in their mouth or cheeks or residual food kept in their mouth after meals, complaints of difficulty swallowing, continuous throat clearing, et cetera (etc). Observe for new or worsening swallowing issues and notify the physician. Refer to speech therapy services as appropriate. Serve the diet as ordered with follow-up to the registered dietician as needed, three times a day between 10:00 p.m. and 6:00 a.m., then between 6:00 a.m. and 2:00 p.m., then between 2:00 p.m. and 10:00 p.m. The physician's order, dated 9/3/25 10:30 a.m., indicated the staff may leave the resident's medications at bedside for the resident to self-administer. The physician's order was acquired after notification to managed related to resident's medication being left at bedside. The resident's clinical record lacked a physician's order or current self administration assessment prior to the start of the survey. The record lacked documentation of a self-medication evaluation since the resident transferred for assisted living. During an interview, on 9/3/25 at 10:03 a.m., LPN 9 indicated she usually set the resident's medications on her bedside table. The resident was previously at the Assisted Living Hall, when the LPN worked there. The resident (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an order for self-administration of medications when she was there, and she thought the resident still had the order. The resident had been on the current hall for quite a while since then. The Guidelines for Self-Administration of Medications policy, revised 5/22/18, included, but was not limited to, . Procedure 1. Residents requesting to self-medicate or has self medication as part of their plan of care shall be assessed using the observation [corporate name]- Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. 6. A Self Medication plan of care will be initiated and updated as indicated. 7. The assessment will be reviewed quarterly, and PRN with change of condition.3.1-11(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, and interview, the facility failed to ensure the accuracy of skin assessments (Residents 2 and 23) and failed to ensure accurate coding of the Minimum Data Set assessments (Resident 11) for 3 of 6 residents reviewed for assessments. Findings include:1.The record for Resident 2 was reviewed on 9/7/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, osteomyelitis, type II diabetes mellitus with a foot ulcer, and orthopedic care following a surgical amputation The care plan, dated 11/2/21 and revised 7/9/25, indicated the resident was at risk for skin breakdown related to impaired mobility, type II diabetes, nutritional status, hand contractures, noncompliance with wearing a stump shrinking device. The interventions included, but were not limited to, floating the heels as needed, pressure reducing cushion to his chair, using moisture barrier to the perineal area as needed, a pressure reducing mattress to the bed, avoid shearing skin during positioning, turning, and transferring, encourage and provide assistance to turn and reposition for comfort as needed, conduct a weekly skin assessment, keep the linens clean and dry, keep the resident as clean and dry as possible and minimize skin exposure to moisture. The Register Dietary note, dated 9/16/25 at 8:39 a.m., indicated the resident had a diabetic ulcer to the right side of his foot. There was no edema observed to the resident's right foot. The resident was prescribed Prostat (supplement) 30 milligram (ML) twice a day for wound healing. The nurse's note, dated 9/20/24 at 10:54 a.m., indicated the resident had a wound to the right heel and right pinky toe. The right heel measured 3 centimeters (cm) by 3 cm and there was a calloused area to the resident's right pinky toe 2.7 cm by 2 cm. The nurse's note, dated 9/27/24 at 1:57 p.m., indicated the resident had a wound to the right heel and right pinky toe. The right heel measured 3 cm by 3 cm and the calloused area to the right pinky toe measured 2.6 cm by 2 cm. The nurse's note, dated 10/18/24 at 3:14 p.m., indicated the resident's dressing to the right heel was changed. The resident's heels were soft, a protective boot was in place, and a foam dressing was applied. The physician's note, dated 11/9/24 at 4:02 p.m., indicated the wound to the resident's right foot was dry and intact. The resident had a blister to the top of his right foot. He was taking doxycycline for the right foot wound. The nurse's note, dated 11/18/24 at 9:46 a.m., indicated Resident 2 had a dressing change to his right foot wound. A scant amount of sanguineous drainage was observed on the old dressing. The blister site to the top of his right foot was cleansed; and skin prep was applied to the blister and right heel. The nurse's note, dated 12/3/24, at 10:43 a.m., indicated the resident's right foot wound care was provided per physician's order. The wound had some red bloody drainage. Resident 2 was going to the wound care physician. The Nurse Practitioner (NP) note, dated 11/28/24 at 6:24 a.m., indicated the resident was hospitalized for cellulitis of the right foot. He underwent an amputation of the right fifth toe approximately two weeks ago due to a prior admission diagnosis of osteomyelitis. The wound was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing initially, but the resident observed increased erythema on the dorsum of the right foot. The wound nurse evaluated the resident and recommended hospital admission. The patient underwent a debridement and was discharged on an antibiotic. The nurse's note, dated 12/13/24 at 8:17 a.m., indicated the nurse had completed the treatment to the resident's right foot and a bone could be felt on the back end of the wound. The nurse's note, dated 12/21/24 at 3:00 p.m., indicated the resident's dressing to the right foot was completed. The wound was observed to be darker red than a few days ago. The nurse's note, dated 1/3/25 at 5:20 p.m., indicated the resident's dressing was completed. The wound bed was beefy red, and no signs and symptoms of infection were observed. The physician's note, dated 1/30/25 at 5:25 p.m., indicated Resident 2's wound continued to the right foot. Overall, the right foot was dark red, slightly edematous, and of normal temperature. The wound from removal of the pinky toe was epithelialized on all borders. The center was observed to be healthy granulation tissue. The wound posterior to original surgical wound had a punched out round appearance. The wound bed was less than 10 percent loosely adherent slough and the remainder was beefy red granulation tissue. The area to top of foot was observed with red granulation tissue to the wound bed with a very small point of firmly adherent slough in the center. The nurse's note, dated 4/9/25 at 7:23 p.m., indicated the resident was observed to have increased redness when the dressing was changed. The redness went from the top of ankle to the top of the toes. The nurse's note, dated 4/29/25 at 3:20 p.m., indicated the resident returned from an appointment with the physician. The right foot wound had a bone debridement scheduled for 5/7/25. The nurse's note, dated 6/7/25 at 6:08 p.m., indicated the resident was observed to have light yellow drainage from his wound and redness to the top of his right foot and around wound bed. The NP was contacted, and the resident was started on doxycycline 100 milligrams (mg) twice a day for 7 days. The nurse's note, dated 6/12/25 at 10:05 a.m., indicated the treatment was completed to the right foot wound. No edema was observed. Slight redness was observed to the peri wound and a scant amount of green drainage was on the old bandage. Resident 2 was scheduled for a debridement and xenograft on 6/19. The antibiotic and change the treatment to Anasept wound gel. The Clinically at Risk (CAR) note, dated 6/27/25 at 11:21 a.m., indicated the wound had showed improvement. The nurse's note, dated 8/5/25 at 5:07 p.m., indicated the resident returned from a doctor's appointment. The treatment included Prisma to the wound and changing the dressing every 3 days and as needed. The review of the facility skin assessments lacked documentation indicating the resident has a wound to the right foot. The resident's weekly skin assessment documentation indicated the following: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/16/24, the resident's skin assessment had 0 marked to indicated the resident had no skin impairments. -On 9/23/24, the resident's skin assessment had 0 marked to indicated the resident had no skin impairments. -On 9/30/24, the resident's skin assessment had 0 marked to indicated the resident had no skin impairments. -On 10/24/25, the resident's skin assessment had 0 marked to indicated the resident had no skin impairments. had no skin impairment. --On 11/11/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 11/18/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 12/2/24, the resident's skin assessment, lacked documentation indicating a wound or skin issues were present. -On 12/9/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 12/16/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 12/23/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 12/30/24, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 1/6/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 1/13/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 1/20/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 2/3/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 2/10/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 2/17/25, the resident's skin assessment lacked documentation indicating a wound or skin issues (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/14/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 7/21/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 7/28/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 8/4/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 8/11/25, the resident' s skin assessment lacked documentation indicating a wound or skin issues were present. -On 8/18/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. -On 8/25/25, the resident's skin assessment lacked documentation indicating a wound or skin issues were present. During an interview, on 9/5/25 at 11:30 a.m., the DON indicated she had observed recently there was an issue with the skin assessments. During an interview, on 9/8/25 at 11:20 a.m., Licensed Practical Nurse (LPN) 12 indicated the facility skin assessments were done weekly every Monday. If the resident had no skin impairment issues the nurse would document a 0. If during the weekly skin assessment, the nurse found a new wound or skin issue they would document 1 indicating a new skin area. If the resident already had a wound and with no new wounds the nurse would document a 2. She indicated she would document a number each time she did a skin assessment. During an interview, on 9/8/25 at 11:30 a.m., Wound Care Nurse 3 indicated if a new wound was found after the Monday skin assessment the wound would be documented on the next skin assessment as an old wound. If the new wound was found on the day the skin assessments were done it would be classified as a new wound with a number 1. There should always be a number for the skin assessments in the clinical record. If a number was missing, then the assessment wasn't done or the nurse forgot to add the number to the skin assessment documentation. 2. During an observation, on 9/3/25 at 9:46 a.m., Resident 23 was lying on his left side in bed. Pillows were between his knees and under his knees. There was a pillow behind the resident. His caregiver was at his bedside. During an observation of Resident 23, on 9/8/25 at 8:50 a.m., Wound Care Nurse 3 gathered treatment supplies and brought them into the resident's room. CNAs 7 and 8 were using a full body mechanical lift to transfer the resident from his recliner to his bed. The resident was lying on his left back side asleep with a blanket covering him. The resident's caregiver was sitting next to the resident. There was a cushion on the seat of the recliner. Once the resident was transferred into bed, the resident's brief was pulled down and he was in the middle of a bowel movement. The wound dressing was getting soiled. Once the resident was cleaned and the brief was removed, the began to conduct the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound treatment change. The resident started to have another bowel movement. The resident's left hip had a reddened 5-inch diameter circular area. The CNAs applied barrier cream to the left hip. The Wound Care Nurse 3 performed hand hygiene and applied gloves. The staff did not apply gowns. The soiled dressing didn't have a date on it. The resident's coccyx had multiple areas of scarring from old wounds. The new wound had white colored granulation tissue on the quarter sized wound. The lower edge of the wound had a scant area of blood or drainage on it. The Wound Care Nurse 3 indicated the wound looked worse than it did last week. There were four quarter sized wounds around the new wound. The Wound Care Nurse 3 applied two small calcium alginate treatments to the wounds. She then applied the foam dressing over the alginate. Three cup sized red areas were observed on the resident's left buttock. The resident was placed on his left side. One pillow was placed behind the resident's back and hip area. One pillow was placed between his knees. One pillow was placed under his knees. Boots were placed on the resident's feet. During an observation of the resident, on 9/8/25 at 1:21 p.m., the resident was sitting on his left hip in his recliner. The resident was asleep. The record for Resident 23 was reviewed on 9/4/25 at 11:54 a.m. The resident's diagnoses included, but were not limited to dyskinesia, chronic ischemic heart disease, atherosclerotic heart disease of the coronary artery, abdominal aortic aneurysm, paraplegic immobility syndrome, disorders of the lung, bronchiectasis, hypothyroidism, hyperlipidemia, depression, anxiety disorder, anemia, hypertension, weakness, difficulty in walking, lack of coordination, repeated falls, personal history of malignant neoplasm of the prostate, and pneumonia. The care plan, dated 4/3/24 and revised 9/3/25, indicated the resident was at risk for skin breakdown related to impaired mobility, incontinence, bilateral knee contractures, and a history of skin breakdown. The interventions, dated 4/3/24, included, but were not limited to, avoid shearing skin during positioning, turning, and transferring, conduct weekly skin assessments, pay particular attention to the bony prominences, encourage and assist to turn and reposition for comfort and as needed, float the heels as needed and tolerated, keep linens clean and dry, keep the resident as clean and dry as possible, minimize skin exposure to moisture, observe the feet during care for redness, swelling. or changes in condition; notify the physician as needed, pressure reducing cushion to the chair, pressure reducing mattress to the bed, treatments and preventative treatments as or when ordered, use a lifting device as needed for bed mobility, and use a moisture barrier product to the perineal area as needed. The care plan, dated 5/2/24 and revised 9/3/25, indicated the resident had MASD. The interventions, dated 5/2/24, included, but were not limited to, keep the resident's skin clean and dry, observe for pain, itching, or discomfort and treat as ordered, please observe MASD for a decline or signs and symptoms of infection, notifying the physician as needed, and treatment as ordered. The physician's order, dated 3/23/24, indicated staff were to conduct weekly skin assessment for the resident. The weekly skin assessment were documented with the following scale: 0=no impairment, 1=new impairment, 2=old impairment. The weekly skin assessments were completed once a day on Mondays between 6:00 a.m. and 2:00 p.m. The Skin Assessments lacked documentation of skin issues on the following dates: -On 9/16/24, the resident had no skin impairment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/23/24, the resident had no skin impairment. -On 10/14/24, the resident had no skin impairment. -On 10/28/24, the resident had no skin impairment. -On 11/4/24, the resident had no skin impairment. -On 11/11/24, the resident had no skin impairment. -On 11/18/24, the resident had no skin impairment. -On 11/25/24, the resident had no skin impairment. -On 12/2/24, the resident had no skin impairment. -On 12/9/24, the resident had no skin impairment. -On 12/16/24, the resident had no skin impairment. -On 12/23/24, the resident had no skin impairment. -On 12/30/24, the resident had no skin impairment. -On 1/6/25, the resident had no skin impairment. -On 1/13/25, the resident had no skin impairment. -On 1/20/25, the resident had no skin impairment. -On 1/27/25, the resident had no skin impairment. -On 2/17/25, the resident had no skin impairment. -On 3/10/25, the resident had no skin impairment. -On 3/17/25, the resident had no skin impairment. -On 3/24/25, the resident had no skin impairment. -On 3/31/25, the resident had no skin impairment. -On 5/26/25, the resident had no skin impairment. -On 6/2/25, the resident had no skin impairment. -On 8/4/25, the resident had no skin impairment. -On 8/11/25, the resident had no skin impairment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record lacked documentation of accurate weekly skin assessments. The nurse's note, dated 8/4/24 at 4:28 p.m., indicated the nurse was called to resident's room by a CNA stating the resident had an open area to his buttocks. The area on the resident's buttock was cleansed and measured. The wound measured 6 cm long by 2.5 cm wide by less than 0.1 cm deep to the right buttock. The resident's left buttock area was purple in color with pinpoint open areas. The left buttock measured 4 cm long by 3 cm wide with no open areas. Both areas were cleansed and a foam dressing was applied. The care plan, dated 9/3/25, indicated the resident had a skin/wound infection of the moisture associated skin damage (MASD) area to the coccyx. The interventions, dated 9/3/25, included, but were not limited to, administer medications and treatments as ordered, evaluate, report, and record effectiveness, and or signs or symptoms of adverse side effects, assess pain and observe the wound and surrounding skin condition, report emergence of skin excoriation, assist with frequent turning and repositioning of the wound as appropriate, diet as ordered and encourage fluids unless contraindicated, consult with the dietitian as needed, observe for and report new or worsening signs or symptoms of skin/wound infection, observe for and report signs of sepsis, obtain laboratory work and diagnostic tests as ordered, report findings to the physician, obtain vital signs as ordered and indicated, record the amount, type, and odor of drainage from the wound or skin infection site, record the color, consistency, and location of the exudate, use proper infection control contact precautions as indicated and per policy when providing care. The nurse's note, dated 9/17/24 at 2:48 a.m., indicated CNAs were changing the resident, and notified the nurse of open areas to the resident's buttock. The resident had three discovered dime sized open areas on the buttock/coccyx area. The resident's wounds were cleansed and a foam dressing applied. The nutritional note, dated 9/23/24 at 9:26 a.m., indicated the resident's open areas were on the buttock/coccyx area and treatment was in place. The nurse's note, dated 9/26/24 at 1:40 p.m., indicated treatment to the resident's buttock was completed and the MASD appeared to be healing with no worsening. The nurse's note, dated 1/31/25 at 2:47 p.m., indicated the resident's toes were still discolored but appeared to be getting better. There was no pain or discomfort to the resident's toes. A skin prep was applied. The new area to the side of the left foot had appeared. The wound was red and blanchable. A skin prep was applied to it and an a faom dressing was placed for a barrier. The resident's legs were propped up with a pillow. The hospice RN was in to see the area as well, with no concerns per the RN. The nurse's note, dated 7/16/25 at 10:40 p.m., indicated the resident had three Stage 2 pressure ulcers to the left and right buttocks with 2 areas on the right buttock. The wounds were covered with a foam dressing. The nurse's note, dated 7/17/25 at 2:53 p.m., indicated the areas to the resident's buttocks were present as moisture associated skin damage and treatment was in place. The Quarterly MDS assessment, dated 8/29/25, indicated the resident was severely cognitively impaired. He was always incontinent of bowel and bladder and at risk for pressure ulcers or injuries. The nurse's note, dated 9/2/25 at 1:37 p.m., indicated the resident was observed to have an open (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area on the bottom. A foul smell was present when the dressing was removed. The area was cleansed with normal saline and covered with Mepilex. Hospice was in to see the resident and a new order to start 100 mg of doxycycline twice daily for 5 days was placed. The Interdisciplinary note, dated 9/5/25 at 10:05 a.m., indicated the wound care RN assessed the wound. A new treatment plan was in place, and an antibiotic was started. The nurse's note, dated 9/8/25 at 1:33 p.m., indicated the resident had healed areas to the bottom surrounding the wound. The wound area was red and purple in color. The area was blanchable. The treatment orders changed to a Calazyme paste and apply a foam dressing to be applied every 3 days. The resident and family were made aware. 3. The record for Resident 11 was reviewed on 9/8/25 at 1:26 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, without mention of fluctuations; dementia in other diseases classified elsewhere, unspecified severity; without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; Takotsubo syndrome; hypertensive heart disease with heart failure; chronic combined systolic (congestive) and diastolic (congestive) heart failure, and essential hypertension. The Quarterly MDS assessment, dated 7/16/25, indicated the resident was in a High-Risk Drug Classes The resident's medication in the last 7 days or since admission was the following medication: E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin). Review of the current and discontinued physician's orders, from 1/1/25 through 9/8/25, indicated the resident was not prescribed or taking an anti-coagulant. The Signature of the RN Assessment Coordinator verified that the assessment was completed on 7/22/25 and all information was correct. During an interview, on 9/8/25 at 2:15 p.m., the MDS Coordinator indicated the anticoagulant box should have not been checked. It was a mistake in coding, It should have been checked for the antibiotic right below the anti-coagulant box. Resident 11 was not on an anti-coagulant or had not received an anti-coagulant during the assessment time line. The review of the Resident Assessment MDS manual, included, but was not limited to, .Coding instructions: all staff who complete any part of the MDS must enter their signatures, titles, sections or portion(s) they completed, and the date completed.Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS to the best of your knowledge, most accurately reflect the resident's status. The Guidelines for Weekly Skin Observation policy, revised 5/14/25, included, but was not limited to, . The purpose of this policy is to: To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated. Procedure 1. A full body observation shall be completed weekly by the licensed nurse. Cross Reference F684 and F741 3.1-31(d)(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure care plans were revised and implemented with interventions for 2 of 12 residents review for care plan revision. (Residents 2 and 23)Findings include:1.The record for Resident 2 was reviewed on 9/7/25 at 9:48 a.m. The resident's diagnoses included, but were not limited to, osteomyelitis, type II diabetes mellitus with a foot ulcer, and orthopedic care following a surgical amputation. The care plan, dated 11/2/21 and revised 7/9/25, indicated the resident was at risk for skin breakdown related to impaired mobility, type II diabetes, nutritional status, hand contractures, noncompliance with wearing a stump shrinking device. The interventions included, but were not limited to, floating the heels as needed, pressure reducing cushion to his chair, using moisture barrier to the perineal area as needed, a pressure reducing mattress to the bed, avoid shearing skin during positioning, turning, and transferring, encourage and provide assistance to turn and reposition for comfort as needed, conduct a weekly skin assessment, keep the linens clean and dry, keep the resident as clean and dry as possible and minimize skin exposure to moisture. The clinical record lacked documentation indicating the wound care nurse seen the resident before 12/2/24, revised care plan with new interventions and initiated a new care plan with interventions for wounds. The nurse's note, dated 9/6/24 at 11:35 a.m., indicated the resident had a right heel and right pinky toe wound. The right heel wound measured 3.5 cm in length by 2.7 cm in width and the resident's right pinky toe measured 2.0 cm in length by 1.5 cm in width. The Discipline Progress Note and the Observations Events, dated 9/10/25 at 12:02 p.m., indicated the resident's area to the bottom of his heel appeared purplish brown in color. The skin was intact and the resident voiced no complaints of pain or discomfort to area. Treatment orders were in place for the resident's wound. The resident had a history of diabetic ulcerations and had an ulcer to his left foot that had osteomyelitis, and the resident's left leg had been amputated below the knee. The resident had a callus area to the right side of his foot beneath the pinky toe. The treatment was in place as preventative for this area, the resident did not put pressure on the bottom of his foot, he would lay his right foot on its side. The resident had been non-compliant with wearing a pressure reducing boot while in bed, a brace while up, and wearing a shoe. Prior to the development of the wound, the resident had the following pressure reduction modalities in place: offload pressure to the right heel, float heel while in bed, moisture barrier cream, turning and repositioning, a pressure reducing mattress, a pressure reduction cushion to the wheelchair, weekly skin measurements, and the resident was now being followed on Clinical at risk (CAR) by the campus Wound Care Consultant (WCC). The recommendations included, but were not limited to, continue with prostat AWC 30 milliliters (ml) by mouth twice a day; laboratory test including a C-reactive protein (CRP); and a Sedimentation Rate (ESR) to determine a chronic inflammatory process, that could establish a poor healing diagnosis, albumin, pre albumin, lipid profile to determine potential decrease in circulation; and an Ankle-Brachial Index (ABI) to assess blood flow to the lower limbs. Recommended therapies to treat and evaluate as indicated. The resident continued with weekly skin assessments and the resident was to be followed CAR for wounds. The CAR note, dated 10/10/24 at 2:21 p.m., indicated the resident's right heel measured 3.6 cm in (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 7/17/25 at 2:53 p.m., indicated the areas to the resident's buttocks were present as moisture associated skin damage and treatment was in place. The nurse's note, dated 9/2/25 at 1:37 p.m., indicated the resident was observed to have an open area on the bottom. A foul smell was present when the dressing was removed. The area was cleansed with normal saline and covered with Mepilex. Hospice was in to see the resident and a new order to start 100 mg of doxycycline twice daily for 5 days was placed. The Interdisciplinary note, dated 9/5/25 at 10:05 a.m., indicated the wound care RN assessed the wound. A new treatment plan was in place, and an antibiotic was started. The nurse's note, dated 9/8/25 at 1:33 p.m., indicated the resident had healed areas to the bottom surrounding the wound. The wound area was red and purple in color. The area was blanchable. The treatment orders changed to a Calazyme paste and apply a foam dressing to be applied every 3 days. The resident and family were made aware. During an observation of Resident 23, on 9/8/25 at 8:50 a.m., Wound Care Nurse 3 gathered treatment supplies and brought them into the resident's room. CNAs 7 and 8 were using a full body mechanical lift to transfer the resident from his recliner to his bed. The resident was lying on his left back side asleep with a blanket covering him. The resident's caregiver was sitting next to the resident. There was a cushion on the seat of the recliner. Once the resident was transferred into bed, the resident's brief was pulled down and he was in the middle of a bowel movement. The wound dressing was getting soiled. Once the resident was cleaned and the brief was removed, the began to conduct the wound treatment change. The resident started to have another bowel movement. The resident's left hip had a reddened 5-inch diameter circular area. The CNAs applied barrier cream to the left hip. The Wound Care Nurse 3 performed hand hygiene and applied gloves. The staff did not apply gowns. The soiled dressing didn't have a date on it. The resident's coccyx had multiple areas of scarring from old wounds. The new wound had white colored granulation tissue on the quarter sized wound. The lower edge of the wound had a scant area of blood or drainage on it. The Wound Care Nurse 3 indicated the wound looked worse than it did last week. There were four quarter sized wounds around the new wound. The Wound Care Nurse 3 applied two small calcium alginate treatments to the wounds. She then applied the foam dressing over the alginate. Three cup sized red areas were observed on the resident's left buttock. The resident was placed on his left side. One pillow was placed behind the resident's back and hip area. One pillow was placed between his knees. One pillow was placed under his knees. Boots were placed on the resident's feet. The record lacked updated care plan interventions related to wounds after 5/2/24 through 9/2/25, even through the resident continued to have skin impairment issues. The Comprehensive Care Plan Guideline policy, revised 5/22/18, included, but was not limited to, . Procedure 1. c. Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan. 3. The comprehensive care plan should be reviewed no less than quarterly and revised to reflect changes in the resident's condition as they occur . Cross Reference F684 and F741. 3.1-35 (d)(2)(B)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure resident's wounds had accurate documentation for size, staging, and treatment for 2 of 2 residents reviewed for non pressure wounds.Findings include:1.During an observation of the resident on 9/8/25 at 1:21 p.m., the resident was sitting on his left hip in his recliner. The resident was asleep. The Infection Control Infection Tracker Event Report, dated 9/2/25, indicated Resident 23 had Cellulitis/Soft Tissue/Wound to the buttocks with light green drainage. This was a healthcare-associated infection. The signs and symptoms of the cellulitis/soft tissue/wound infection was redness, tenderness, and purulent drainage. The interventions were to give medications as prescribed for the infection, encourage fluids, monitor for effectiveness of the antibiotic, and monitor for signs and symptoms of the infection. The care plan, dated 5/2/24 and reviewed 9/3/25, indicated Resident 23 had moister associated skin damage (MASD. The interventions, dated 5/2/24, included, but were not limited to, keep the resident's skin clean and dry, observe for pain, itching, or discomfort and treat as ordered, please observe MASD for a decline or signs and symptoms of infection, notifying the physician as needed, and treatment as ordered. The nurse's note, dated 8/4/24 at 4:28 p.m., indicated the nurse was called to the resident's room by a CNA indicating the resident had an open area to his buttocks. The areas to the right buttock, were cleansed and measured 6 cm long by 2.5 cm wide by less than 0.1 cm deep. The area of the resident's buttocks was purple in color with pinpoint open areas throughout. The resident's left buttock measured 4 cm long by 3 cm wide with no open areas to the left buttock. Both areas were cleansed and a foam dressing was applied. Staff were educated to attempt to offload the resident's hips while up in the recliner. The Interdisciplinary note, dated 8/5/24 at 9:22 a.m., indicated the resident had moisture associated skin damage to the buttocks. The treatment and monitoring were in place at this time. The Wound Management assessment, dated 8/9/24 at 9:31 a.m., indicated the resident had dermatitis to the right buttock. The area was MASD not a true dermatitis. The nurse's note, dated 9/17/24 at 2:48 a.m., indicated CNAs were changing the resident and notified the nurse of open areas to the buttock. The resident had 3 dime sized open areas on the buttock/coccyx area. The area was cleansed and a foam dressing was applied. The Wound Management assessment, dated 9/26/24, indicated the resident's right buttock wound was 1 cm long by 1 cm wide. The resident continued with incontinence associated dermatitis with small open areas of skin damage from moisture. The follow-up wound note lacked documentation of measurements or treatment. The nurse's note, dated 7/16/25 at 10:40 p.m., indicated the resident had three Stage 2 pressure ulcers to the left and right buttocks with 2 areas on the right buttock. The wounds were covered with a foam dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order, dated 7/16/25, indicated staff were to apply magic butt cream cream; Nystatin 100,000 unit per gram (u/gram) ointment, bacitracin zinc 500 u/gram ointment, Hydrocortisone 1% ointment, zinc oxide 20%. See the package; topically four times a day and PRN. The Wound Management assessment, dated 7/16/25, indicated the first observation of the two open areas to the right buttock measured 0.5 cm long by 0.5 cm wide. The wound was documented as an unspecified ulcer. The nurse's note, dated 7/17/25 at 2:53 p.m., indicated the area to the resident's buttocks presented as moisture associated skin damage. The physician's order, dated 7/17/25, indicated staff were to observe the resident's dressing to the residents open area(s) of the buttocks every shift for drainage on the dressing and dislodgement. The physician's order, dated 7/17/25, indicated to cleanse the resident's wound to the buttocks PRN with wound cleanser or normal saline, pat dry, apply skin prep to peri-wound, and cover with foam dressing if dislodged or soiled. The Wound Management assessment, dated 7/17/25, indicated the open areas to the resident's right buttock were documented as MASD and were discontinued from Wound Management. The physician's order, dated 7/17/25, indicated to cleanse MASD wound to the buttocks with wound cleanser or normal saline, pat dry, apply skin prep to peri-wound, and cover with foam dressing every 5 days between 7:00 a.m. and 3:00 p.m. The physician's order, dated 8/20/25, indicated the resident was admitted under hospice services related to a terminal diagnosis of a neurocognitive disorder with Lewy Bodies. If the disease ran a normal course, the life expectancy was 6 months or less. The Quarterly MDS assessment, dated 8/29/25, indicated the resident was severely cognitively impaired. He was always incontinent of bowel and bladder and was at risk for pressure ulcers or injuries. The nurse's note, dated 9/2/25 at 1:37 p.m., indicated the resident was observed to have an open area on the bottom. A foul smell was present when the dressing was removed. The area was cleansed with normal saline and covered with Mepilex. Hospice was in to see the resident and a new order to start 100 mg of doxycycline twice daily for 5 days for the infection was placed. The care plan, dated 9/3/25, indicated the resident had a skin/wound infection of the MASD area to the coccyx. The interventions, dated 9/3/25, included, but was not limited to, administer medications and treatments as ordered, evaluate, report, and record effectiveness, and or signs or symptoms of adverse side effects, assess pain and observe the wound and surrounding skin condition, report emergence of skin excoriation, assist with frequent turning and repositioning of the wound as appropriate, diet as ordered and encourage fluids unless contraindicated, consult with the dietitian as needed, observe for and report new or worsening signs or symptoms of skin/wound infection, observe for and report signs of sepsis, obtain laboratory work and diagnostic tests as ordered, report findings to the physician, obtain vital signs as ordered and indicated, record the amount, type, and odor of drainage from the wound or skin infection site, record the color, consistency, and location of the exudate, use proper infection control contact precautions as indicated and per policy when providing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. The Interdisciplinary note, dated 9/5/25 at 10:05 a.m., indicated Wound Care Nurse 3 assessed the resident's wound. A new treatment plan was in place, and an antibiotic was started. During an interview on 9/5/25 at 10:28 a.m., the Regional Director of Clinical Operations (RDCO) indicated she had not looked at the wounds in the facility for at least three weeks. The wound nurse just quit last week. She did not always agree with the previous wound nurse's assessment and had educated the Former Wound RN 6 many times. The wound was something and it should be staged. The new Wound Care Nurse 3 was in training as the wound nurse. During an interview, on 9/5/25 at 11:50 a.m., the RDCO indicated not every wound would be included in the Wound Management. On 12/25/24, all types of skin areas were to be documented in Wound Management. The wound on 7/16/25 should have been documented in Wound Management. Even though the resident was having MASD, No physician would look at the wounds, unless they were very severe. Hospice would assess the wound and place orders for the most recent wound on 9/2/25. They did not order a wound culture. The documentation did not show what the wound was at times and the classification of the wound was confusing. The nurse's note, dated 9/8/25 at 1:33 p.m., indicated the resident had healed areas to the bottom surrounding the new wound. The wound area was red and purple in color. The area was blanchable. The treatment orders were changed to Calazyme paste and apply a foam dressing to be applied every 3 days. The physician's orders, dated 9/8/25, indicated to cleanse the resident's wound to the MASD buttocks with wound cleanser or normal saline, pat dry, apply skin prep to the peri-wound, apply Calazyme ointment to the wound bed and cover with a foam dressing every 3 days. 2. The record for Resident 2 was reviewed on 9/7/25 at 9:48 a.m. The diagnoses included, but were not limited to, osteomyelitis, type II diabetes mellitus with a foot ulcer, and orthopedic care following a surgical amputation. The care plan, dated 11/2/21 and revised 7/9/25, indicated the resident was at risk for skin breakdown related to impaired mobility, type II diabetes, nutritional status, hand contractures, noncompliance with wearing a stump shrinking device. The interventions included, but were not limited to, floating the heels as needed, pressure reducing cushion to his chair, using moisture barrier to the perineal area as needed, a pressure reducing mattress to the bed, avoid shearing skin during positioning, turning, and transferring, encourage and provide assistance to turn and reposition for comfort as needed, conduct a weekly skin assessment, keep the linens clean and dry, keep the resident as clean and dry as possible and minimize skin exposure to moisture. The nurse's note, dated 8/29/24 at 3:01 p.m., indicated the resident was observed to have a deep tissue injury to the right lateral distal foot joint measuring 1.5 cm in length by 0.5 cm in width. The resident's foot turned out placing pressure on the area when sitting with his foot down. The nurse's note, dated 9/5/24, the resident had a blistered tissue that was intact. The tissue had 25 percent dark purple tissue and 75 percent flesh colored. The nurse's note, dated 9/6/24 at 11:35 a.m., indicated Resident 2 had a right heel and right pinky toe (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound. The measurements for the right heel measured 3.5 cm in length by 2.7 cm in width. The toe measured 2.0 cm in length by 1.5 cm in width. The preventive measures included Preservision, Neuriva, and followed by the wound nurse. The Discipline Progress Note and the Observations Events, dated 9/10/25 at 12:02 p.m., indicated the resident's area to bottom of heel appears purplish brown in color, the skin was intact and voiced no complaints of pain or discomfort to area. Treatment orders were in place. Resident 2 had a history of diabetic ulcerations and had an ulcer to his left foot that had osteomyelitis, and the left leg had been amputated below the knee. The resident had a callus area to the right side of foot beneath the pinky toe. The treatment was in place as preventative for this area, as the resident was not noted to put pressure on the bottom of his foot, rather, he lays the right foot on its side. The resident had been non-compliant with wearing pressure reducing boot while in bed and bracing while up and wearing a shoe. Prior to the development of the wound, the resident had the following pressure reduction modalities in place: offload pressure to the right heel, float heel while in bed, moisture barrier cream, turning and repositioning, a pressure reducing mattress, a pressure reduction cushion to the wheelchair, weekly skin measurements, and the resident was now being followed on Clinical at Risk (CAR) by the campus WCC. The recommendations included continue with prostat AWC 30 milliliters (ml) by mouth twice a day, laboratory test including a C-reactive protein (CRP) and a Sedimentation Rate (ESR) to determine a chronic inflammatory process, that could establish a poor healing diagnosis, albumin, pre albumin, lipid profile to determine potential decrease in circulation, and an Ankle-Brachial Index (ABI) to assess blood flow to the lower limbs. Recommended therapies to treat and evaluate as indicated. Continue with weekly skin assessments and continue to follow in CAR for wounds. The nurse's note, dated 9/12/24 at 10:59 a.m., indicated the wound to the resident's right foot was without improvement. The NP was notified and indicated she would order a doppler to evaluate the arterial blood flow and investigate the possibility of getting a boot for offloading pressure. The nurse's note, dated 9/26/24, indicated the resident had a diabetic wound with dark brownish red intact tissue. The nurse's note, dated 10/3/24 at 2:03 p.m., indicated the resident's wound to the right lateral foot wound bed had turned dark purple in color. The foot was red, warm, and edematous. The resident was sent to the hospital. The CAR note, dated 10/10/24 at 2:21 p.m., indicated the resident's right heel measured 3.6 cm in length and 2.5 cm in width. The resident had a calloused area to the pinky toe that measured 3.4 cm in length by 2.5 cm in width. The pinky side wound had eschar tissue loosely attached, and the heel wound remained intact. A scant amount of purulent drainage was observed. The preventive measures included preservision, Neuriva, followed by the wound nurse and Registered Dietician (RD), and an air mattress. On 10/17/24, the resident had a diabetic wound to the right bottom of the foot on the posterior planter's aspect. The epidermis had dried up and came off. The underlying tissue was pink and appeared fragile. A foam dressing applied. The nurse note, dated 10/17/24, indicated the resident had a diabetic wound to the right bottom of the foot on the posterior planter's aspect. The epidermis had dried and came off. The underlying tissue was pink and appeared fragile. A foam dressing applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 11/1/24 at 7:22 a.m., indicated Resident 2 had increased confusion. The resident's temperature was 103.1 Fahrenheit. Staff were concerned the resident may be septic from his foot wound. The nurse's note, dated 11/14/24 at 10:09 a.m., indicated the resident's dressing was changed to the resident's right foot. Eschar spots remained intact. Red beefy meat continued to the top of the right foot with bleeding observed. A blister to the top of the food was still intact. The nurse's note, dated 11/21/24 at 4:02 p.m., indicated the resident's treatment to the right foot was completed. The wound had 75 percent granulating tissue and 25 percent firmly adherent necrotic tissue. The entire top of the right foot and bottom base of the toes were reddened and edematous. The resident was sent to the hospital. The nurse's note, dated 11/27/24 at 3:49 a.m., indicated the resident returned from the hospital. The resident's right foot wound was debrided while in the hospital. The resident was to continue to take antibiotics. The nurse's note, dated 12/01/24 at 1:53 p.m., indicated the resident's right side of his foot wound measured 8 cm in length by 4 cm in width by 1.5 cm in depth. The wound on the top of the resident's foot measured 1.5 cm in length by 3 cm in width by 0.3 cm in depth. The wound note, dated 12/2/24, indicated the resident's surgical incision had an open area. The surrounding tissue was warm to touch with serous drainage. The Physician Assistant (PA) note, dated 12/3/24 at 10:43 a.m., indicated the resident had a history of osteomyelitis and recent right foot toe amputation. The resident was seen for a follow-up of cellulitis of the right foot. He was previously hospitalized for cellulitis of the right foot and had a right foot toe amputation due to osteomyelitis, followed by debridement. He was discharged on Levaquin, which he completed. At the last visit, he was prescribed doxycycline 100 mg BID for 7 days, which he tolerated well. He reported reduced warmth of the foot and no fever or other signs of infection. The wound was healing as expected, with minimal drainage. He had an appointment with the wound physician on 12/3/24 and would continue doxycycline for three more weeks. The wound note, dated 12/5/24 at 12:53 p.m., indicated the resident's surgical incision had an open area. The wound was red with sanguineous drainage present. The wound measured 2.7 cm in length and 1.5 cm in width. The nurse's note, dated 12/12/24 at 2:00 p.m., indicated the nurse completed the treatment of the resident's right foot and observed a bone could be felt in the back end of the wound. The wound care physician was notified. The CAR note, dated 12/13/14 at 12:05 p.m., indicated the pinky toe removal measured 8 cm in length by 4 cm in width, and the top of the foot measurements were 2.5 cm in length by 2 cm in width. The surgical wound to the top of the right foot remained stable and the surgical wound to the pinky toe removal was red with beefy granulation tissue. Preventive measures were preservision, Neuriva, followed by the wound care nurse and RD, air mattress on bed and pain medication. The wound note, dated 1/30/25 at 5:36 p.m., indicated the surgical incision had an open area. The open area was red and had separated from the original incision and healing separately. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurements included 1.6 cm in length and 1.6 cm in width. The wound note, dated 2/23/25 at 2:27 p.m., indicated the resident's incision with the open area was normal in color with sanguineous drainage. The measurements included 3 cm in length and 2 cm in width. The wound note, dated 3/27/25, indicated the resident had a surgical incision. The resident had a wound to the top of his right foot distal to the ankle. The nurse's note, dated 4/9/25 at 7:23 p.m., indicated the resident was observed to have increased redness during the dressing change. The redness ran from the top of the ankle to the top of the toes. The physician was notified, and a wound culture was ordered. If the resident's condition worsened at midnight the change contact the physician again with pictures of the area. The nurse's note, dated 4/10/25 at 12:14 p.m., indicated the treatment was completed to the wounds on the resident's right foot. The right foot was red in color and warm to touch. The wound bed was pale pink. The peri-wound was macerated with darkening of the tissue. The Physician Assistant (PA) was notified, and antibiotics were started. The nurse's note, dated 4/10/25 at 9:19 p.m., indicated the resident was observed with increased confusion, making unrealistic comments, and difficulty finding the proper words. The resident was aware he was confused and concerned about an infection to his foot. The resident was sent to the hospital. The nurse's note, dated 4/17/25 at 7:58 p.m., indicated the resident returned to the hospital. The right foot wound measured 5 cm in length by 3 cm in width. The resident was in contact isolation related to Methicillin Resistant Staphylococcus Aureus (MRSA). The PA notes, dated 4/24/25, indicated the resident was hospitalized for osteomyelitis which developed from a diabetic foot ulcer. A bone scan confirmed the osteomyelitis. The cultures indicated MRSA and started on antibiotics. He would follow up with surgery after completing the antibiotic course. It is unclear if debridement was performed during the hospitalization. The wound note, dated 4/25/25 at 2:26 p.m., indicated the resident's surgical wound edges were well approximated. Two surgical wounds had emerged. The surgical wound measured 3.5 cm in length by 2 cm in width. The nurse's note, dated 5/7/25 at 11:49 a.m., indicated the resident returned from the wound physician from wound debridement. The wound note, dated 5/29/25 at 2:32 p.m., indicated the resident's surgical incision was normal in color with serous drainage. The measurements included 3.5 cm in length by 2.4 cm in width. The wound note, dated 6/12/25 at 10:09 a.m., indicated the resident's surgical incision with the open area was red with purulent drainage. The tissue was 100 percent red non-granulating tissue. The peri wound was reddened, and a scant amount of green drainage was observed. The nurse's notes, dated 6/19/25 at 2:57 p.m., indicated the resident was admitted to the hospital for Xenograft procedure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PA notes, dated 6/20/25 at 8:35 a.m., indicated the resident underwent an outpatient procedure at the hospital to obtain a skin graft for the foot, but was informed that the graft was not effective and would result in further amputation. The wound note, dated 7/17/25 at 12:09 p.m., indicated the resident's foot had an open area. The resident's skin was normal in color with sanguineous drainage. The tissue was 100 percent granulating tissue with patches of dark thickened tissue. The wound measured 2 cm in length by 1.5 cm in width. During an interview, on 9/5/25 at 11:00 a.m., the [NAME] Director of Clinical Operations indicated the resident's wound documentation was not accurate and consistent. The wound should be determined what type of wound it was and be consistent with those diagnoses. If a wound was debrided it was still a pressure or vascular wound not a surgical wound. She indicated she documented a prevention and treatment plan for the resident's wounds on 9/10/24 and staff did not follow the plan. The clinical record lacked documentation indicating the residents wounds were stage appropriate and implementation of the recommended treatments as documented. The Comprehensive Care Plan Guideline policy, revised 5/22/18, included, but was not limited to, . Procedure 1. c. Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan. 3. The comprehensive care plan should be reviewed no less than quarterly and revised to reflect changes in the resident's condition as they occur . Cross Reference F657 and F741. 3.1-37(a)