

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Elkader Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 116 Reimer Street SW Elkader, IA 52043	

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 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>25854</p> <p>Based on observations, clinical record review, Nurse Practitioner/Physician/Providers interviews, resident and staff interviews, and facility policy review, the facility failed to provide proper assessments and interventions in a timely manner for 2 of 3 residents following a change of condition (Residents #3 & #2). The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>1. The facilities Pressure Ulcer Prevention Program policy (not dated) directed the facility staff should have a system in place that assured assessments were completed timely and appropriate; interventions implemented, monitored and revises as appropriate; and changes in condition recognized, evaluated, reported to the resident's attending practitioner and other healthcare professionals, ie.wound nurse and etc as appropriate. The Procedure included the following:</p> <p>a. Assess, reassess and document the ulcer's characteristics weekly.</p> <p>1. Date.</p> <p>2. Location of ulcer and staging.</p> <p>3. Size.</p> <p>4. Depth</p> <p>5. Presence, location and extent of undermining or tunneling/sinus tract.</p> <p>6. Exudate (drainage)</p> <p>a. Type: purulent/serous</p> <p>b. Color.</p> <p>c. Odor</p> <p>d. Amount</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. Pain</p> <p>f. Wound bed.</p> <p>1. Color and type of tissue/character, including evidence of healing (granulation tissue) or necrosis (slough or eschar).</p> <p>g. Description of wound edges and surrounding tissue:</p> <p>1. Rolled edges.</p> <p>2. Redness.</p> <p>3. Hardness/induration (thickening or hardening of the skin).</p> <p>4. Maceration (excessive moisture or fluid accumulation in the skin, leading to softening, swelling and skin integrity breakdown).</p> <p>5. Description of the healing of the pressure ulcer.</p> <p>b. Observation for infection.</p> <p>1. Purulent exudate (drainage).</p> <p>2. Peri-wound warmth.</p> <p>3. Swelling.</p> <p>4. Induration.</p> <p>5. Erythema (redness of the skin).</p> <p>6. Increasing pain or tenderness around the site.</p> <p>7. Delayed wound healing.</p> <p>A Minimum Data Set (MDS) assessment form dated 10.10.24 indicated Resident #3 had diagnoses that included Radiculopathy of the Lumbar region, Cardiomyopathy, urine retention, Heart Failure (HF), Renal Insufficiency, and Diabetes Mellitus (DM). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact), required substantial to maximum assistance with most activities of daily living (ADL's), as frequently incontinent of urine, at risk for pressure ulcers, with one (1) stage II pressure ulcer on admission and not on a turning and repositioning program.</p> <p>(continued on next page)</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>The resident's Initial Care Plan reportedly located in the resident's paper chart initiated 10.4.24 indicated the resident as admitted to the facility on 10.4.24 with a stage II pressure area to her left buttock with a current order for a specified dressing and discontinued 10.17.24 due to the completion of the Comprehensive Care Plan. The Initial Care Plan failed to address a turning or repositioning program but rather indicated the resident as independent.</p> <p>A Functional Abilities form dated 10.10.24 at 2:23 p.m. indicated the resident required substantial to maximum assistance of staff with toileting hygiene, personal hygiene, transfers, and ambulation.</p> <p>A Wound/Skin Healing Record form indicated the resident had a pressure ulcer on her left buttock with the onset dated 10.4.24. The assessments included the following:</p> <p>a. 10.4.24 (no time documented) - A stage II pressure ulcer that measured 0.7 centimeters (cm) by (x) 0.3 cm and less than 0.1 cm deep with purple and non-blanchable surrounding skin that measured 1.5 cm x 1.5 cm. The staff failed to assess the resident's ulcerated areas exudate, odor, exudate amount, wound bed, surrounding skin color and surrounding tissue/wound edges. Staff indicated the resident's Care Plan as updated.</p> <p>During an interview 10.18.24 at 12:29 p.m. Staff A, Registered Nurse (RN) confirmed she should have completed a more thorough assessment of the resident's decubitus ulcer on 10.4.24 and that she should have reported to the resident's Primary Physician the increase in size and slight odor of the decubitus following her 10.10.24 assessment. The staff member indicated when the resident initially arrived with the decubitus ulcer and purple surrounding skin she felt like the area had been waiting to open up.</p> <p>2. An MDS assessment form dated 8.6.24 indicated Resident #2 had diagnoses that included Seizure/Epilepsy disorder, Borderline Personality disorder, Mild Intellectual disabilities, Anxiety, Depression, Respiratory Failure with Hypercapnia, and morbid obesity. The assessment indicated the resident had a BIMS score of 15 (cognitively intact) and required staff assistance with ADL's.</p> <p>A Care Plan included the following Focus areas and Interventions/Tasks as dated:</p> <p>a. The resident required 24 hour care related to (r/t) a Seizure disorder. (initiated and revised 2.26.21)</p> <p>b. The resident had altered respiratory status r/t sleep apnea and hypoxia. (revised 1.5.23)</p> <p>1. Monitor for and symptoms of respiratory distress and report to the Physician as needed (PRN) the following:</p> <p>a. Decreased pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, Empty (cough up blood from lungs), cough, Pleuritic pain (sharp chest pain that worsens with a cough or movement), accessory muscle usage, skin color changes, anxiety, shortness of breath (SOB) at rest. (initiated 3.12.21)</p> <p>(continued on next page)</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>2. Monitor/document/report abnormal breathing patterns to the Physician: increased or decreased rate, periods of Apnea (no breathing), prolonged inhalation or exhalation, shallow breathing, prolonged deep breathing, usage of accessory muscles, pursed lip breathing and nasal flaring. (initiated 3.12.21)</p> <p>c. Non-invasive ventilator as ordered. (initiated 3.22.24)</p> <p>Progress Note entries included the following as dated:</p> <p>a. 10.11.24 at 12:56 p.m. - The resident stated she felt unwell. Runny nose, sore throat, and felt more tired. Lung sounds clear in all quadrants. Covid negative. A NP had been notified and directed the staff to have monitored the resident for worsening symptoms. Vital signs (VS) consisted of a Temperature (T) of 98.0 degrees Fahrenheit, Blood Pressure (B/P) 118/72, Pulse (P) 76, Respirations (R) 15 and an Oxygen Saturation (O2) at 88%.</p> <p>b. 10.12. 24 at 1:11 a.m. - A full assessment completed with no complaints of having felt poorly.</p> <p>c. 10.12.24 at 2:01 p.m. - T 98.0 and O2 saturation of 88-90% at various times however the facility staff failed to complete a thorough assessment.</p> <p>d. 10.12.24 at 8:57 p.m. - T 97.8 with no further assessment completed.</p> <p>e. 10.13.24 at 8:17 a.m. - Called to resident's room by a certified nursing assistant (CNA). Resident appeared to lethargic and not her mental status baseline. Resident unable to answer questions other than grunts. Resident lips cyanotic. Vitals obtained. Inability to raise her O2 saturation level above 84% post interventions. Bilateral lung sounds with crackles in all lobes. Sent to the local emergency room (ER).</p> <p>A State of Iowa Certificate of Death indicated the resident passed away 10.16.24 at 7:54 p.m. from Acute on Chronic Hypoxemic and Hypercapnic Respirator Failure due to (D/T) or as a consequence of Viral Pneumonia.</p> <p>During an interview 10.22.24 at 2:33 p.m., the resident's NP (Nurse Practitioner) confirmed she would have expected the facility staff to have completed a more thorough assessment and intervention for the resident until stable per standard of practice of 48-72 hours however the outcome probably would not have been different d/t the resident's co-morbidities.</p> <p>During an interview 10.22.24 at 1:06 p.m. Staff A, Licensed Practical Nurse (LPN) indicated per nursing judgment staff should have assessed a full set of vitals, lung sounds and any issue that affected the resident's symptoms.</p> <p>During an interview 10.22.24 at 1:24 p.m., Staff B, Registered Nurse (RN) indicated she had not been sure a B/P would have made a difference however hindsight is 20/20 and she should have assessed the resident's B/P.</p> <p>During an interview 10.22.24 at 3:30 p.m., Staff C, RN confirmed she would have assessed the resident from head to toe, which included the resident's lung sounds and edema per nursing judgement.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>25854</p> <p>Based on observations, clinical record review, Nurse Practitioner/Providers interview, resident and staff interviews, and facility policy and procedure review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers from developing or worsening on residents with a history of pressure ulcers for one of three residents reviewed (Resident #3). The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:</p> <p>Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</p> <p>Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.</p> <p>Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>Other staging considerations include:</p> <p>Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.</p> <p>These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>The facilities Pressure Ulcer Prevention Program policy (not dated) directed the facility staff should have a system in place that assured assessments were completed timely and appropriate; interventions implemented, monitored and revises as appropriate; and changes in condition recognized, evaluated, reported to the resident's attending practitioner and other healthcare professionals, ie.wound nurse and etc as appropriate. The Procedure included the following;</p> <ul style="list-style-type: none"> a. Assess, reassess and document the ulcer's characteristics weekly. <ul style="list-style-type: none"> 1. Date. 2. Location of ulcer and staging. 3. Size. 4. Depth 5. Presence, location and extent of undermining or tunneling/sinus tract. 6. Exudate (drainage) <ul style="list-style-type: none"> a. Type: purulent/serous b. Color. c. Odor d. Amount e. Pain f. Wound bed. <ul style="list-style-type: none"> 1. Color and type of tissue/character, including evidence of healing (granulation tissue) or necrosis (slough or eschar). g. Description of wound edges and surrounding tissue: <ul style="list-style-type: none"> 1. Rolled edges. <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. Redness.</p> <p>3. Hardness/induration (thickening or hardening of the skin).</p> <p>4. Maceration (excessive moisture or fluid accumulation in the skin, leading to softening, swelling, and skin integrity breakdown).</p> <p>5. Description of the healing of the pressure ulcer.</p> <p>b. Observation for infection.</p> <p>1. Purulent exudate (drainage).</p> <p>2. Peri-wound warmth.</p> <p>3. Swelling.</p> <p>4. Induration.</p> <p>5. Erythema (redness of the skin).</p> <p>6. Increasing pain or tenderness around the site.</p> <p>7. Delayed wound healing.</p> <p>A Minimum Data Set (MDS) assessment form dated 10.10.24 indicated Resident #3 had diagnoses that included Radiculopathy of the Lumbar region, Cardiomyopathy, urine retention, Heart Failure (HF), Renal Insufficiency, and Diabetes Mellitus (DM). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact), required substantial to maximum assistance with most activities of daily living (ADL's), as frequently incontinent of urine, at risk for pressure ulcers, with one (1) stage II pressure ulcer on admission and not on a turning and repositioning program.</p> <p>The resident's Initial Care Plan located in Point Click Care (PCC) initiated 10.8.24 failed to address her skin breakdown/pressure ulcers but directed the facility staff to have assisted the resident with morning and evening cares.</p> <p>The residents Initial Care Plan reported to have been located in the resident's paper chart initiated 10.4.24 indicated the resident as admitted to the facility on 10.4.24 with a stage II pressure area to her left buttock with a current order for a specified dressing and discontinued 10.17.24 due to the completion of the Comprehensive Care Plan. The Initial Care Plan failed to address a turning or repositioning program but rather indicated the resident as independent.</p> <p>A Function Abilities form dated 10.10.24 at 2:23 p.m. indicated the resident required substantial to maximum assistance of staff with toileting hygiene, personal hygiene, transfers, and ambulation.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Wound/Skin Healing Record form indicated the resident had a pressure ulcer on her left buttock with the onset dated 10.4.24. The assessments included the following:</p> <p>a. 10.4.24 (no time documented) - A stage II pressure ulcer that measured 0.7 centimeters (cm) by (x) 0.3 cm and less than 0.1 cm deep with purple and non-blanchable surrounding skin that measured 1.5 cm x 1.5 cm. The staff failed to assess the resident's ulcerated areas exudate, odor, exudate amount, wound bed, surrounding skin color and surrounding tissue/wound edges. Staff indicated the resident's Care Plan as updated.</p> <p>b. 10.10.24 (not time documented): - A stage II pressure ulcer that measured 8.0 cm x 2.0 cm and 0.01 cm deep with no exudate, slight odor, wound bed with epithelial tissue, slough and purple, normal surrounding skin color and tissue and wound edges, no tunneling or pain. The wound deteriorated in status.</p> <p>During an interview 10.18.24 at 12:29 p.m. Staff A, Registered Nurse (RN) confirmed she should have completed a more thorough assessment of the resident's decubitus ulcer on 10.4.24 and that she should have reported to the resident's Primary Physician the increase in size and slight odor of the decubitus following her 10.10.24 assessment. The staff member indicated when the resident arrived with the decubitus ulcer and purple surrounding skin she felt like the area had been waiting to open up.</p> <p>A Physician Progress Note form dated 10.15.24 at 11:48 p.m. indicated the resident's Assessment and Plan included the following in relation to the decubitus ulcer:</p> <p>a. At that time with the resident's Neutropenia (low white cells which hindered the ability to fight infections), the decubitus ulcer located at a high risk area for infection and lethargy had been treated with antibiotics due to the high probability of infection.</p> <p>During an interview 10.18.24 at 12:42 p.m. the Nurse Practitioner (NP) indicated her concern incurred when the resident came to them from home and originally left the hospital with barely an ulcer and when they saw her back in such a short period of time the status of the decubitus appeared shocking. The NP indicated the report she received from the facility addressed the ulcerated area as a sore on her bottom but the area appeared certainly more than a sore. The NP indicated the area could have been prevented and/or minimized however the resident ended up septic with the decubitus the likely source and/or the contributing factor to her death.</p> <p>During an interview 10.18.24 at 11:31 a.m. the resident's primary Physician indicated she had no knowledge of the increase in size of the decubitus ulcer during her visit on 10.10.24 as the facility had faxed the status to her office after she had left for the day so she never assessed the area during that visit. The Physician also addressed the following issues during this interview:</p> <p>a. The resident presented with risk factors for a decubitus such as chronic kidney disease, HF, and DM.</p> <p>b. Not sure if the decubitus could have been prevented without having observed the area but she felt the decubitus progressed substantially in a short period of time.</p> <p>c. She had been aware when the resident presented in the emergency roaignom on 10.15.24 the staff informed her the area had been odorous which added to the significance of infection.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>During an interview 10.18.24 at 12:16 p.m. the primary Physician indicated she felt there had been something the facility could have done to minimize the fast progression of the ulcerated area and that there should had been better communication with her as the primary Physician. The Physician reiterated the ulcerated area worsened faster than it should have at the time. The Physician indicated the resident passed away at 11:36 a.m. that morning from concerns with sepsis from the ulcerated area and worsening renal failure.</p> <p>A Clinically Unavoidable Pressure Ulcer form signed by a Physician 10.18.24 addressed the pressure ulcer as unavoidable.</p> <p>During an interview 10.18.24 at 1:44 p.m. the resident's Primary Physician (same as above) confirmed she signed the Unavoidable Pressure Ulcer form that morning but thought the form had been a checklist of symptoms that could have caused the decubitus ulcer but her intent had not been meant for the form to have been conclusive. Again, the Physician reiterated if the staff would have communicated to her better related to the decubitus ulcer it could have been avoided and/or minimized. The Physician confirmed when she rounded and assessed the resident on 10.10.24 facility staff accompanied her but failed to communicate the worsening decubitus ulcer at that time and she would have expected a full report on the resident's current condition and worsening decubitus.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>25854</p> <p>Based on observations, clinical record review, Nurse Practitioner/Providers interviews, resident and staff interviews and facility policy review, the facility staff failed to follow their own policy and procedures as a means to prevent and or minimize pressure ulcers from developing on residents with history of pressure ulcers for one of three residents reviewed (Resident #3). The facility reported a census of 28 residents.</p> <p>Findings include:</p> <p>The facilities Pressure Ulcer Prevention Program policy (not dated) directed the facility staff the facility should of had a system in place that assured assessments were completed timely and appropriate; interventions implemented, monitored and revises as appropriate; and changes in condition recognized, evaluated, reported to the resident's attending practitioner and other healthcare professionals, ie.wound nurse and etc as appropriate. The Procedure included the following;</p> <ul style="list-style-type: none"> a. Assess, reassess and document the ulcer's characteristics weekly. <ul style="list-style-type: none"> 1. Date. 2. Location of ulcer and staging. 3. Size. 4. Depth 5. Presence, location and extent of undermining or tunneling/sinus tract. 6. Exudate (drainage) <ul style="list-style-type: none"> a. Type: purulent/serous b. Color. c. Odor d. Amount e. Pain f. Wound bed. <p>1. Color and type of tissue/character, including evidence of healing (granulation tissue) or necrosis</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(slough or eschar).</p> <p>g. Description of wound edges and surrounding tissue:</p> <ol style="list-style-type: none"> 1. Rolled edges. 2. Redness. 3. Hardness/induration (thickening or hardening of the skin). 4. Maceration (excessive moisture or fluid accumulation in the skin, leading to softening, swelling and skin integrity breakdown). 5. Description of the healing of the pressure ulcer. <p>b. Observation for infection.</p> <ol style="list-style-type: none"> 1. Purulent exudate (drainage). 2. Peri-wound warmth. 3. Swelling. 4. Induration. 5. Erythema (redness of the skin). 6. Increasing pain or tenderness around the site. 7. Delayed wound healing. <p>A Minimum Data Set (MDS) assessment form dated 10.10.24 indicated Resident #3 had diagnoses that included Radiculopathy of the Lumbar region, Cardiomyopathy, urine retention, Heart Failure (HF), Renal Insufficiency, and Diabetes Mellitus (DM). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact), required substantial to maximum assistance with most activities of daily living (ADL's), as frequently incontinent of urine, at risk for pressure ulcers, with one (1) stage II pressure ulcer on admission and not on a turning and repositioning program.</p> <p>The resident's Initial Care Plan located in Point Click Care (PCC) initiated 10.8.24 failed to address her skin breakdown/pressure ulcers but directed the facility staff to have assisted the resident with morning and evening cares.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Elkader Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 116 Reimer Street SW Elkader, IA 52043	
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's Initial Care Plan reported to have been located in the resident's paper chart by the Administrator and initiated 10.4.24 indicated the resident as admitted to the facility on 10.4.24 with a stage II pressure area to her left buttock with a current order for a specified dressing and discontinued 10.17.24 due to the completion of the Comprehensive Care Plan. The Initial Care Plan failed to address a turning or repositioning program but rather indicated the resident as independent.</p> <p>A Function Abilities form dated 10.10.24 at 2:23 p.m. indicated the resident required substantial to maximum assistance of staff with toileting hygiene, personal hygiene, transfers and ambulation.</p> <p>A Wound/Skin Healing Record form indicated the resident had a pressure ulcer on her left buttock with the onset dated 10.4.24. The assessments included the following:</p> <p>a. 10.4.24 (no time documented) - A stage II pressure ulcer that measured 0.7 centimeters (cm) by (x) 0.3 cm and less than 0.1 cm deep with purple and non-blanchable surrounding skin that measured 1.5 cm x 1.5 cm. The staff failed to assess the resident's ulcerated area's exudate, odor, exudate amount, wound bed, surrounding skin color and surrounding tissue/wound edges.</p> <p>During an interview 10.18.24 at 12:29 p.m. Staff A, Registered Nurse (RN) confirmed she should have completed a more thorough assessment of the resident's decubitus ulcer on 10.4.24 and that she should have reported to the resident's Primary Physician the increase in size and slight odor of the decubitus following her 10.10.24 assessment. The staff member indicated when the resident arrived with the decubitus ulcer and purple surrounding skin she felt like the area had been waiting to open up.</p> <p>During an interview 10.18.24 at 12:16 p.m. the primary Physician indicated she felt there had been something the facility could have done to minimize the fast progression of the ulcerated area and that there should have been better communication with her as the primary Physician. The Physician reiterated the ulcerated area worsened faster than it should have at the time. The Physician indicated the resident passed away at 11:36 a.m. that morning from concerns with sepsis from the ulcerated area and worsening renal failure.</p>		