

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Heritage Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 Bailey Avenue Haynesville, LA 71038	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>40015</p> <p>Based on record review and interviews, the facility failed to ensure an alleged injury of unknown origin was reported to the State Survey Agency for 1 (#37) out of 4 (#7, #26, #32, #37) sampled residents investigated for accidents.</p> <p>Findings:</p> <p>Review of the facility's SIMS (Statewide Incident Management System) Investigation and Reporting Policy Statement policy with the latest revision date of 01/15/2025 revealed, in part:</p> <p>All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source, falls with fractures related to unknown origin, and elopement shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Finding of abuse investigations will also be reported.</p> <p>1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source, falls with fracture related to unknown origin or elopement is reported, the Administrator begin the investigation immediately in compliance with federal and state guidelines.</p> <p>5. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.</p> <p>Role of the Administrator and/or DON (Director of Nursing):</p> <p>Reporting:</p> <p>1. All alleged violations involving abuse, neglect including injuries of an unknown source (falls with fractures with unknown origin) .will be reported by the facility Administrator, or his/her designee, to the following persons or agencies if deemed necessary:</p> <p>a. The State licensing/certification agency responsible for surveying/licensing the facility;</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. An alleged violation of abuse, neglect . or unknown injury with suspected abuse will be reported immediately, but not later than:</p> <p>a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or</p> <p>b. Twenty-four (24) hours if the alleged violation does not involve abuse (falls with injury unknown origin; elopement) AND has not resulted in serious bodily injury.</p> <p>Review of Resident #37's medical record revealed an initial admitted [DATE] with the following diagnoses which included, but not limited to: Parkinsonism, urinary tract infection, bradycardia, hypertension and an acute cough.</p> <p>Review of Resident #37's progress note dated 12/08/2024 at 5:39 a.m. revealed in part, did not sleep through the night if he slept at all. Constantly moving and attempting to get out of bed causing the bed alarm to sound. Was restless, needs possible sleep aid. Confusion is noted.</p> <p>Review of Resident #37's progress note dated 12/08/2024 at 7:45 p.m. revealed in part, found on floor beside bed lying on his back; head injury noted; sent to the emergency room for evaluation; see incident report.</p> <p>Review of Resident #37's progress note dated 12/08/2024 at 10:42 p.m. revealed in part, received a call from the hospital. Resident #37 would be transferred to another hospital with a positive CT (Computed Tomography) scan of the head showing a brain bleed related to the fall.</p> <p>Review of the facility's Incident/Accident Log revealed a report for Resident #37 dated 12/08/2024 at 7:45 p. m. Further review revealed the following statement in part, the writer was on the hall giving meds and went in Resident #37's room to check on him. Resident #37 was noted to be lying on his back on the floor behind the bed. Head injury noted x2 and bleeding from laceration to left eyebrow and laceration to middle of forehead with swelling present. Resident #37 was sent to hospital for evaluation for the head injury. Resident #37 was taken to the hospital via ambulance on 12/08/2024 at 8:05 p.m.</p> <p>During an interview on 03/26/2025 at 9:50 a.m. S2 DON reviewed Resident #37's medical record and incident report, and acknowledged Resident #37 had an unwitnessed fall on 12/08/2024 which resulted in an injury of unknown origin. S2 DON confirmed the hospital notified the facility of Resident #37's CT results which revealed a brain bleed as a result of the incident. S2 DON acknowledged the incident should have been reported to the state survey agency and was not.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665</p> <p>Based on record review and interview the facility failed to ensure a baseline care plan was developed for 1 (#34) of 20 sampled residents. The facility failed to ensure a baseline care plan was developed for Resident #34 within 48 hours of admission to the facility.</p> <p>Findings:</p> <p>Review of Resident #34's medical record revealed an admitted [DATE] with a diagnosis of but not limited to acute combined systolic (congestive) and diastolic (congestive) heart failure, anemia, and essential hypertension.</p> <p>Review of Resident #34's medical record failed to reveal a baseline care plan had been developed for Resident #34.</p> <p>During an interview on 03/26/2025 at 11:00 a.m. S2 DON (Director of Nurses) confirmed a baseline care plan should have been developed within 48 hours of Resident #34's admission to the facility and had not been.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40015</p> <p>Based on record review and interviews the facility failed to implement a comprehensive person-centered care plan for 1 (#26) of 4 (#1, #12, #26, #87) residents reviewed for nutrition. The facility failed to ensure Resident #26 was weighed weekly as per the physician order and in accordance with Resident #26's plan of care.</p> <p>Findings:</p> <p>Review of Resident #26's medical record revealed and admitted [DATE] with diagnoses including, in part, type 2 diabetes mellitus with diabetic neuropathy unspecified, dysphagia oropharyngeal phase, unspecified protein-calorie malnutrition, depression, and essential (primary) hypertension.</p> <p>Review of 02/26/2025 Quarterly MDS (Minimum Data Set) revealed Resident #26 had a BIMS (Brief Interview Mental Status) score of 5 out of 15, which indicated severe cognitive impairment.</p> <p>Review of Resident #26's physician orders revealed an order dated 02/18/2025 for Weekly weights X4 weeks - one time a day every Tue for 4 weeks. (Start date of 02/25/2025)</p> <p>Review of Resident #26's care plan revealed the resident had a nutritional problem related to swallowing difficulty with interventions that included, in part, weigh weekly.</p> <p>Review of Resident #26's weights revealed a weight of 126.0 pounds on 11/22/2024 and a weight of 112 pounds on 02/18/2025 which indicated a weight loss of 11.11% between 11/22/2024 and 02/18/2025.</p> <p>Review of Resident #26's medical record failed to reveal weights were conducted weekly as per 02/18/2025 physician order and the care plan.</p> <p>During an interview on 03/26/2024 at 4:45 p.m. S10 MDS Nurse reported Resident #26 had weight loss and residents with weight loss were to have weights conducted every week.</p> <p>During an interview on 03/26/2025 at 5:05 p.m. S10 MDS Nurse and S2 DON (Director of Nursing) reported Resident #26's weekly weight order was to start 02/25/2025 and the weekly weights had not been obtained as ordered.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>37867</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure 2 (#4, #12) of 20 sampled residents (#2, #37, #32, #34, #87, #6, #10, #27, #1, #19, #8, #20, #26, #4, #7, #36, #33, #25, #35, #12) received treatment and care in accordance with professional standards of practice by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident #4 was administered Lasix (a diuretic medication) as ordered by the physician 2. Resident #12 was care planned for diabetes and had not been evaluated by a registered dietician. <p>Findings:</p> <p>Resident #4</p> <p>Review of Resident #4's record revealed an admitted [DATE] and diagnoses including end stage heart failure.</p> <p>Review of Resident #4's current Physician orders revealed orders included:</p> <p>-an order dated 02/12/2025-Monitor for Edema every shift. Chart Severity. Chart 0= No edema noted; 1= +1 Edema; 2= 2+ Edema, 3= 3+ Edema, 4= 4+ Edema noted, and;</p> <p>-an order dated 11/18/2024-Furosemide Oral Tablet 20 mg (milligrams) Give 1 tablet by mouth every 24 hours as needed for 2+ edema related to end stage heart failure-every day when 2+ edema is present.</p> <p>Review of Resident #4's March 2025 MAR (Medication Administration Record) revealed edema checks with 2+ edema was documented on 03/03/2025, 03/17/2025, 03/18/2025, 03/19/2025, and 03/20/2025. Further review revealed no furosemide was administered as ordered on the days Resident #4 had 2+ edema.</p> <p>During an interview on 03/26/2025 at 2:37 p.m. S2 DON (Director of Nursing) reviewed Resident #4's orders and March 2025 MAR and confirmed the resident should have received furosemide on days she had 2+ edema and did not.</p> <p>Resident #12</p> <p>Review of Resident #12's record revealed an admitted [DATE] with diagnoses which included type 1 diabetes mellitus.</p> <p>Review of Resident #12's Physician orders dated 01/03/2025 revealed a NAS (no added salt) and NCS (no concentrated sweets) diet, regular texture.</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 - Some</p>	<p>Review of Resident #12's Baseline Care Plan dated 01/03/2025 revealed the following, in part, the resident has a potential nutritional problem related to diet restrictions, provide diet as ordered, Registered Dietician to evaluate and make diet change recommendations as needed. Further review revealed the resident had a potential for pressure ulcer development.</p> <p>Review of Resident #12's record failed to reveal an evaluation from the Registered Dietician and a care plan for diabetes.</p> <p>An observation on 03/24/2025 at 12:05 p.m. revealed Resident #12 was served a regular diet which included, riblet bites, macaroni and cheese, fried okra, roll, Oreo dessert and a banana.</p> <p>During an interview on 03/26/2025 at 5:35 p.m. S2 DON reported she was not aware the dietician needed to be notified for Resident #12 upon admission.</p> <p>During an interview on 03/26/2025 at 7:23 p.m. S2 DON reviewed Resident #12's medical record and confirmed there was not a care plan for diabetes and should have been.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30115</p> <p>37867</p> <p>40015</p> <p>Based on record review and interviews, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent the development of new pressure ulcers for 3 (#4, #8, and #19) of 3 (#4, #8, and #19) residents investigated for pressure ulcers by failing to:</p> <ol style="list-style-type: none"> 1. perform weekly wound assessments for pressure ulcers for Resident # 4, #8, and #19 and; 2. conduct weekly skin assessments for Resident # 8 3. develop a care plan for pressure ulcers for Resident #4, #19 <p>Findings:</p> <p>Review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol (undated) revealed in part:</p> <p>The nurse shall describe and document/report the following:</p> <ol style="list-style-type: none"> a. Full assessment of pressure sore including location, stage, length, and width and depth, presence of exudates or necrotic tissue; b. Pressure sores are to be measured weekly along with its condition <p>Review of the facility's Pressure Ulcer and Skin Injury Risk Assessment Policy revealed in part:</p> <p>The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries.</p> <p>General Guidelines: 7. Perform weekly skin audits on residents who are at high risk for skin/pressure injuries.</p> <p>Resident #4</p> <p>Review of Resident #4's record revealed an admitted [DATE] and diagnoses including: pressure ulcers to the left heel, right heel, and sacral region.</p> <p>Review of Resident #4's admit MDS (Minimum Data Set) assessments with ARD (Assessment Reference Date) of 11/07/2024 revealed in part:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device=No</p> <p>-Is this resident at risk of developing pressure ulcers/injuries? = No</p> <p>-Does this resident have one or more unhealed pressure ulcers/injuries? = No</p> <p>Review of Resident #4's MDS assessments with ARD of 01/29/2025 revealed in part:</p> <p>Does this resident have one or more unhealed pressure ulcers/injuries? = Yes</p> <p>Number of Stage 2 pressure ulcers = 1</p> <p>Number of Stage 3 pressure ulcers =1</p> <p>Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar = 1</p> <p>Review of Resident #4's weekly Skin Only Evaluations revealed no evaluations/assessments were completed between 02/20/2025 and 03/15/2025.</p> <p>Review of Resident #4's comprehensive care plan revealed no problems, goals, or interventions related to the treatment or prevention of pressure ulcers had been developed.</p> <p>During an interview on 03/26/2025 at 2:14 p.m. S3 ADON/Wound Care Nurse confirmed there were no assessments of Resident #4's pressure ulcers between 02/20/2025 to 03/15/2025, and further reported she had been off work during that time.</p> <p>During an interview on 03/26/2025 at 2:20 p.m. S2 DON reviewed Resident #4's comprehensive care plan and agreed there were no problems, goals, or interventions developed for Resident #4's pressure ulcers and there should be.</p> <p>Resident #8</p> <p>Review of Resident #8's record revealed a readmitted [DATE] and diagnoses including: difficulty in walking, pressure ulcer of right heel, atherosclerosis of native arteries of extremities with intermittent claudication, right leg.</p> <p>Review of Resident #8's Quarterly MDS dated [DATE] revealed in part: Resident did not have any unhealed pressure ulcers.</p> <p>Review of Resident #8's Quarterly MDS dated [DATE] revealed in part: Resident had one unstageable pressure ulcer.</p> <p>During an interview on 03/26/2025 at 6:22 p.m. S10 MDS (Minimum Data Sets) Nurse reported Resident #8's pressure ulcer to the right heel was first identified on 12/30/2024.</p> <p>During an interview on 03/26/2025 at 1:49 p.m. S2 DON reported Resident #8 did not have weekly skin audits from 12/03/2024 to 12/30/2024 and should have.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/26/2025 at 1:57 p.m. S3 ADON/Wound Care Nurse reported she was off from 12/07/2024 to 12/15/2024, and S2 DON was responsible for completing the Skin Assessments while she was off work. S3 ADON/Wound Care Nurse further reported weekly wound assessments were not completed for Resident #8 on 01/06/2025 and 01/20/2025 and should have been.</p> <p>Resident #19</p> <p>Review of Resident #19's medical record revealed an admitted [DATE] with diagnoses that included: multiple sclerosis, pressure ulcer of unspecified site unstageable, pressure ulcers of other site Stage 3.</p> <p>Review of 01/08/2025 Quarterly MDS revealed Resident #19 had two stage 3 pressure ulcers/injury and one unstageable pressure ulcer/injury.</p> <p>Further review of Resident #19's record revealed weekly wound assessments had not been conducted between 02/17/2025 and 03/13/2025.</p> <p>Review of Resident #19's comprehensive care plan revealed no problems, goals, or interventions related to the treatment or prevention of pressure ulcers had been developed.</p> <p>During an interview on 03/26/2025 at 11:30 a.m. S3 ADON/Wound Care Nurse reviewed Resident #19's record and confirmed between 02/17/2025 and 03/13/2025 weekly wound assessments had not been conducted and should have been.</p> <p>During an interview on 03/26/2025 at 12:36 p.m. S2 DON reviewed Resident #19's record and confirmed weekly wound assessments had not been conducted between 02/17/2025 and 03/13/2025 and should have been.</p> <p>During an interview on 03/26/2025 at 1:10 p.m. S10 MDS Coordinator reviewed Resident #19's care plan and confirmed care plan interventions did not include Resident #19's pressure ulcers, wound treatments, and other interventions to promote wound healing and keep Resident #19 from acquiring new pressure ulcers.</p> <p>During an interview on 03/26/2025 at 1:38 p.m. S2 DON (Director of Nursing) reported all residents should get weekly skin audits from the time of admission. S2 DON further reported she was responsible for conducting weekly assessments of pressure ulcers during times when S3 ADON Wound Care Nurse was off work.</p>		