STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225387	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Court Nursing Care & Rehabilitation Center	389 Alden Road Fairhaven, MA 02719

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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure one Resident (#84), out of a total sample of 26 residents received the necessary care and treatment to promote wound healing. Specifically, the facility failed to ensure treatment orders were transcribed accurately and for the correct wound location per the Wound Physician's recommendations. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, #9324, dated as last revised April 11, 2018, indicated but was not limited to the following: -It is the responsibility of the licensed nurse to ensure that there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication -Licensed nurses accept, verify, transcribe, and implement orders. -Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. -The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurse's knowledge of that patient's care needs at that time. -It is the responsibility and the obligation of a nurse to question a patient care order that is deemed inappropriate by a nurse according to his/her educational preparation and clinical experience. In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Pressure Ulcer (injury) Prevention Program, dated 2/10/23, indicated but was not limited to the following: -Pressure ulcers (injuries) can occur whenever pressure has impaired circulation to tissue. -The facility shall have a system in place that assures assessments are timely and appropriate; interventions are implemented, monitored and revised as appropriate; and changes in condition are recognized, evaluated, reported to the resident's attending practitioner and other healthcare professionals. (continued on next page)

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility shall provide care, treatment and services to promote the prevention of pressure ulcer development, promote the healing of pressure ulcers that are present, and prevent development of additional pressure ulcers. -Nursing Staff shall follow practitioner's orders for treatment of the pressure ulcer, including cleansing and dressing. Review of the facility's contract for Wound Care Services, dated 10/16/15, indicated but was not limited to the following: -Facility responsibilities include providing a dedicated nurse to round with the clinician, informing the primary care provider of the recommendations within 24 hours, discussing recommendations/care plans with the clinician on the day of rounds, and to allow the clinician, once consulted, to provide services and procedures to such resident as determined to be medically necessary. Resident #84 was admitted to the facility in December 2024 with diagnoses which included severe protein malnutrition, type two diabetes mellitus, and history of skin cancer. Review of the Minimum Data Set (MDS) assessment, dated 3/20/25, indicated Resident #84 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she was cognitively intact. Additionally, he/she had two unhealed pressure ulcers and had wound care dressings applied. Review of the active Physician's Orders indicated but were not limited to the following: -Left, Distal First Toe (top of great toe): Cleanse with Normal Saline (NS), apply Calcium Alginate with Silver (absorbent antimicrobial dressing) and a dry protective dressing (DPD) every evening shift. -Right, Anterior Ankle (front of ankle): Cleanse with NS, apply Mupirocin (antibiotic ointment) cream followed by Xeroform (mesh petroleum gauze to maintain moist wound bed) and a foam dressing. -Right, Dorsal Foot (top of foot): Cleanse with NS, apply Bactroban (Mupirocin), Xeroform and DPD every evening shift. -Right, Distal, First Medial Toe (top inner side of great toe): Cleanse with NS, apply Mupirocin and Xeroform followed by a DPD every evening shift. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Assessments show that I have the following care area needs: Fragile skin, Unstageable Deep Tissue Injury (DTI) Right Dorsal Foot, Stage 3 pressure (full thickness wound extending to subcutaneous tissue) Left Distal First Toe (resolved), and Stage 4 (full thickness wound with exposed bone, tendon, or muscle) Left Medial First Toe. GOAL: Skin/Wound Goal: My pressure ulcers will show signs of healing and remain free from infection. INTERVENTIONS: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Follow facility policies/protocols for the prevention/treatment of skin breakdown. -Monitor/document/report to doctor changes in skin status. -Treatment: Administer as ordered and monitor for effectiveness. Document and communicate findings. Right Lateral Foot, Left Medial First Toe (resolved), and Right First Toe. Review of the medical record including Physician Orders, Wound Physician Notes, Nursing and Physician progress notes, and Treatment Administration Records (TAR) indicated but were not limited to the following: MARCH 2025 Review of the Wound Physician Summary, dated 3/7/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 7: Left, Distal First Toe Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Review of the TAR indicated the three treatment orders were implemented per Wound Physician recommendations. Resident #84 was sent to the hospital in March 2025. Review of the TAR indicated the above treatment orders were discontinued and new orders written upon return from the hospital as follows: -Right Anterior Ankle: Cleanse with NS, apply Xeroform and DPD. (start/stop 3/13/25) -Right Dorsal Foot: Cleanse with NS, apply Xeroform and DPD. (start 3/13/25) -Left and Right Great Toes: Paint with Betadine (antiseptic) and cover with Band-Aid. (start 3/13/25) Review of the Wound Physician Summary, dated 3/14/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 7: Left, Distal First Toe Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% cover with gauze island dressing once daily. Review of the TAR indicated the following: -Right Dorsal Foot: Cleanse with NS, apply Xeroform and DPD daily. -Left, Distal, First Toe: Cleanse with NS, apply Xeroform and DPD daily. -Right, Distal, First Toe: Cleanse with NS, apply Mupirocin and Xeroform followed by DPD daily. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description. There was no treatment order written for the Right Anterior Ankle only one for the Right, Dorsal foot. Review of the Wound Physician Summaries, dated 3/21/25 and 3/25/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 7: Left, Distal First Toe Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% cover with gauze island dressing once daily. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description. There was no treatment order written for the Right Anterior Ankle only one for the Right, Dorsal foot. Review of the Wound Physician Summary, dated 3/28/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dressing Treatment Plan: Xeroform gauze and gauze island dressing once daily. Site 7: Left, Distal First Toe RESOLVED Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% cover with gauze island dressing once daily. Review of the TAR indicated the treatments to the Right Dorsal foot and Right, Distal, Medial, First Toe remained active. The treatment order to the Left, Distal First Toe was discontinued and rewritten. Review of the Nursing and Physician Progress notes failed to indicate the physician wanted to continue the treatment after the wound had resolved. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description. There was no treatment order written for the Right Anterior Ankle only one for the Right, Dorsal foot, and failed to discontinue the treatment to the Left, Distal First toe, which had resolved. APRIL 2025 Review of the Wound Physician Summary, dated 4/4/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: -The treatment to the Left, Distal First toe, which had resolved on 3/28/25 still had an active order. The order was rewritten again on 4/1/25. -Right, Dorsal Foot: Cleanse with NS, apply Bactroban and Xeroform and DPD (4/1/25). -Right, Distal, Medial, First Toe: Cleanse with NS, apply Mupirocin and Xeroform and DPD (3/14/25). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description. There was no treatment order written for the Right, Anterior Ankle only one for the Right, Dorsal foot, and failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25. Review of the Wound Physician Summary, dated 4/16/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Review of the TAR indicated the treatment to the Left, Distal First toe, which had resolved on 3/28/25 still had an active order. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description. There was no treatment order written for the Right Anterior Ankle only for the Right, Dorsal foot, and failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25. Review of the Wound Physician Summary, dated 4/18/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: -The treatment to the Left, Distal First toe, which had resolved on 3/28/25 still had an active order. -Right, Dorsal Foot: Cleanse with NS, apply Bactroban and Xeroform and DPD (4/1/25). -Right, Anterior Ankle: Cleanse with NS, Apply Mupirocin cream, followed by Xeroform and foam dressing once daily. (4/21/25) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure there was only one active treatment for the identified the Right, Anterior Ankle wound, he/she had one treatment order written for the Right, Anterior Ankle and one for the Right, Dorsal Foot, and failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25. Review of the Nursing and Physician Progress notes failed to indicate the physician wanted to continue the treatment after the wound had resolved and failed to indicate the Right Anterior Ankle and the Right, Dorsal Foot were two separate areas versus anatomical location descriptions being used interchangeably for the same area. Review of the medical record failed to indicate a new area had developed. Review of the Wound Physician Summaries, dated 4/23/25, 4/25/25, and 4/29/25 indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: -The treatment to the Left, Distal First toe, which had resolved on 3/28/25 was still an active order. -Right, Dorsal foot: Cleanse with NS, apply Bactroban, Xeroform, and DPD once daily. (4/1/25) -Right, Anterior ankle: Cleanse with NS, Apply Mupirocin cream, followed by xeroform and foam dressing once daily. (4/21/25) The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and he/she had two treatments with different anatomical locations for the same wound and failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25. MAY 2025 Review of the Wound Physician Summary, dated 5/6/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Review of the TAR indicated the treatment to the Left, Distal First toe, which had resolved on 3/28/25 was still an active order. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and he/she still had two treatments with different anatomical locations for the same wound and failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25. Review of the Wound Physician Summary, dated 5/9/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze followed by gauze island dressing once daily. Review of the TAR indicated the treatment to the Left, Distal First toe, which had resolved on 3/28/25 was still an active order. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and still had two treatments with different anatomical locations for the same wound, failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25, and failed to discontinue the Mupirocin 2% to the Right, Distal, Medial First Toe per the 5/9/25 recommendation. Review of the Nursing and Physician Progress notes failed to indicate the physician declined the Wound Physicians recommendation and wanted to continue the Mupirocin 2%. Review of the Wound Physician Summaries, dated 5/14/25 and 5/20/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Xeroform gauze and Mupirocin 2% followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze followed by gauze island dressing once daily. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the TAR indicated the treatment to the Left, Distal First toe, which had resolved on 3/28/25 was still an active order. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and still had two treatments with different anatomical locations for the same wound, failed to discontinue the treatment to the Left, Distal First toe, which had resolved on 3/28/25, and failed to discontinue the Mupirocin 2% to the Right, Distal, Medial First Toe per the 5/9/25, 5/14/25, and 5/20/25 recommendations. Review of the Wound Physician Summary, dated 5/23/25, indicated but was not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Alginate Calcium with Silver followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: -The previous treatment to the Right Anterior Ankle remained active. It was not changed per the recommendation to Calcium Alginate with Silver. -The treatment to the Right, Dorsal foot remained active. -The treatment to the Right, Distal, Medial, First Toe was not changed per the repeated recommendations and still had Mupirocin 2% being applied to the wound. -The treatment to the Left, Distal First toe, which had resolved on 3/28/25 remained an active order until 5/23/25 when it was changed as follows: Left, Distal First toe: Cleanse with NS, apply Calcium Alginate with Silver and a DPD once daily (5/23/25). The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and still had two treatments with different anatomical locations for the same wound and failed to change the treatment per the recommendation to Calcium Alginate with Silver, failed to discontinue the Mupirocin 2% to the Right, Distal, Medial First Toe per the repeated recommendations, and transcribed a new treatment order to the Left, Distal First toe, with the recommended treatment that was intended for the Right, Anterior Ankle. Review of the Nursing and Physician Progress notes failed to indicate the physician had declined the recommendation for the Right Anterior Ankle, failed to indicate the physician declined the repeated Wound Physicians recommendation for the Right, Distal, Medial, First Toe and wanted to continue the Mupirocin 2%, and failed to indicate the physician wanted the treatment indicated for the Right Anterior Ankle be applied to the Left, Distal First toe. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Physician Summaries, dated 5/27/25 and 5/30/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Alginate Calcium with Silver followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: -The treatment to the Right, Anterior Ankle was not changed per the repeated recommendation to Calcium Alginate with Silver and the Mupirocin and Xeroform order remained active. -The treatment to the Right, Dorsal Foot remained active. -The treatment to the Right, Distal, Medial, First Toe was not changed per the repeated recommendations and still had Mupirocin 2% being applied to the wound. -The treatment to the Left, Distal First toe, which had been rewritten on 5/23/25 for Calcium Alginate with silver remained active although the medical record failed to indicate there was an active wound at this location, since it had resolved on 3/28/25. The facility failed to identify the Right, Anterior Ankle wound with the proper anatomical description and still had two treatments with different anatomical locations for the same wound and failed to change the treatment per the recommendation to Calcium Alginate with Silver, failed to discontinue the Mupirocin 2% to the Right, Distal, Medial First Toe per the repeated recommendations, and continued a treatment order written on 5/23/25 to the Left, Distal First toe, with the recommended treatment that was intended for the Right Anterior Ankle. JUNE 2025 Review of the Wound Physician Summaries, dated 6/3/25 and 6/6/25, indicated but were not limited to the following: Site 5: Right, Anterior Ankle Dressing Treatment Plan: Alginate Calcium with Silver followed by gauze island dressing once daily. Site 8: Right, Distal, Medial, First Toe Dressing Treatment Plan: Xeroform gauze followed by gauze island dressing once daily. Review of the TAR indicated but was not limited to the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The treatment to the Right Anterior Ankle was not changed per the repeated recommendation to Calcium Alginate with Silver and the Mupirocin and Xeroform order remained active. -The treatment to the Right, Dorsal Foot remained active. -The treatment to the Right, Distal, Medial, First Toe was not changed per the repeated recommendations and still had Mupirocin 2% being applied to the wound. -The treatment to the Left, Distal First toe, which had been rewritten on 5/23/25 for Calcium Alginate with silver remained active although the medical record failed to indicate there was an active wound at this location, since it had resolved on 3/28/25. The facility failed to identify the Right Anterior Ankle wound with the proper anatomical description and still had two treatments with different anatomical locations for the same wound and failed to change the treatment per the repeated recommendations to Calcium Alginate with Silver, failed to discontinue the Mupirocin 2% to the Right, Distal, Medial First Toe per the repeated recommendations, and continued a treatment order written on 5/23/25 to the Left, Distal First toe, with the recommended treatment that was intended for the Right Anterior Ankle. During an interview on 6/11/25 at 11:06 A.M., the Wound Nurse said she recently took over doing wounds rounds and was still learning the process. She said if a new area was noted, it would be on the weekly skin check, a progress note written and staff would notify her. She said there was no indication Resident #84 had additional wounds on the skin checks or in the progress notes. She said she rounded with the Wound Doctor and would then write the orders. She said he gave a verbal report during rounds, and his full written report was uploaded later in the day. She said initially, she was writing orders based on his verbal report, but realized the orders did not always match, so more recently she has been waiting for the written report and would cross reference to what he said to what was written. The Wound Nurse said the location of the wound should match what the physician wrote on the wound care summary and was unsure why the Right Anterior Ankle and Right Dorsal Foot had been used interchangeably and why both orders were active as there was only one wound on the top of the foot in that area. She said it appeared when Resident #84 returned from the hospital, the description of the area had been changed, however when the Resident was seen by the wound doctor the next day, the area should have been clarified to the Right Anterior Ankle and not the Right Dorsal Foot, so everything matched. She said the Mupirocin should have been discontinued per the recommendation on 5/9/25 and it was not. She was unsure why it was not done, and she was unsure why the treatment to the Left, Distal First toe remained active after being resolved in March. She said when the Wound Doctor would say no changes, she wasn't looking at the treatment assuming what was in the computer was correct. The Wound Nurse said she should have cross referenced the orders and the recommendations to ensure the orders matched. Additionally, she said she was unsure why the treatment recommendation made for the Right, Anterior Ankle was written for the Left, Distal First Toe and not the Right, Anterior Ankle. The Surveyor and Wound Nurse went to Resident #84's room and observed his/her feet. During the observation of Resident #84's bilateral feet, the Wound Nurse and Resident #84 confirmed the only two active wounds on his/her feet were on the Right, Anterior Ankle and the Right, Distal Medial, First Toe. The Wound Nurse said there appeared to have been some errors and confusion with the orders and she would have to investigate it further. (continued on next page)

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	225387	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Court Nursing Care & Rehabilitation Center	389 Alden Road Fairhaven, MA 02719

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 2:30 P.M., the Director of Nurses (DON) said the Wound Nurse recently took over the role and they are still working to find a system that works for her. She said the wound location should match the wound doctor's description to ensure accuracy. She said it appeared the staff were using the Right, Anterior Ankle and Right, Dorsal Foot locations interchangeably and then Resident #84 ended up with two active treatment orders for the same wound. She said she was unsure why the other orders did not match the recommendations as they should. She said she would have to review the orders further to ensure they were all accurate. She said if there was a new area noted it would be on the weekly skin check and a progress note written and there was no indication he/she had an additional wound, just the two areas followed by the Wound Doctor.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed for one Resident (#84), out of a total sample of 26 residents, to assess their history of trauma and failed to develop a plan of care accounting for the Resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization. Findings include: Review of the facility's policy titled Trauma Informed and Culturally Competent Care, dated as last revised [DATE], indicated but was not limited to the following: -Trauma Informed Care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of traumas. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma in care plans, policies, procedures and practices to avoid re-traumatization. -Trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. -Traumatic events which may affect residents during their lifetime include physical, sexual, and emotional abuse, neglect, violence, serious illness or injury, bullying, forces displacement, racism, war, and generational or historical trauma. -For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. -Triggers are highly individualized. Some common triggers may include experiencing a lack of privacy, confinement in a small space, exposure to loud noises, or bright/flashing lights, certain sights, such as objects, and/or sounds, smells, and physical touch. -Resident Screening includes trauma history, including type, severity, and duration, trauma related or dissociative symptoms, risk for safety, concerns with sleep or intrusive experiences, behavioral concerns, and historical mental health diagnoses. -Resident Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identified triggers. -Resident Care Planning involves developing individualized care plans that address the past trauma in collaboration with the resident and family, as appropriate, and identifying and decreasing exposure to triggers that may cause re-traumatization. -Resident Care Strategies include recognizing that trust is earned over time and individuals may not disclose information until a relationship is established. Resident #84 was admitted to the facility in [DATE] with diagnoses which included anxiety, major depression, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #84 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she was cognitively intact, and had a diagnosis of PTSD. During an interview on [DATE] at 2:55 P.M., Resident #84 said he/she almost died when they were in the service. Resident #84 said he/she could tell some stories of almost having his/her head blown off. Additionally, Resident #84 said he/she had PTSD from their first spouse who hit the children. Resident #84 said he/she did not recall anyone else ever asking questions about his/her PTSD before or what helps or makes it worse. Review of the Social Service admission Assessment, dated [DATE], indicated but was not limited to the following: -Resident #84 recently lost his/her spouse of 48 years and was grieving this loss. -Life Events/Stress Response Review (Discussion of possible life events including disasters, explosions, accidents, assault, abuse, combat/war exposure, unexpected death of someone, repeated dreams/images, feeling as though re-living the experience) indicated no trauma history. Review of the progress notes in [DATE] indicated Resident #84's daughter requested a Psych evaluation for an increase in his/her anti-depressant medication related to depression. Review of the Psych note, dated [DATE], indicated but was not limited to the following: -Chief Complaint: Mood -Problem: Anxiety, OCD, PTSD, Depression -Severity: Moderate -Timing/Frequency/Duration: Constant/Years -Triggers: Dementia/Illness -Associated Symptoms: Anxiety; Concentration: Impulsivity -Modifying Factors: Psychiatric Meds and Non-Pharmacological Interventions -Military History: National Guard -Other Trauma/Loss: spouse died recently, military incidents. -Assessment: Recalls several traumatic incidents in the military, said a grenade blew up nearby and impacted his/her hearing and a fellow soldier fired a rifle in the barracks, and they were injured and accused of firing the rifle. -Recommendation made to increase Zoloft (anti-depressant) to help with symptoms. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Psych note, dated [DATE], indicated but was not limited to the following: -Chief Complaint: was in the hospital-returned -Problem: Anxiety, OCD, PTSD, Depression -Severity: Moderate -Timing/Frequency/Duration: Constant/Years -Triggers: Dementia/Illness -Associated Symptoms: Anxiety; Concentration: Impulsivity -Modifying Factors: Psychiatric Meds and Non-Pharmacological Interventions -Military History: National Guard -Other Trauma/Loss: spouse died recently, military incidents. -Assessment: No Suicidal Ideations, mania, or psychosis. Feels mood is stable. The facility failed to complete a quarterly trauma assessment in [DATE]. Review of the Psych note, dated [DATE], indicated but was not limited to the following: -Chief Complaint: a lot of religious and military related conversation -Problem: Anxiety, OCD, PTSD, Depression -Severity: Moderate -Timing/Frequency/Duration: Constant/Years -Triggers: Dementia/Illness -Associated Symptoms: Anxiety; Concentration: Impulsivity -Modifying Factors: Psychiatric Meds and Non-Pharmacological Interventions -Military History: National Guard -Other Trauma/Loss: spouse died recently, military incidents. -Assessment: Main theme is about religion and military. Review of the progress notes failed to indicate a discussion with Resident #84 related to his/her trauma and potential triggers since admission ([DATE]). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Assessments show I have the following Care Area Needs: Behavior Issues: I have mood/behavior episodes-withdrawn and receive anti-depressant medication. INTERVENTIONS: -Consult: Psych services may follow as needed. ([DATE]) -Consult: Social Services to follow as needed. ([DATE]) -Monitor/Document report to my MD as needed ongoing symptoms of Depression. ([DATE]) -Monitor my behavior episodes and attempt to determine underlying cause. ([DATE]) -Monitor for side effects of psychotropic medication. ([DATE]) FOCUS: I have an alteration in the following body systems/ health status: and the need for: PTSD, OCD, Depression, Anxiety INTERVENTIONS: -Psychosocial/Mood: Staff continue to monitor for possible triggers that would upset Resident #84 in order to avoid re-traumatization. Main theme is about religion and the military. He/she takes comfort in prayer, prefers private prayer, Social Worker to provide 1:1 visits as needed for opportunity to express feelings/share. In-house psych services and counseling are available as needed/desired. ([DATE]) During an interview on [DATE] at 11:03 A.M., Charge Nurse #1 said Social Service handles the PTSD assessments. She said if a resident had PTSD they should also be seen by psych, be discussed with the Interdisciplinary Team (IDT), and have the Care Plan updated. She said she was unsure who reviews the psych notes and who would be the one to identify triggers; she thought Social Service handled all of that. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:25 A.M., with Social Workers (SW) #1 and #2, they said a resident with PTSD should be assessed on admission and followed up quarterly and as needed, a Care Plan related to the diagnosis should be developed and include possible triggers, and they would be routinely followed by psych services and have 1:1 therapy set up, if agreeable. SW #1 said a covering SW did the initial admission assessment and she was unsure why Resident #84's trauma history was not identified at that time. She said he/she was vocal about his/her history. Additionally, SW #1 said she reviews the psych notes and was unsure why the known trauma history as documented by psych in [DATE] had not made it to his/her care plan at that time or why it was not assessed in March during his/her quarterly review. Additionally, she said she did not know why when the psych note again references trauma history in April, there was no follow up and it was not added to the care plan. SW #1 and #2 said there should have been an assessment and/or progress note related to potential triggers and his/her history and there was not. SW #2 said he just realized Resident #84 had a diagnosis of PTSD last week and added it to the Care Plan. He said he was in the process of arranging psych services for 1:1 therapy, but that has not started yet, and he did not know anything about Resident #84's triggers yet. During an interview on [DATE] at 2:14 P.M., the Director of Nurse (DON) said the SW does the trauma assessments on admission and ongoing if needed, they come up with interventions, discuss the resident at IDT Meetings and Care Plan Meetings, update the Care Plans to include potential trigger to prevent and/or mitigate re-traumatization. She said the SW gets a copy of the psych notes and should document and follow up accordingly. She said Resident #84 is very vocal and she did not see any documentation from the SW related to his/her trauma and triggers since admission.