STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health Care Center	7012 Lake Road Woodbury, MN 55125

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review the facility failed to promote dignity for 1 of 4 residents (R4) when his call light was not answered timely, staff did not honor a request to don R4's protective heel boots, and did not provide a blanket to cover his body. Findings include: R4's Medicare 5-Day Minimum Data Set (MDS) dated [DATE] indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following:11/15/23- dependent on staff to put on/take off shoes4/2/26- indicated R4 had potential and actual skin impairment, admitted to the facility on [DATE] with an unstageable right heel venous ulcer (sores that typically occur on the legs due to poor blood circulation), left medial malleolus (bony prominence on the inner side of ankle) diabetic ulcer, a left plantar (foot) ulcer, and right medial calf (inner side of the lower leg).4/2/26- actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all time initiated 5/4/23. During continuous observation on 5/22/26, starting at 1:13 p.m., R4 was lying in bed covered in a white sheet, his protective boots were sitting in his recliner out of reach. R4's call light was activated. At 1:51 p.m., the nursing assistant (NA)-D responded to R4's call light. R4 told the NA-D he would like his boots on and asked the NA-D to tell the nurse he was waiting for his wound care. The NA-D responded to R4, Right now? R4 told the NA-D his boots were supposed to have been on since after his morning bath. The NA-D shut R4's door, and when it was opened again at 1:54 p.m., R4's protective boots were on his feet. R4 was covered with a sheet. During an interview on 5/22/26 at 1:13 p.m., R4 stated he had been trying to get a blanket after his morning bath but was told the facility did not have a blanket to give him. R4 was covered in a white sheet but wanted a blanket because he had visitors coming and didn't want just a see-through sheet, so his visitors didn't see his wounds. It was R4's birthday, and he just wanted to be covered properly for his guests. R4 stated he had asked his NA about what was in his recliner several times and was told only a pillow was in the recliner. The NA did not tell R4 his boots were also in the recliner. Because R4 didn't have feeling in his lower extremities, and had poor vision, R4 stated that he could not see what was in the chair and did not know his boots were not on his feet. During an interview on 5/22/26 at 1:54 p.m., the nursing assistant (NA)-C stated he was not R4's NA that day but just came to answer R4's call light. The NA-C stated staff was supposed to answer call lights within five minutes, NA-C stated R4 would likely be upset about having to wait to get assistance from staff and would be embarrassed if he was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not able to cover his body with a blanket as requested. During an interview on 5/22/26 at 2:05 p.m., the registered nurse (RN)-C stated all staff were responsible for answering call lights. RN-C hadn't seen R4's call light because she was not able to see the banner which displayed the activated call lights. Further, the RN-C stated R4 would not feel important to staff if he had to wait all morning to get a blanket or his protective boots and further stated the NA should have looked for a blanket for R4 on another floor. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the shift, and stated R4's boots were supposed to go on in the morning. The NA-D stated he informed NA-C he was going on break and NA-C should have answered R4's call light. The NA-D acknowledged R4 wanted his protective boots, a blanket, and staff didn't answer R4's call light timely. The NA-D stated R4 would be sad, disappointed, and not well cared for when his needs weren't met. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated waiting 38 minutes for a call light response was too long, and staff were expected to answer call lights as quickly as possible, Thirty-eight minutes sitting there waiting feels like a lifetime. Further, the DON stated R4 would feel terrible waiting for his protective boots, and when residents asked for help, staff was expected to help meet their needs. The Promoting/Maintaining Dignity policy dated 4/1/26 indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance guidelines included: During interactions with residents, staff must report, document and act upon information regarding resident preferences.Respond to requests for assistance in a timely manner. The Call Lights Accessibility and Timely Response policy dated 4/2025 indicated that all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to develop a comprehensive care plan for 1 of 4 resident (R1) reviewed for compressive care plan. Additionally, based on interviews, observations, and document review, the facility failed to implement care planned interventions for 2 of 4 residents (R2, R4) reviewed for care plan implementation. Findings include: R1 R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1's orders dated 4/23/26, indicated wrap bilateral lower extremities with Kerlix and then ACE wraps, one time a day for edema, on in the morning, off at bedtime. R1's care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues) treatment with compression and pumps. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1. Nursing placed bandages and ACE wraps on R1's legs for lymphedema, and R1's husband put lymphedema pumps on R1's legs. The RN-A stated she was unsure if R1 had a care plan for lymphedema care, but all care interventions required a care plan. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care plan for lymphedema care because nursing staff was not trained for lymphedema care, only for the bandages and ACE wraps. RN-B acknowledged ACE wraps were mentioned on R1's care plan but the care plan did not indicate why. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. R1's family member was managing R1's compression wraps and pumps. The DON acknowledged R1's care plan did not include focus areas or interventions for staff or R1's family to manage R1's lymphedema care but should have. This was important so staff would know how to manage the lymphedema care. R2 R2's annual MDS dated [DATE], indicated severe cognitive impairment. R2 was always incontinent of bowel and bladder, was at risk for developing pressure ulcers (PU), and had diagnoses that included dementia and arthritis. R2's care plan dated 4/21/25, indicated two staff were required to dress R2's upper body. During an observation on 5/20/26 at 3:56 p.m., with the FM-D, video footage from the video camera in R2's room which was not dated or timed, revealed one staff dressing R2. During an interview on 5/20/26 at 4:23 p.m., the FM-D stated she had video footage from the camera in R2's room that showed one staff dressing R2 when it should have been two staff. The video showed the staff putting her full weight into dressing R2 because it appeared to be too difficult for one staff to manage. During an observation on 5/22/26 at 4:20 p.m., with the director of nursing (DON) review of footage from the video camera in R2's room that was not dated or timed revealed one staff dressing R2. During an interview on 5/22/26 at 4:20 p.m., the DON identified the staff in the video as NA-A, acknowledged the NA-A did not use two staff to dress R2. The DON stated R2's care plan indicated two staff for upper body dressing due R2's upper extremities were difficult to move with only one staff. The DON stated it was not good care provided by the NA-A. During an interview on 5/26/26 at 2:32 p.m., the NA-A stated R2 required the assistance of two staff for dressing because R2's limbs were stiff, and difficult to manage with one staff. The NA-A acknowledged she dressed R2 by herself, didn't know (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what the care plan directed regarding number of staff to assist with R2 dressing. NA-A stated they could look on R2's Kardex to find out, but hadn't. R4 R4's Medicare 5-Day MDS dated [DATE], indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear. R4 had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan dated 4/2/26, indicated actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema. Interventions included pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed. During an observation on 5/20/26 at 12:07 p.m., the RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying on the floor near the end of R4's bed when RN-D left R4's room. During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the NA-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and NA-B left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room. During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin. During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room and had activated his call light. R4's protective boots were in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, Right now? Your aide will be back from break soon. R4 explained to the NA-C that his protective boots should have been put on in the morning, after he was weighed. During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was sitting in his recliner, and the NA had responded saying only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels. During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and forgot about them. The NA-D acknowledged R4 could develop more wounds if he were not wearing the protective boots. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders directed for R4 to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed. A policy regarding developing and implementing care plans was requested but not provided.

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F 0684 Level of Harm - 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 interview and document review the facility failed to assess and monitor a change in condition for 3 of 4 residents (R1, R2, R4) reviewed for wound care. The lack of assessment and monitoring for R1 resulted in harm for R1 when R1 appeared to be sleeping in bed but instead had a change in responsiveness and mentation, was not assessed timely for the change, and was hospitalized . The lack of thorough assessment and monitoring for R2 resulted in delay in treatment for wounds related to moisture associated skin damage (MASD). Wound care staff identified wounds on 4/28/26, but were not evaluated until 5/11/26. The wounds were open and R2 reported pain associated with the wounds. The lack of assessment and monitoring for R4 resulted in harm when R4 was noted to have a change in condition, staff did not perform ongoing assessments and monitoring, the provider was not notified of the changing and deteriorating condition, and R4 was found unresponsive in bed two days after becoming ill and was subsequently transferred to the hospital. Findings include: R1 R1's admission Minimum Data Set (MDS) dated [DATE] indicated intact cognition, dependence upon staff for assistance with activities of daily living (ADLs), no behaviors including refusals of care, and diagnoses that included kidney insufficiency, urinary tract infection (UTI) in the previous 30 days, liver disease, and hypertension. R1's provider progress note dated 4/29/26 indicated the provider reviewed the resident with the facility nursing staff and nurse manager to watch R1 carefully as she may need further hospitalization for diuresis (pass increased amount of urine), and to watch vital signs (VS). R1's provider orders dated 4/29/26 indicated Lasix (diuretic - medication used to promote the production of urine by the kidneys used to flush out excess salt and water) 40 milligrams (mg) one time a day at 8:00 a.m., and 20 mg one time a day at 1:00 p.m., for edema. The provider orders lacked indication staff were to monitor R1's carefully for indication she may need further hospitalization for diuresis per the provider's progress note on 4/29/26. R1's care plan lacked mention R1 was taking a diuretic or needed careful monitoring for the need for further diuresis at the hospital. R1's progress notes indicated the following:5/2/26 at 10:01 p.m., vital signs (VS) were checked at 10:22 p.m.: blood pressure (BP) 101/55, pulse (P) 79, respirations (R) 18, temperature (T), 96.9 Fahrenheit (F), oxygen saturation (O2 sats) 99% on room air (RA). Resident was alert and oriented and coherent, with clear speech. 5/2/26 at 10:20 p.m., vital signs stable, pedal pulse on left ankle not palpable. 5/2/26 at 10:43 p.m., R1 was taken to the hospital. R1's After Visit Summary from the hospital dated 5/2/26 indicated R1 had a diagnosis of cellulitis (bacterial infection of the skin and underlying tissue) and was started on an antibiotic. R1's diagnosis list dated 5/3/26 indicated a diagnosis of cellulitis of the left lower limb. R1's progress notes after the hospitalization indicated the following: 5/3/26 at 6:40 a.m., returned from hospital with new orders and diagnosis. 5/3/26 at 10:50 a.m., VS were assessed at 7:48 a.m. and were BP 100/58, P 94, R 16, T 97.4 F, O2 sats 96% on RA, resident followed commands, was alert and oriented. 5/3/26 at 6:09 p.m., VS BP 118/60, P 84, R 18, T 96.9 F, O2 sats 98% on RA, alert and oriented, coherent with clear speech. 5/4/26 at 2:26 p.m., VS T 97.6 F assessed at 12:49 p.m., P 85 and R 18 assessed at 2:28 p.m. Resident was alert and oriented, and able to follow commands. The progress note lacked indication BP and O2 sats were assessed. 5/4/26 at 9:42 p.m., VS T 97.7 F assessed at 9:09 p.m., P 87 and R 17 assessed at 9:43 p.m. Resident was alert and oriented and able to follow commands. The progress note lacked indication BP and O2 sats were assessed. 5/5/26 at 12:29 p.m., VS BP 92/53, P 114, R 18, T 97.0 F. Resident complained of hip and left calf pain at 12:00 p.m.; Tylenol was given. The progress note lacked indication O2 sats were assessed and lacked further mention of the low BP and elevated P, lacked later reassessment of the VS, and lacked indication the VS were reported to the provider. 5/5/26 at 3:15 p.m., VS P 85, R18, T 97.7 F. Resident is alert and oriented, followed commands. The progress note lacked indication BP or O2 sats were assessed. 5/6/26 at 3:29 p.m., VS BP 45/26, P 66, R 22, T 97.0 F, O2 sats 98% on RA. Resident had very low BP and was alert knew her first and last name but did not know where she was (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and was lethargic.5/6/26 at 4:16 p.m., VS 50/26, pulse 66, R 22, T 97.0 F. Resident follows commands, has not been eating any of her food, especially this shift. 5/6/26 at 4:27 p.m., when caregivers offered to do cares, R1's family would tell staff to come back because R1 was sleeping. At 2:30 p.m. during medication pass, the trained medication aide (TMA) came to pass meds, and was told to come back later. The licensed practical nurse (LPN)-A went to check on R1 and BP was noted to be very low; the provider was updated and gave orders to send R1 to the emergency room (ER). The progress note lacked indication staff assessed R1 even though it was unusual for her to sleep during the day. R1's death certificate dated 5/7/26 at 12:27 p.m., indicated R1 died of multiorgan failure due to septic and hemorrhagic shock, acute renal (kidney) failure, and acute respiratory failure. During an interview on 5/19/26 at 11:33 a.m., social worker (SW)-A stated when R1 was intubated shortly after she arrived at the hospital on 5/6/26, and family reported R1 was not acting like herself and didn't want to talk to her husband that day which was not normal for R1. The SW-A stated R1's family reported being very concerned about the care R1 received at the facility. During an interview on 5/21/26 at 2:46 p.m. the family member (FM)-A stated the day after R1 died, she visited the facility to discuss with a registered nurse (RN) how R1 was fine one day, and on lift support the next day. The FM-A stated FM-B and FM-C had seen R1 the morning R1 was transferred to the hospital. R1 complained of a headache the morning of 5/6/26, and was sleeping a lot, which was unusual for her; her baseline was lively and talkative. The FM-A stated FM-C visited R1 in the morning on 5/6/26, and FM-B visited around 10:00 a.m., and R1 slept through both visits. FM-A stated it was after lunchtime when staff checked on R1, but FM-C asked staff to let R1 sleep. A nurse came in later, and assessed R1, and then rushed to send R1 to the hospital. During an interview on 5/21/26 at 3:27 p.m., the FM-C stated on 5/6/26 R1 was sleeping a lot which was not normal. A nurse came to R1's room at approximately 10:00 a.m., physical therapy and occupational therapy staff came and left when I sent them away. The FM-C stated she looked for a wound care nurse in the facility because the wounds on R1's legs were weeping. A nursing assistant (NA) entered R1's room around 2:00 p.m., and wanted to give R1 some medication, but because R1 had complained about that NA previously, the FM-C asked them to leave. The NA sent a nurse back in to give the medication but didn't give the medication and instead called emergency medical services to send R1 to the hospital. She had just been in the hospital with sepsis the Thursday or Friday after Easter. The day before she went to the hospital on 5/6/26, R1 kept saying she wanted her mom and didn't seem real energized but was usually more alert than she was that week. She seemed to be declining all week. During an interview on 5/21/26 at 4:04 p.m., the nurse practitioner (NP)-A stated she was not informed R1 had an UTI, and a urine test had not been ordered for R1 after her hospitalization in April. R1 was very ill and had been declining. Staff had to monitor R1 closely because she was immobile, at risk for infection, and had so many contributing co-morbidities. During an interview on 5/22/26 at 10:14 a.m., the FM-C stated when R1 went to the hospital on 5/6/26, hospital staff told the FM-C R1 was very sick may not make it through the night. They put a tube down her throat, and when they pulled that out, R1 died about 30 minutes later. The FM-C stated he visited R1 on 5/6/26 at the facility, and stated staff looked at R1 in her room, and walked away, but did not assess her. During an interview on 5/22/26 at 2:54 p.m., the RN-A stated after R1 returned from the hospital in April 2026, the care provided included checking R1's blood pressure, wounds care for the wounds on R1's legs, and catheter care. During an interview on 5/26/26 at 11:39 a.m., the licensed practical nurse (LPN)-A stated she took R1's VS on 5/6/26 and was very concerned. R1 was conscious and speaking but didn't know where she was. She was sleepy all day and hadn't felt well. The DON didn't want me to send R1 to the hospital again, but we did send her in later in the day. During a subsequent interview on 5/26/26 at 12:29 p.m., the NP-A stated any resident required assessment when they were sick and the provider should be updated any time a resident had a change in condition. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 was assessed on 5/6/26 right before she was sent to the hospital but did not appear to have any assessment on 5/6/26 that day prior to that because the family wanted her to sleep. If (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the nurse was concerned, she should have awakened her to assess her. When nurses do a set of VS, they should include a blood pressure, pulse, respirations, temperature, and oxygen saturations, and usually pain. Staff would not know R1's condition if they didn't assess her. During an interview on 5/26/26 at 2:46 p.m., the medical director (MD)-A stated R1 was very frail and compromised and should have been assessing for signs of infection and fever. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated the expectation was if R1 or her family refused care, the expectation was for nursing staff to educate the resident or the family about the need for care, and then document in a progress note that care was refused and education was provided about the risks and benefits of refusing the care. If R1's BP was low, staff should recheck the BP, and if it is still low, report it to the provider. R2 R2's annual MDS dated [DATE], indicated severe cognitive impairment, R2 was always incontinent of bowel and bladder, was at risk for developing pressure ulcers (PU), and had diagnoses that included dementia and arthritis. R2's grievance log entry dated 3/31/26, indicated R2's was supposed to be added to wound rounds but had not been. R2's grievance log entry dated 5/11/26, indicated R2's FM-D was concerned about R2's wound. R2's care plan indicated the following:5/14/22, revised 6/22/22, indicated R2 wore incontinence products daily, apply barrier cream/protective ointment after each incontinent episode. 5/14/22, revised 4/21/25, reposition every 2-3 hours and as needed10/28/25, check and change for incontinence every 2-3 hours5/14/22, revised 5/20/26, indicated R2 had potential impairment to skin integrity related to incontinence, immobility, and medication use with current MASD with treatment with an ointment. Interventions were added 5/18/26 including see the Skin/Wound tab in the medical record for current skin measurements and interventions, treatment as ordered and notify provider if the skin alteration was worsening or shows signs and symptoms of infection or no improvement in fourteen days. R2's progress notes indicated the following:4/1/26 at 11:27 a.m., new skin issue, MASD on the intergluteal cleft (the deep vertical groove that runs between the buttocks) 3.99 centimeters (cm) x 4.25 cm, 100% granulation tissue, no drainage, cleaned with generic wound cleaner, treated with Calmoseptine Ointment used to prevent and soothe skin irritations), to be treated daily and as needed (PRN). The progress notes lacked mention the provider was notified. 4/7/26 at 9:36 a.m., MASD on the intergluteal cleft was healed. 4/7/26 at 3:38 p.m., MASD, in-house acquired, on intergluteal cleft that had not been evaluated by a provider. The note lacked mention of treatment, clinical treatment suggestions, or notification to the provider. 4/14/26 at 3:20 p.m., MASD in the intergluteal cleft, in-house acquired with a clinical suggestion to apply barrier cream to the skin, that had not been evaluated by a provider. The progress note lacked mention of notification to the provider. 4/17/26 at 6:10 p.m., Calmoseptine External Ointment 0.44020.6% was ordered, apply to buttocks two times a day for wound care to buttocks twice a day (BID) and PRN4/28/26 at 3:13 p.m., MASD, in-house acquired on the left gluteal fold that had not been evaluated by a provider; barrier cream was applied. The progress note lacked mention of notification to the provider. 5/5/26 at 12:26 p.m., MASD, in-house acquired on the intergluteal cleft that had not been evaluated by a provider. The progress note lacked mention of treatment, clinical suggestions, or notification to the provider. 5/5/26 at 10:01 p.m., a Braden Evaluation (assessment tool used to predict risk of developing pressure ulcers) was completed with a score of 12, which indicated a high risk of developing PU. 5/9/26 at 11:35 p.m., resident's daughter indicated R2 might have a wound on her bottom she was not informed about. The LPN-B performed an assessment that revealed on-going MASD and a Stage 1 PU(skin is not broken but is red and discolored or may show hardness or temperature change compared to the skin around it) about 1 cm to 2 cm on R2's coccyx. The LPN-B informed the nurse on-coming nurse for the subsequent shift and advised that nurse to inform the resident provider on Monday, 5/11/26, so they can possibly prescribe a topical ointment for the resident coccyx. The progress note lacked evidence the LPN-B notified the provider of the PU. 5/11/26 at 2:01 p.m., MASD on the gluteal cleft that had been evaluated by a provider, noted as an in-house acquired new wound that measured 1.36 cm in width (W) x 1.45 cm in depth (D), with 100% granulation tissue (new pink connective tissue that fills (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the base of a wound), with orders to clean the wound with generic wound cleaner and cover it with Calmoseptine Ointment daily and PRN. R2's Skin Issues/ Skin Checks notes indicated the following:4/1/26 at 11:27 a.m., Skin Issues: new issue, intergluteal cleft, MASD, 3.99 cm x 4.34 cm, 100% granulation tissue, no drainage. The care planning and clinical suggestions sections were not completed. 4/7/26 at 9:36 a.m., Skin Issue: in-house acquired MASD on intergluteal cleft, resolved. 4/7/26 at 3:38 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, with no education provided, no provider/family notifications or clinical suggestions noted. 4/14/26 at 3:20 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no education provided, no provider/family notifications noted. Clinical suggestion indicated apply barrier cream to skin. 4/22/26 at 9:59 a.m., Skin Issues: in-house acquired MASD on intergluteal cleft, resolved. 4/28/26 at 3:13 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no provider/family notifications or clinical suggestions noted. 5/5/26 at 12:26 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft, no provider/family notifications or clinical suggestions noted. 5/11/26 at 2:01 p.m., Skin Issues: evaluated, in-house acquired MASD on intergluteal cleft, new wound, 1.36 cm x 1.45 cm, 100% granulation tissue, none exudated noted, but has exudate noted to be serosanguinous (mixture of serous - clear pale watery fluid and sanguinous fluid-contains fresh blood or has a blood-like appearance), with a pink wound bed, and minimal dressing saturation, treated with Calmoseptine ointment daily and PRN, with no care plan or wound interventions noted.The skin assessments lacked indication a skin check was performed on R2 the week of 4/21/26. R2's provider orders indicated the following:2/3/26 Calmoseptine Ointment .44-20.6% ointment, apply to buttock topically two times a day (BID) for wound cares to buttock and PRN During an interview on 5/20/26 at 3:56 p.m., the FM-D stated R2 had a wound on her bottom for the 3rd or 4th time, because facility staff didn't change R2's incontinence brief frequency enough and R2 lays on her backside in bed for hours in a row. The FM-D stated for the last six months, she requested R2 be put to bed after 9:00 p.m., and to be gotten up on the morning before 10:00 a.m. The FM-D stated she visits R2 almost daily, and leaves the facility around 7:00 p.m. or 7:30 p.m. nightly, and the video camera footage in the room revealed staff putting R2 to bed around 7:45 p.m., nightly after the FM-D leaves for the day. The video camera footage revealed staff gets R2 up in the morning between 11:00 a.m. and 11:30 a.m., and then don't change R2's incontinence brief again util they put her to bed at night. The FM-D further stated she has talked to staff about it daily for about three weeks because the routine had not changed, but not R2 at least gets checked and changed at the end of first shift and is them up in her chair again until bedtime. The FM-D stated she discovered R2 has a wound on her bottom when she saw a soiled incontinence wipe and undergarment in the garbage that had blood on them on 5/2/26. The FM-A stated she asked the facility DON to have a wound nurse assess the wound, and was told it happened, but when she reviewed camera footage, discovered no wound rounds occurred for R2. The FM-A then spoke to the DON, stated she had been lied to about the wound care team seeing R2, and asked again for the wound care team to see R2. The DON assessed the wound, ordered a product from the pharmacy called butt goop, and told the FM-D the wound should have been assessed long before it was. Now, as seen by the FM-D on video footage, the wound care team visits R2 weekly on Wednesdays. The FM-A stated she just wants the wound treated, was concerned about infection, and the wound looked really raw and red the last tine she saw it, approximately two weeks prior to the interview. Additionally, the FM-D stated she had video footage of staff wiping R2's wounds and R2 hollered out in pain during the care. The FM-D stated, if the wounds had been found before they were open, they might not be so painful to clean. During an interview on 5/26 26 at 10:09 a.m., the LPN-B stated R2 had ongoing MASD, and it was possible the treatment was not working because it kept returning. The treatment was to apply a barrier cream and reposition R2 every two to three hours. The LPN-B stated weekly skin checks were performed each week during the resident's bath time, and if it was not completed weekly, skin deterioration could be missed that wasn't identified previously. During an interview on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5/26/26 at 12:29 p.m., the NP-A stated if R2 did not get the wound checks and assessments as ordered, new wounds could be missed, or the wounds could get worse. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated staff told the wound team about wounds on R2's bottom, but during assessment, the wound team did not locate the wounds. Twice, staff sent pictures to the wound team, and the wound team did not find the wounds. After R2's family got upset with the DON, the wound team looked a third time, and moved skin folds around more, and discovered two wounds on R2's perineum (region of the body located between the thighs between the anus and vaginal opening). The RN-B stated the wound did not likely recur but were likely present each time. The RN-B stated she didn't think repositioning in a wheelchair would make a difference, but instead it was the sitting on the area that was likely causing the issue. The RN-B stated she was unsure if that education was provided to the family and did not find any documentation indicating education to the family about not sitting on the wounds had occurred. The RN-B acknowledged R2 did not have a skin check the week of 4/21/26 and stated the facility could miss new wounds when the assessments were not done weekly. During an interview on 5/26/26 at 2:32 p.m., the nursing assistant (NA)-A stated she thought R2 had pain with the wounds on her bottom and sometimes hollered out during checks and changes for incontinence. During an interview on 5/26/26 at 3:31 p.m., the DON stated R2 had previous MASD wounds, and then recently staff found them again. Ensuring skin checks are completed timely, education about refusals of care, and keeping R2 as dry as possible were keys to ensure MASD didn't occur. The DON acknowledged R2 did not have a skin check on 4/21/26 but should have and acknowledged skin checks were utilized to discover new skin issues, and skin issues forms were utilized to assess current skin issues, and stated It could have potentially made a difference if that skin check had been done. I wish we had noticed the wounds sooner. R4 R4's Medicare 5-Day MDS dated [DATE] indicated R4 had intact cognition, was dependent upon staff for applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following:5/4/23 difficulty sleeping 6/13/23 type II Diabetes 6/13/23 altered cardiac status related to congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and hypertension (high blood pressure)7/24/23 peripheral vascular disease (slow progressive circulatory disorder characterized by the narrowing, blockage, or spasms of blood vessels, most commonly reducing blood flow to the arms, legs, and feet5/12/25 impaired vision6/30/25 incontinence of bowel12/12/25 encephalopathy (broad term for any disease, damage, or malfunction that affects the brain's function, with an altered mental state that may include confusion, memory loss, or personality changes)12/18/25 kidney failure related to Type II diabetes4/2/26 actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23. R4's orders included the following:4/17/26 Novolog (a short-acting insulin given before meals, often given in combination with a long-acting insulin) Flex Pen 100 units/milliliter (unit/ml), inject 20 units subcutaneously (subq) before meals 4/18/26 Novolog Flex Pen 100 unit/ml sliding scale, inject subq before meals: if blood glucose (BG):150-199 give 3 units200-249 give 6 units250-299 give 9 units300-349 give 12 units250-399 give 15 units400+ give 18 units and call physician4/17/26 oxycodone hydrochloride (HCl - narcotic pain medication administered for moderate to severe pain) 5 milligrams (mg), give 5 mg by mouth as needed for pain one time daily in the morning, in the evening, and PRN for pain one time (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	daily. 4/17/26 Sildenafil citrate 20 mg, give 20 mg three times daily related to pulmonary hypertension (high blood pressure in the arteries that carry blood from the heart to the lungs)5/11/26 UA/UC for cloudy urine and chills R4's diagnoses list dated 5/20/26, included diagnosis of sepsis dated 5/19/26. R4's care timeline provided by email by the facility after the survey exit as supplemental documentation on 5/28/26 at 5:55 p.m., indicated the timeline was developed using nursing documentation and review of video footage from the facility, revealed the following:5/12/26 at 7:38 a.m., not feeling well, provider ordered UA/UC, observed vomiting, resident declined going to the Emergency Department. The timeline lacked indication a nursing assessment was completed, or VS were taken. 5/12/26 at 8:00 a.m., NA entered the room, daily weight taken. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 8:53 a.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 9:02 a.m., a nurse entered the room to administer medication. The timeline lacked indication a nursing assessment was performed, or VS were taken. 5/12/26 at 10:27 a.m., a nurse and trainee were observed entering the room briefly to monitor. The timeline lacked mention of what monitoring occurred, nor what was observed. 5/12/26 at 11:34 a.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 11:41 a.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 12:21 p.m., a NA brought lunch to the room. The timeline lacked information about the condition of the resident. 5/12/26 at 1:04 p.m., the timeline indicated, Oxygen tank with no further reference. 5/12/26 at 2:10 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 3:33 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 2:24 p.m. a nurse and trainee entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident. 5/12/26 at 4:20 p.m., the NP was notified the UA was back. No further assessment details were included. 5/12/26 at 5:30 p.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident.5/12/26 at 6:08 p.m., a NA entered the room. The timeline lacked indication VS were taken, what care was provided, or the condition of the resident. 5/12/26 at 6:22 p.m., a nurse took R2's temperature. The timeline lacked indication a nursing assessment was performed, additional VS were taken, or the condition of the resident.5/12/26 at 7:49 p.m., a NA entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident.5/12/26 at 8:15 p.m., a NA entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident.5/12/26 at 8:44 p.m., a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident.5/12/26 at 10:21 p.m., a nurse documented lethargy all shift, and indicated her note she was frequently monitoring from 2:30 p.m., to 10:30 p.m. The timeline lacked indication a nursing assessment was performed (other that indicating lethargy), VS were taken, or the condition of the resident.5/12/26 at 10:47 p.m. a nurse entered the room. The timeline lacked indication a nursing assessment was performed, VS were taken, or the condition of the resident.5/13/26 at 12:53 a.m., assessed by nurse and sent to ER. The timeline included 18 opportunities for staff to take VS, 11 opportunities for a nurse to perform an assessment including taking VS and reporting on the condition of the resident. The timeline lacked mention R4 started feeling ill on 5/11/26, lacked mention of any VS other than one temperature, and lacked an update on R4's condition to the provider other than to report the UA was back. R4's progress notes indicated:5/11/26 at 2:01 p.m., oxycodone Hcl 5 mg was administered for back pain5/11/26 at 3:55 p.m., urine was cloudy this shift and temperature was 99.3 [Fahrenheit (F)]. The nurse practitioner was notified and an order was given for UA/UC (urinalysis - a urine test and urine culture - to test for bacteria). Report given to p.m. shift nurse. 5/11/26 at 4:59 p.m., urine specimen (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	collected this evening. Lab has been called for collection. 5/11/26 at 5:11 p.m., refused scheduled Novolog injection but allowed the Novolog sliding scale injection, and did not want to eat dinner. 5/12/26 at 6:40 a.m., indicated R2 was not feeling well, a UA/UC were collected, resident was weak and had vomited, R2's VS were P-83, O2 sats 91 %, on 5 liters (L) O2 per his baseline, with a temperature of 101.1. The nurse offered to send R4 to the ER, but R4 declined to go. R4 requested PRN Tylenol 1000 mg which he took. The VS lacked assessment of BP and respirations. The nurse reported R4's condition to on-coming staff. The note lacked mention of an update to the resident's provider or family. 5/12/26 at 7:46 a.m. resident's current condition inhibited any leg treatments. The progress note lacked mention of a nursing assessment or VS taken. 5/12/26 at 11:15 a.m., resident refused to eat. The progress note did not indicate why, a nursing assessment, or VS.5/12/26 at 2:14 p.m., Tylenol 1000 mg given for pain. The resident had a temperature of 100.5 F. The progress note lacked mention of the location of the pain, other VS, or additional nursing assessments. 5/12/26 at 2:20 p.m., oxycodone HCl 5 mg administered for back pain5/12/26 at 3:27 p.m., Tylenol effective was rated as ineffective with pain rated as 5/10. R4 also had oxycodone HCl 5 mg at 2:20 p.m. The progress note lacked an update to the provider about unmanaged pain or that an extra oxycodone HCl was required or administered. 5/12/26 at 3:28 p.m., refused Novolog 20 units insulin. The note lacked indication that the provider was notified of insulin refusals on 5/11/26 and 5/12/26 or education about the risks and benefits of refusing the medication. 5/12/26 at 4:20 p.m., the provider was notified of resident change in condition. 5/12/26 at 9:49 p.m., resident refused Sildenafil Citrate 20 mg, resident if very lethargic. The progress note lacked mention of notification to the provider the resident refused the medication or education about the risks and benefits of refusing the medication. 5/12/26 at 10:16 p.m., resident lethargic all shift, waiting for culture results from UA, brother was present and will be back 5/13/26, resident refused some of his meds, did not eat or drink and needed help holding a cup. The progress notes lacked VS, a nursing assessment, or indication the provider was aware of R4's current condition. 5/13/26 at 1:15 a.m., R4 was found unresponsive in his bed, O2 sats 77% on 5 L O2 at 12:50 a.m. Provider notified at 12:53 a.m., and order received to send R4 to the ER for further evaluation and treatment. The progress notes lacked an assessment of VS other than O2 sats. 5/13/26 at 3:30 a.m., R4 admitted to hospital, noted with temperature of 103.3F. The progress notes lack evidence of nursing assessments including full vital signs, pain assessment, changes in cognition and speech, lung sounds, changes in mobility or elimination, and lacked evidence of education provided to either the resident or the resident's family member about the risks and benefits of medication refusals, delay in care and hospitalization, or palliative care options. R4's vital signs records lacked indication a blood pressure was assessed after 5/1/26 at 3:47 p.m., a pulse was assessed between 5/1/26 at 3:47 p.m., and 5/12/26 at 9:55 p.m., or a temperature was taken between 5/1/26 at 3:47 p.m., and 5/12/26 at 6:28 p.m., other than the two mentioned in the progress notes. During an interview on 5/20/26 at 11:58 a.m., R4 stated he had returned from the hospital the day prior for an infection in his blood. During an interview on 5/22/26 at 9:57 a.m., the FM-E stated R4 had many hospitalizations, seemingly related to his catheter and UTIs. The FM-E stated he was concerned about R4's recent hospitalization because it seemed like a del

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure pressure ulcer (PU) preventative measures indicated on the care plan were implemented for 2 of 4 residents (R2, R4) reviewed for wounds. Findings include:R2R2's annual Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, R2 was always incontinent of bowel and bladder, and was at risk for developing PU. R2's diagnoses included dementia and arthritis. R2's care plan dated 5/14/22, revised 5/20/26, indicated R2 had potential impairment to skin integrity related to incontinence, immobility, and medication use with current MASD (moisture associated skin damage) with treatment with an ointment. Interventions added 5/18/26, included: See the Skin/Wound tab in the medical record for current skin measurements and interventions; treatment as ordered and notify provider if the skin alteration was worsening or shows signs and symptoms of infection or no improvement in fourteen days. R2's Skin Issues/ Skin Check notes indicated the following:4/7/26 at 3:38 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft (groove between the buttocks that extends from just below the sacrum to the perineum, containing the anus). The skin check failed to include if education was provided, if family and/or provider were updated and clinical suggestions. 4/14/26 at 3:20 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. Clinical suggestion indicated apply barrier cream to skin. The skin check failed to include if education was provided and if family and/or provider were updated.The skin assessments lacked indication a skin check was performed on R2 the week of 4/21/26.4/28/26 at 3:13 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions. 5/5/26 at 12:26 p.m., Skin Check: skin issue needs review, in-house acquired MASD on intergluteal cleft. The skin check failed to include if family and/or provider were updated and clinical suggestions. During an interview on 5/20/26 at 3:56 p.m., the family member (FM)-D stated R2 had a wound on her bottom for the third or fourth time since admission, because facility staff didn't change R2's incontinence brief frequent enough and R2 laid on her backside in bed for hours in a row. The FM-D stated, If the wounds had been found before they were open, they might not be so painful to clean. During an interview on 5/26 26 at 10:09 a.m., the licensed practical nurse (LPN)-B stated R2 had ongoing MASD. It was possible the treatment was not working because the MASD kept returning. The treatment included to apply a barrier cream and reposition R2 every two to three hours. The LPN-B stated skin checks were performed each week during the resident's bath time. If not completed weekly, skin breakdown not previously identified could be missed. During an interview on 5/26/26 at 12:29 p.m., the nurse practitioner (NP)-A stated if R2 did not get the wound checks and assessments as ordered, new wounds could be missed, or the wounds could get worse.During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated staff told the wound team about wounds on R2's bottom, but during assessment, the wound team did not locate the wounds. Pictures of the wounds were sent to the wound care team weekly for two weeks. R2's skin was assessed following each notification of wounds, but the wound team did not find the wounds. After R2's family got upset with the DON, the wound team looked a third time and moved skin folds. Two wounds were noted on R2's perineum (region of the body located between the thighs, between the anus and vaginal opening). The RN-B stated the wounds were likely present during first two assessments but were not seen by the wound team due to R2's body size. RN-B stated with the initial two attempts to find the reported wounds, the wound team did not move R2's skin folds as thoroughly as was done with the third attempt. The RN-B stated she didn't think repositioning in a wheelchair would make a difference, but instead it was the sitting on the area that was likely causing the issue. The RN-B stated she was unsure if that education was provided to the family and did not find any documentation indicating education to the family had occurred. The RN-B acknowledged R2 did not have a skin check the week of 4/21/26 and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, New wounds could be missed when the assessments were not done weekly. During an interview on 5/26/26 at 3:31 p.m., the DON stated R2 had previous MASD wounds, and then recently staff found them again. Ensuring skin checks are completed timely, education about refusals of care, and keeping R2 as dry as possible were keys to ensure MASD didn't occur. The DON acknowledged R2 did not have a skin check on 4/21/26 but should have and acknowledged skin checks were utilized to discover new skin issues, and skin issues forms were utilized to assess current skin issues, and stated It could have potentially made a difference if that skin check had been done. I wish we had noticed the wounds sooner. R4R4's Medicare 5-Day MDS dated [DATE], indicated R4 had intact cognition, was dependent upon staff for applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer, diabetes, and diabetic foot ulcers. R4's care plan indicated the following:5/4/23 difficulty sleeping6/13/23 type II Diabetes6/13/23 altered cardiac status related to congestive heart failure (chronic progressive condition in which the heart cannot pump blood efficiently enough to meet the body's needs) and hypertension (high blood pressure)7/24/23 peripheral vascular disease (slow progressive circulatory disorder characterized by the narrowing, blockage, or spasms of blood vessels, most commonly reducing blood flow to the arms, legs, and feet5/12/25 impaired vision6/30/25 incontinence of bowel12/12/25 encephalopathy (broad term for any disease, damage, or malfunction that affects the brain's function, with an altered mental state that may include confusion, memory loss, or personality changes)4/2/26 actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (chronic condition of build-up of fluid from the lymphatic system (network of tissues, organs, and vessels that maintain fluid balance, absorbs dietary fats, and defends the body against infections and circulates lymph fluid (colorless, watery fluid) throughout the body) in the body's soft tissues, usually in the arms or legs often started with swelling in the hands or feet). Interventions included protecting bony areas with pillows and supportive devices initiated 1/6/22, and pressure relief ankle foot orthosis (PRAFO, used to stabilize the ankle, prevent foot drop, and eliminate pressure on the heels) boots on at all times, initiated 5/4/23.During an observation on 5/20/26 at 11:58 a.m., R4's heel protectors were lying on the floor near the end of R4's bed. R4's legs were resting directly on a disposable pad at the end of the bed.During an observation on 5/20/26 at 12:07 p.m., the RN-D entered R4's room to bring R4's meal tray and medication. R4's heel protectors were left lying on the floor near the end of R4's bed when the RN-D left R4's room.During an observation on 5/20/26 at 1:19 p.m., R4's heel protectors were lying on the floor near the end of R4's bed, the RN-D and the nursing assistant (NA)-B entered the room to perform wound care for R4. During wound care, R4 requested the RN-D and the NA-B don his protective boots and stated they were to be worn most of the time. When the wound care was completed, both the RN-D and the NA-A left the room without donning R4's protective boots. During an interview on 5/20/26 at 2:14 p.m., the RN-D stated R4 was supposed to wear his protective boots as much as possible to help prevent pressure ulcers and acknowledged she did not put them on R4 before leaving his room.During an interview on 5/20/26 at 2:18 p.m., the NA-B acknowledged he did not put R4's protective boots on R4's feet, and stated the boots were used to prevent openings on R4's skin.During a continuous observation on 5/22/26 starting at 1:13 p.m., R4 was in his room, R4's call light was activated. R4's protective boots were sitting in his recliner. At 1:51 p.m., the NA-C answered R4's call light. R4 asked the NA-C to don his protective boots. The NA-C responded, Right now? Your aide will be back from break soon. R4 explained to the NA-C that his protective boots should have been put on in the morning after being weighed. The NA-C shut R4's door. When the NA-C opened the door again at 1:54 p.m., R4 was wearing the protective boots.During an interview on 5/22/26 at 1:13 p.m., R4 stated he asked a NA several times what was in his recliner, and the NA had responded only a pillow was in the recliner. R4 stated he had poor vision and could not see what was in his chair for himself, could not feel his legs from his knees to his feet, so he did not know staff had not donned his boots. R4's routine was to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have his weight checked daily around 6:30 a.m., and staff would don his boots afterwards to protect his feet and offload his heels.During an interview on 5/22/26 at 2:25 p.m., the NA-D stated he was R4's assigned NA for the morning shift, and R4 had asked what was on his recliner. The NA-D stated he knew from his care sheet R4 was supposed to be wearing his protective boots, but was not because the NA-D had gotten busy and had forgotten about them. The NA-D acknowledged R4 could develop more wounds if he were not wearing the protective boots. During an interview on 5/26/26 at 10:36 a.m., the licensed practical nurse (LPN)-D stated R4 legs were supposed to have bandages, black stockings over the bandages, and protective boots over the stockings. If R4 doesn't wear the protective boots, his wounds can worsen, or he could develop new wounds. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated if R4's care plan and orders indicated to wear the protective boots, then R4 should have been wearing them. During an interview on 5/26/26 at 3:31 p.m., the DON stated R4 was supposed to always wear the protective boots on his feet when he was in bed to float his heels off the bed, and to prevent new wounds. Without the boots, R4 was at risk for new PU. The Skin Management Program dated 11/2017 indicated the program was utilized to promote the prevention of alterations in skin integrity, promote healing of skin alteration, and to prevent further loss of skin integrity. All residents will be assessed for skin integrity alterations or changes in skin conditions upon preadmission screening, admission, daily within the plan of care, and weekly with a bath. A body audit will be completed weekly, preferably on bath day. Risks for impaired skin integrity included impaired mobility, decreased functional ability, co-morbid conditions such as end stage renal disease, diabetes, obesity, cognitive impairment, exposure to moisture on the skin, resident refusal, pain, and poor sleep. Interventions for skin integrity management included heel protection, skin observations during cares, and management of incontinence.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to follow orders for catheter removal and failed to ensure catheter was in place for a valid medical reason for 1 of 3 residents (R1) reviewed for catheter care. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, impairment in both upper extremities, dependence upon staff for lower extremity dressing, and diagnoses that included kidney disease, hypertension, liver disease, and a history of urinary tract infection (UTI) in the previous 30 days. R1's provider orders dated 4/18/26, indicated remove the Foley catheter (type of indwelling urinary catheter, used to drain urine from the bladder) on 4/23/26. ˆ R1's medication orders indicated the following: 4/18/26 furosemide (diuretic - medication used to promote the production of urine by the kidneys used to flush out excess salt and water) 40 milligrams (mg), starting 4/19/26 give 40 mg by mouth one time daily for acute congestive heart failure (condition where the heart muscle becomes too weak or stiff to pump blood efficiently) for 3 days 4/23/26 furosemide 20 mg, give 20 mg mouth related to congestive heart failure for 3 days for edema, in the morning and evening 4/29/26 Lasix (name brand for furosemide) 40 mg one time a day at 8:00 a.m., and 20 mg one time a day at 1:00 p.m., for edema ˆ R1's care plan was reviewed on 5/22/26, and lacked a focus area for R1's Foley catheter. ˆ R1's progress notes dated 4/20/26 at 9:28 a.m., as a late entry, indicated R1 was re-admitted to the facility after hospitalization on 4/18/26, with diagnoses that included septic shock (serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), lymphedema (swelling caused by accumulation of protein-rich fluid in the body's tissues), heart failure, elevated liver function tests and was treated with antibiotics for UTI. R1 had a Foley catheter placed, to be removed in three-to-five days. R1's progress notes dated 4/23/26 at 2:42 p.m., indicated registered nurse (RN)-A spoke with R1's provider and received the order to keep the Foley catheter inserted because the resident did not want to be turned for brief changes. R1 would need frequent brief changes because she had started taking a diuretic. If R1 refused to be changed, she could have moisture associated skin damage. The progress note lacked mention of education to R1 about the risks and benefits of leaving the catheter inserted. R1's provider noted dated 4/29/26, indicated R1 had an indwelling Foley catheter for comfort because R1 was taking a diuretic. During an interview on 5/19/26 at 11:33 a.m., hospital social worker (SW)-A stated when R1 discharged from the hospital on 4/18/26, the catheter was supposed to be removed within five days, but when R1 readmitted to the hospital, R1 still had a catheter.ˆ ˆ During an interview on 5/21/26 at 2:46 p.m., family member (FM)-A stated R1 had an indwelling urinary catheter. R1 did not want it out because R1 had started taking a diuretic. Without the catheter R1 would require more frequent incontinence brief changes and bed linen changes. Staff asked R1 once to change the catheter, but R1 refused. Staff called R1's FM-B when R1 refused to eat and FM-B would come to the facility to get her to eat but did not call FM-B when R1 refused to have her catheter changed. The FM-A stated when R1 went to the hospital on 5/6/26, she was very sick, and when R1 refused her catheter change on 4/23/26 and 4/27/26, she may have already been sick and may not have understood what she was refusing or why it was important to take it out.ˆ ˆ During an interview on 5/22/26 at 10:14 a.m., FM-B stated he asked a nurse at the facility if they were going to change or remove R1's catheter and was told they would, but it never happened. FM-B stated he could not remember who he spoke to, nor which day he inquired about the catheter.ˆˆ ˆ During an interview on 5/22/26 at 2:54 p.m., registered nurse (RN)-A stated she did not recall the date, but when she attempted to remove R1's catheter, R1 didn't want the catheter removed. When a resident refused care, staff were supposed to provide education about the order, the risks and benefits of refusing care, and notify the provider of the refusal. The RN-A stated she notified the nurse practitioner (NP) R1 didn't want the catheter removed and told the nurse manager. The RN-A stated (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 had the right to refuse because she was alert and oriented. RN-A acknowledged she did not see any indication in the electronic health record education was provided to R1 about why the catheter was supposed to be removed or the risks and benefits of leaving it inserted. ˆ During an interview on 5/21/26 at 4:04 p.m., the NP-A stated if R1 returned from the hospital with a urinary tract infection (UTI), then the facility should have changed the catheter. The NP-A stated if R1 refused to allow the catheter change, staff should have reapproached R1 later to try again, talked to family to see if family could reason with her, and should have provided education to R1 about the risks and benefits of leaving the catheter in when it was ordered to be removed. The NP-A stated R1's infection could have gone septic because the catheter was not removed.ˆ During an interview on 5/26/26 at 2:46 p.m., the medical director stated a resident should be notified of the risks of leaving a catheter inserted when it was ordered to be removed, it was the resident's primary provider's responsibility to provide the education, make sure the resident understood the education, and document it because leaving the catheter in could cause sepsis. The facility should have tried to remove it, and if that failed, document why it failed. The medical directed expected the facility to document the need for the catheter. The regulations are clear and very limited for diagnoses related to using an indwelling urinary catheter. It was used for comfort for [R1]. [R1] needed to know the risk of infection, and that infection could lead to sepsis. Communication with the [R1] would have been the most vital point, and the catheter use would be flagged for inappropriate use. [R1] was very frail, very compromised, had melena (dark stool) that indicated a bleed in the upper gastrointestinal area. Her death certificate indicated sepsis and hemorrhagic (severe or excessive bleeding) shock. With her low blood pressure, the bleeding likely caused her death. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated there were no progress notes that indicated staff or the provider educated R1 about the risks and benefits of leaving the Foley catheter inserted, it was not left for an appropriate reason, and it was the provider's decision, despite it being inappropriate. The Incontinence Policy dated 5/1/26 indicated for residents with urinary incontinence, the facility will ensure that residents are not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. Residents who enter the facility with an indwelling catheter, or received one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization was necessary.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues) care was provided as ordered for 1 of 4 residents (R1) reviewed for wound care. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, impairment in both upper extremities, and dependence upon staff for lower extremity dressing. R1's diagnoses included kidney disease, hypertension, and liver disease. R1's Hospitalist Discharge summary dated [DATE], indicated R1 was admitted [DATE] with septic shock (a serious medical condition that occurs when an infection leads to dangerously low blood pressure and organ failure), acute kidney injury, elevated liver function test, chronic lymphedema with significant skin changes, required an increase in hospital resources and staff for care related to severe obesity, and was treated in the intensive care unit (ICU) for the management of septic shock. R1 was stable when transferred back to the facility on 4/18/26. Regular activity was encouraged including getting up in a chair for each meal, consider going to the bathroom routinely while awake, and turn often while in bed. R1's hospital discharge orders dated 4/18/26 indicated the following:After caring for wounds, date the dressing and change dressing prior to each lymphedema physical therapy (PT) wrap change on Mondays, Wednesdays, and Friday (MWF) or as needed (PRN) for saturation, loss of integrity, or soiling. Physical therapy evaluation and treatment: lymphedema treatment R1's provider orders indicated the following:4/18/26- occupational therapy to evaluate and treat4/18/26- physical therapy to evaluate and treat4/20/26- lymphedema treatment4/23/26- wrap bilateral lower extremities with Kerlix (gauze wrap) and then ACE wraps (compression wraps) one time a day for edema, on in the morning, off at bedtime R1's April 2026 Treatment Administration Record (TAR) indicated the following:Kerlix wraps resumed as ordered on 4/24/26 R1's care plan dated 3/27/26, indicated R1 wore ACE wraps, on in the morning, and off at bedtime. The care plan lacked the indication for use and lacked mention of lymphedema treatment with compression and leg pumps. R1's PT Encounter Notes indicated the following:4/20/26- R1 would not allow the PT to touch her legs due to pain, unable lift either leg from the surface of the bed.4/22/26- R1 seen for evaluation of lymphedema and reported severe pain with light touch of either leg, severely progressed lymphedema to stage 4 (the most severe and advanced stage characterized by massive swelling, significant skin thickening, scarring, and wart-like growths that can severely limit mobility which can result in persistently heavy, achy, and fluid leakage areas of the skin). Measurements of the right lower extremity girth had significantly increased. Recommend proceeding with compression at the discretion of the doctor due to open areas and weeping of the skin. R1 would not be able to tolerate wrapping her legs in the current condition due to pain, but benefit from using her lymphedema pumps (medical machines that are rhythmic, forced air to inflate a specialized sleeve worn over a swollen limb that reduce swelling by mimicking natural lymphatic massage, gently pushing excess lymph fluid out of the extremities and back towards the core for circulation) if allowed. During an interview on 5/21/26 at 2:46 p.m., the family member (FM)-A stated R1 was admitted to the facility for lymphedema care because R1 and FM-A were told the facility had a lymphedema specialist. We were told they had the position open for months but could not fill the position. The person who used to wrap them at a previous facility offered to come to the facility to train the staff how to wrap [R1's] legs properly, but was told the staff knew how to wrap them, and didn't allow that person to come. During an interview on 5/21/26 at 4:04 p.m., the nurse practitioner (NP)-A stated R1 was supposed to have lymphedema treatment. The facility had a lymphedema specialist who resigned. The facility could have sent R1 out for lymphedema therapy but had not. Nursing staff were doing wraps instead. During an interview on 5/22/26 at 10:14 a.m., the FM-B stated R1 was supposed to have compression pumps to treat lymphedema and was supposed to wear them for a couple of hours a day. The facility staff told the FM-B they didn't want to do it because they didn't have an order for it. The FM-B didn't (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand why the facility couldn't get an order to use them. The FM-B stated he was having to help with the compression pumps but that was the service they were paying for. The FM-B stated he assisted R1 with the pumps every other day because the facility staff would not do it. During an interview on 5/22/26 at 11:22 a.m., the admissions coordinator (AC)-A stated R1 had orders for lymphedema care upon admission, which used to be managed by the therapy department, but was now managed by the nursing department. When R1 was admitted to the facility on [DATE], her orders indicated PT lymphedema treatment, and on 3/12/26 R1 had orders from the hospital for PT lymphedema treatment. The facility should not have taken R1 if she didn't have orders for the compression pumps, or if PT staff were not available manage the treatments. During an interview on 5/22/26 at 11:54 a.m., the physical therapist (PT)-A stated R1 used compression pumps at home and another facility prior to admission to this facility. R1 was able to demonstrate how to correctly use the pumps. The therapy department advocated for R1 to continue to use the compression pumps because R1's legs got very large with fluid, and the pumps would have helped push some of the fluid out of her legs. The PT-A stated the facility director of nursing (DON) did not allow R1 to use the pumps initially because the nursing department was not familiar with the pumps. Then the DON wouldn't allow R1 to use them out of fear R1 could not shut the pump off if she needed to. R1 demonstrated to the therapy department that she could turn the power off, and unzip the compression sleeves. R1 further demonstrated she understood the settings on the pumps, but was still not allowed to use them. The PT-A stated R1's hospital orders indicated she was supposed to have PT lymphedema therapy which was available for a couple of days a week when R1 admitted to the facility, but not for the daily treatment she needed. The PT staff who was trained to do lymphedema treatment was only on site twice a week, and having just come from the hospital, that would not have been enough to manage the lymphedema. The PT department was trying to eliminate the barriers to using the pumps, but they were just not allowed. During an interview on 5/22/26 at 2:54 p.m., the registered nurse (RN)-A stated the therapy department provided lymphedema care for R1, the nursing staff placed bandages and ACE wraps on R1's legs for lymphedema, and R1's husband put lymphedema pumps on R1's legs. The nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at approximately 1:30 p.m., the RN-B stated R1 did not have a care plan for lymphedema care because nursing staff was not trained for lymphedema care. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated R1 was admitted to the facility with orders for lymphedema wraps for her legs, which the facility therapy department provided but at some point (the DON didn't know the date), the therapy department deferred R1's lymphedema care to the nursing staff. Instead, R1's family member was managing R1's compression wraps and pumps. There was a six-to-seven-day delay for the therapy department to do the assessment to ensure R1 and her family member knew how to use the pumps. It should not have taken that long. The nursing staff was not trained to use compression sleeves and pumps. It was 3/25/26 when therapy stated she could use them. The DON stated she was unsure why the PT notes indicated on 4/22/26 R1 would benefit from using them, R1 should have been using them, with the help from her husband, but the DON was unsure if they were in use. The DON stated the delay in care for the lymphedema pumps could have contributed to R1's legs swelling more. A policy about lymphedema care was requested but not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and document review, the facility failed to maintain an effective infection prevention and control program by ensuring staff utilized proper hand hygiene and appropriate glove use during wound care treatments for 1 of 1 resident (R4) reviewed for wound care. Findings include: R4's Medicare 5-Day Minimum Data Set (MDS) dated [DATE] indicated R4 had intact cognition, was dependent upon staff for activities of daily living (ADLs) including applying footwear, had a pressure ulcer, and was at risk of developing additional pressure ulcers. R4's diagnoses included an unstageable pressure ulcer (a severe wound with full-thickness skin and tissue loss where true depth and severity of the damage cannot be determined), diabetes, and diabetic foot ulcers . R4's care plan indicated the following:4/21/25- chronic methicillin-resistant Staphylococcus aureus (MRSA, bacteria that have developed resistance to common antibiotics) in wounds requiring standard precautions for infection control6/30/25- incontinence of bowel4/2/26- actual and potential impairment to skin integrity related to immobility, diabetes, obesity, incontinence, chronic moisture associated skin damage (MASD), and lymphedema (swelling caused by an accumulation of protein-rich fluid in the body's tissues). Interventions include treatments as ordered, initiated 1/6/22. R4's wound care orders dated 5/19/26, for wounds on bilateral lower legs and heel indicated the following:Cleanse the wound bed with Vashe (professional grade wound cleansing solution) and pat dryPlace silver non-adherent contact layer - green package - cut to fit wound, over open wounds. Cover with 4 x 4 gauze or abdominal pad (ABD) and secure with Kerlix (gauze for wrapping around the leg)Change every 48 hours or as needed for saturation, soiling, or dislodgement. During an observation on 5/20/26 at 1:10 p.m., the registered nurse (RN)-D provided wound care for R4. The RN-D cleansed the wound on R4's right leg, doffed her gloves and then donned clean gloves without performing hand hygiene between glove changes. R4 asked the RN-D to don his compression stocking on his right leg before performing wound care on the left leg. The RN-D donned R4's right compression stocking and then removed the dirty bandages from R4's left leg. R4 cleaned the wound and applied clean bandages over the wounds on R4's left leg without changing gloves. During an interview on 5/20/26 at 2:14 p.m., the RN-D acknowledged she was supposed to perform hand hygiene between gloves changes, and change gloves after removing soiled dressings, before applying clean dressings to prevent infection, but had not because she forgot. During an interview on 5/26/26 at 3:31 p.m., the director of nursing (DON) stated when performing wound care, nurses should change gloves between touching anything dirty and anything clean and between wounds. The DON expect the nurse to perform hand hygiene in between gloves changes to prevent infection in the wounds. An infection control policy for wound care was requested but not provided.