STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerenity Care Center on Humboldt	512 Humboldt Avenue Saint Paul, MN 55107

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to accurately assess 1 of 3 residents (R1) reviewed upon admission to the facility. R1 was admitted with two pressure ulcers, a deep tissue injury and a shearing wound that the facility did not assess or create inventions for during his stay at the facility. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since 1/6/23 -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. -A Peripheral inserted central catheter (PICC) single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's skin assessment dated [DATE] at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one or more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound. No description information was documented. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in moving. -R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications of dressing. No other measures were taken. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, his skin was not good. She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin red, raw, and bleeding on his buttocks. She stated she believed the nursing staff was aware of his skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his bottom and back had rashes all over that were bleeding from multiple open areas. She stated that the nursing department was aware because they would assist NA-C to change R1 and clean him when he was incontinent. She stated R1 would cry whenever the skin on his back was touched. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would look into that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that she wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff does the skin observations and reports concerns to her or refers the residents directly to wound care. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated R1 did not admit with any wounds. She stated a few days after admission R1's FM-A was asking about using acetic acid on his back however RN-A stated R1 did not have any rash or redness. RN-A stated she was not aware of the documented wounds on the hospital discharge. She stated the wounds were more than likely overlooked because there were no orders attached to them from the hospital. RN-A was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out to the facility, did not seen R1 on that date and R1 was discharged on [DATE]. Upon interview on 7/11/24 at 1:53 p.m. RN-B the Resident Assessment Instrument (RAI) coordinator stated she was aware that R1 had some shearing on his buttocks, surgical sutures and a PICC line. She stated she was not aware of any other wounds. RN-B stated she does not observe residents directly when completing her assessments, she goes by what the staff has documented. Upon interview on 7/11/24 at 2:09 p.m. licensed practical nurse (LPN)-A, Infection Preventionist stated she added to R1's care the intervention for wound care to see R1 weekly. She stated the reason was because he had a surgical wound with known infections. She was not aware of any other wounds. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had, what appeared to be, a couple of open blisters that had popped on two of R1's toes. He stated due to shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.

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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** 44649 Based on interview and record review the facility failed to comprehensively assess and follow the hospital discharge orders to keep a cast completely dry for 1 of 3 residents (R1) reviewed for orders. R1 was harmed when he was admitted to the facility with a post-surgical cast covering his right leg with orders that the cast must remain dry, and the facility failed to keep the cast dry. R1 was sent to the hospital where the cast was found to be soiled with urine and feces, contributing to continuous infections. Findings include: R1's hospital discharge information to the facility dated 6/25/24 indicated R1 was medically complicated. R1 had a right knee open reduction dislocated hinged total knee arthroplasty revision on 6/20/24 with confirmation of infectious bacteria: staphylococcus aureus and pseudomonas aeruginosa. Following the lab results R1 underwent placement of a peripherally inserted central catheter (PICC) line to directly treat the bacteria infections with antibiotics. R1 had a history chronic and multiple episodes of bacteremia: methicillin-susceptible staphylococcus aureus (MSSA), group B strep, pseudomonas aeruginosa, corynebacterium, and s. epidermidis. of the right infected total knee prosthesis dating back to 2020. R1's active problem list also included atrial fibrillation, cardiomyopathy ischemic, coronary artery disease, chronic kidney disease stage 4, obesity, presence of automatic cardiac defibrillator with pacemaker, declined functional status, delirium, history of right fractured ankle with open reduction and internal fixation (ORIF) 2021 and left knee arthroplasty total knee replacement 2021, history of left shoulder arthroscopy date unknown with a current views on 6/19/24 indicating the surgical components appeared intact. R1 had history of falling, deep vein thrombosis, anemia, anxiety, obstructive sleep apnea. R1's hospital after visit summary dated 6/26/24 indicated R1's knee incision was covered by a long leg cast. Do not put anything under the cast. Keep the cast completely dry. R1 was to maintain the long leg cast until a return appointment on 7/9/24. Do not let cast get wet, if does get wet, notify the orthopedic surgeon immediately. R1's skin assessment dated [DATE] at 7:10 p.m. indicated R1 was always continent of bowel. No intervention of bowel care was initiated on the care plan. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects (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 0684 Level of Harm - Actual harm Residents Affected - Few	-Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan failed to document problem, goals, and an approach for R1's toileting, transferring, and what assistance was required for activities of daily living. R1's care plan failed to assess whether R1 was to wear an incontinent pad or not or if he were to use the urinal by himself. In addition, R1's care plan did not identify that R1's cast was to kept dry and methods to keep it dry. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Progress note dated 7/5/24 at 8:58 a.m. indicated: R1 had a covered cast on his right knee, no drainage noted. R1 had dull pain of his right knee. R1's toileting was dependent. R1's skin condition was not assessed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	emergency room encounter 7/7/24 at 8:51 p.m. indicated R1 was an [AGE] year-old male with multiple medical problems from a facility with failure to thrive, decreased mental status and fatigue. Recently R1 was discharged from another hospital after he was found to have an infected right total knee replacement. R1's groin was red and irritated with no signs of Fournier's gangrene. His cast was soaked in the upper and half due to urine. His left lower extremity was all bandaged and specifically a dorsal wound of the third toe which appears to be infected. Posteriorly R1 had Stage II (partial loss of skin, but no deeper than the dermis) pressure ulceration on his essentially backside from the mid-thigh through the mid lumbosacral (five large vertebrae that make-up the lumbar portion of the spine) region. R1 will be sent to larger hospital where he had surgery for further care as well as treatment. emergency room nursing note dated 7/7/24 at 11:48 p.m. R1 came in looking red, flush, and complaining of pain. Upon skin assessment staff noticed the following: -Red, swollen skin to the scrotum, penis and peri-area, penis had a large amount of smegma (thick cheesy secretion around genital that collects when not washed regularly). -Skin around R1's cast on the right leg was excoriated, red and non-blanchable and cast was noted to have a strong odor to it along with being saturated with urine and stool. -Left arm had a cast stocking on it from the hand to midway past the elbow, damp and visually soiled. Hospital admission note dated 07/08/24 at 12:00 p.m. indicated R1 presented with septic shock secondary from infected right knee on 7/8/24. His dressing was removed by orthopedics and noted significant soiling of the dressing with concern for infection of the knee. R1 was transferred to the intensive care unit (ICU) for continuing care on 7/9/24. Orthopedic surgeon was planning a washout vs. amputation of R1's right leg. Infectious disease summary 7/8/24 indicated on admission R1 was found to have fecal and urine contamination of his right knee incisions under the cast. His incisions were noted to be macerated (a softening and breaking down of skin resulting from prolonged exposure to moisture) and dehiscence (separation of wound edges). He was also noted to have foul smelling drainage. Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, stated R1 was incontinent of bowel and bladder and often had diarrhea. R1's urinal would spill under him because he would leave I between his legs and fall asleep. Staff checked on him every two hours, but when he was finished using the urinal, he would not press the call light when he was finished with the urinal. NA-A stated no other means of toileting was attempted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 7/10/24 at 3:23 p.m. Family member (FM)-A stated R1 arrived at the large regional hospital and was awaiting amputation of his right leg. She stated at the emergency room (ER) R1's cast was cut off due to the odor and then staff found the entire cast was seeping with urine and feces. FM-A stated the ER noticed the infected surgical knee sight and immediately notified the hospital where he had surgery and wanted him sent back due to their ability to handle infections of that level. FM-A stated she noted the smell of urine and feces in his room and noticed the top cloth portion of the cast was yellow with urine. She stated the facility did not speak with her about interventions other than a urinal to keep him dry. The facility did not drape anything over the cast, discuss a catheter or make an attempt to stop his diarrhea. Upon interview on 7/10/24 at 4:01 p.m. occupation therapist, (OT)-A stated she was only saw R1 on one occasion and that was the day after his admission when she completed her assessment. She stated she attempted to sit R1 at the edge of his bed and he became incontinent of very runny stool. Cleaning him required the assistance of the nursing assistants. She stated she does not recall the stool getting on his cast, but did not see how it could not, as he had to be laid down in bed and rolled to be cleaned. She stated she was aware that R1 used a urinal for urination and stated it was right of the family to choose the method they prefer. She stated occupation therapist assistant (OTA)-A told her R1 frequently had his urinal between his legs, and it would spill. OT-A stated she did not do another assessment on R1's safe use of a urinal. She stated nursing would be more likely to do that as they do the bowel and bladder assessment. OT-A stated R1 had been incontinent of bowel and bladder since his day of admission to the facility. Upon interview on 7/10/24 at 4:41 p.m. R1's orthopedic surgeon stated, in a few moments R1 was going to have his right leg amputated above his knee. He stated, I can't say 100% that the urine and feces filled cast caused the infection requiring amputation, but it certainly had a contributing factor. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she did not notice any odor or urine on R1's cast. She stated that the facility did not reach out to her and ask for a catheter or any other invention, such as a barrier cover. She stated having R1 use a urinal with a cast within inches of R1's right groin and a dislocated left shoulder was not a good plan for a cast needing to stay dry. She stated she was not aware R1 was having diarrhea therefor no interventions were ordered. Upon interview on 7/11/24 at 11:10 a.m. R1's occupation therapy aide (OTA)-A stated she did notice frequently when she went to work with R1 that he had a urinal between his legs and his bedding was soiled. She stated she did not notice the cast was soiled. She stated on the 7/7/24 she assisted the nursing assistants with cleaning R1 after an episode of diarrhea. She stated that the feces did get on the cast and cast was yellow tingled from urine. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated that she was aware that R1 used a urinal, she was not aware of any spillage from the use. She denied staff ever reporting that the cast had gotten soiled if it did the surgeon would have been called immediately. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing and treating the residents to follow the resident's orders. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the resident assessment instrument (RAI) tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Abuse Prevention Plan Prevention dated 2017 indicated neglect is the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0686 Level of Harm - 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** 44649 Based on interview and record review the facility failed to ensure 1 of 3 residents (R1) reviewed for pressure ulcers received care consistent with professional standards of practice to prevent pressure or worsening of pre-admission pressure ulcers. R1 was harmed when the facility failed to promote healing of current pressure ulcers and prevent new ulcers from developing. R1 was admitted with two pressure ulcers, and a shearing wound on 6/26/26. R1 discharged from the facility on 7/7/14 with three pressure ulcers and the shearing wound turned into stage II pressure ulcers in multiple areas from his thigh to his mid-dorsal back. R1's hospital discharge information to the facility dated 6/25/24 indicated R1 was medically complicated. R1 had a right knee open reduction dislocated hinged total knee arthroplasty revision on 6/20/24 with confirmation of infectious bacteria: staphylococcus aureus and pseudomonas aeruginosa. Following the lab results R1 underwent placement of a peripherally inserted central catheter (PICC) line to directly treat the bacteria infections with antibiotics. R1 had a history chronic and multiple episodes of bacteremia: methicillin-susceptible staphylococcus aureus (MSSA), group B strep, pseudomonas aeruginosa, corynebacterium, and s. epidermidis. of the right infected total knee prosthesis dating back to 2020. R1's active problem list also included atrial fibrillation, cardiomyopathy ischemic, coronary artery disease, chronic kidney disease stage 4, obesity, presence of automatic cardiac defibrillator with pacemaker, declined functional status, delirium, history of right fractured ankle with open reduction and internal fixation (ORIF) 2021 and left knee arthroplasty total knee replacement 2021, history of left shoulder arthroscopy date unknown with a current views on 6/19/24 indicating the surgical components appeared intact. R1 had history of falling, deep vein thrombosis, anemia, anxiety, obstructive sleep apnea. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since 1/6/23 -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-A Peripheral inserted central catheter (PICC) single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's after visit summary dated 6/26/24 indicated on 10/27/22 - present for R1's dermatitis perianal was to include acetic acid soaks for 15 minutes followed by zinc oxide keeping the area open and dry. R1's skin assessment dated [DATE] at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound, no description documented. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan dated 6/27/24 did not indicate R1 had any pressure ulcers. In addition, R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's care plan failed to assess whether R1 was to wear an incontinent pad or not or if he were to use the urinal by himself. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: -R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in moving. R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications of dressing. No other measures were taken, and the care plan was not updated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Progress note dated 7/5/24 at 8:58 a.m. indicated: R1 had a covered cast on his right knee, no drainage noted. R1 had dull pain of his right knee. R1's toileting was dependent. R1's skin condition was not assessed. R1's nursing progress note dated 7/5/25 at 10:17 a.m. R1's family member (FM)-A was in the facility taking pictures of R1's skin. FM-A started placing acetic acid to skin on R1's buttocks and told the NA she was going to leave it on for 1 hour. FM-A stated this was the order that the hospital was performing. LPN-A attempted to education FM-A that an hour was too long. FM-A stated this is the only way the redness will improved. FM-A stated that R1's bottom was very red, sore, and bleeding in areas where the skin is excoriated or split open. LPN-A observed the skin the prior day and the skin was red and intact. FM-A also asked when R1 had his last oxycodone (a narcotic pain medication) as FM-A felt R1 was too sedated. R1 had not received any oxycodone since 7/2/24 at 2:00 p.m. FM-A did not want R1 to receive any more oxycodone, but also stated R1 was in so much pain because of his bottom hurt him. LPN-A explained R1 will not lay in bed on his side, he sits in a chair or lies on his back and the skin does not get any relief. FM-A stated that the staff are not making him lie on his side. LPN-A stated the staff cannot make him change position. LPN-A called the primary care clinic triage and left a message for the NP regarding pain management and informed her that FM-A was doing acetic acid treatments and leaving on the skin for a longer period that was order. The progress note did not indicate a description of R1's skin on 7/5/25 just the prior day observation or what the facility was doing for the R1's skin. emergency room encounter 7/7/24 at 8:51 p.m. indicated R1 was an [AGE] year-old male with multiple medical problems from a facility with failure to thrive, decreased mental status and fatigue. Recently R1 was discharged from a regional hospital after he was found to have an infected right total knee replacement. R1's groin was red and irritated with no signs of Fournier's gangrene. His cast was soaked in the upper and half due to urine. His left lower extremity was all bandaged and specifically a dorsal wound of the third toe which appears to be infected. Posteriorly R1 had Stage II (partial loss of skin, but no deeper than the dermis) pressure ulceration on his essentially backside from the mid-thigh through the mid lumbosacral (five large vertebrae that make-up the lumbar portion of the spine) region. R1 will be sent back to the [NAME] larger hospital where he had surgery for further care as well as treatment. emergency room nursing note dated 7/7/24 at 11:48 p.m. R1 came in looking red, flush, and complaining of pain. Upon skin assessment staff noticed the following: -Red, non-blanchable, grossly excoriated, bleeding skin of the gluteus maximus, gluteus Medius, and gluteus minimus. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Red, swollen skin to the scrotum, penis and peri-area, penis had a large amount of smegma (thick cheesy secretion around genital that collects when not washed regularly). -Red excoriated skin to the right abdominal folds and right axillary. -Skin around R1's cast on the right leg was excoriated, red and non-blanchable and cast was noted to have a strong odor to it along with being saturated with urine and stool. -Left thigh, knee and shin aberrations from leg rubbing on the cast. -Left arm had a cast stocking on it from the hand to midway past the elbow, damp and visually soiled. -Left top of foot had an open sore weeping serosanguinous drainage. Hospital admission note dated 07/08/24 at 12:00 p.m. indicated: #1 Wound 07/08/24 Incontinence Associated Dermatitis Buttocks and posterior thighs. Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Buttocks Wound Description (Comments): and posterior thighs Shape Irregular *Wound Bed Open; Red; Shiny Tissue Exposed None Odor None Exudate Amount Small Drainage Description Serosanguineous Peri-wound Assessment Fragile ;Friable; Painful; Rash #2 Wound 07/08/24 Incontinence Associated Dermatitis Groin Bilateral and thighs. Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Groin Wound Location Orientation: Bilateral Wound Description: and thighs Shape Irregular *Wound Bed Closed; Red; Shiny Odor None (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Friable; Painful; Red; Rash #3 Wound 07/08/24 Intertriginous Dermatitis Pannus Right Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Pannus Wound Location Orientation: Right Shape Irregular *Wound Bed Closed; Red; Shiny Odor None Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Fragile; Red; Rash #4 Wound 07/08/24 Intertriginous Dermatitis Axilla Bilateral Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Axilla Wound Location Orientation: Bilateral Shape Irregular *Wound Bed Closed; Red; Shiny Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Maceration; Rash #5 Wound 06/21/24 Pressure Injury Stage 4 Toe Third Left; Dorsum Date First Assessed/Time First Assessed: 06/21/24 1020 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 4 Location: Toe Third Wound Location Orientation: Left; Dorsum Shape Round / oval *Wound Bed Full thickness; Red; Yellow Tissue Exposed Bone (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Odor None Exudate Amount Small Drainage Description Sanguineous Peri-wound Assessment Intact #6 Wound 01/06/23 Pressure Injury Stage 3 Toe 2nd Right; Dorsum Date First Assessed/Time First Assessed: 01/06/23 1315 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 3 Location: Toe 2nd Wound Location Orientation: Right; Dorsum Shape Irregular *Wound Bed Red; Pink; Open Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Maceration Wound 07/08/24 Pressure Injury Deep Tissue Heel Right #7 wound Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Pressure Injury Pressure Injury Staging: Deep tissue Location: Heel Wound Location Orientation: Right Shape Round / oval *Wound Bed Black; Brown; Pink (mixed wound bed, evolving purple discoloration with sloughing edges revealing pink tissue) Tissue Exposed None Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Fragile (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, his skin was not good. She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin red, raw, and bleeding on his buttocks. Sometimes he would have an incontinence pad on and sometimes he would not, if he were having frequent diarrhea, staff would put an incontinent pad on and if not, staff would let him sit without an incontinence pad. She stated she believed the nursing staff was aware of R1's skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not. R1 used the urinal on his own and with staff assistance. The urinal would spill under R1 as he would leave the urinal between his legs and fall asleep. The urine would spill on his skin and his cast. Staff checked on him every two hours, but when he was finished using the urinal, he would not press the call light for assistance. Upon interview on 7/10/24 at 3:23 p.m. FM-A stated she visited R1 almost daily and she would find him incontinent of urine or stool. She stated R1 was not to have an incontinent pad on because his skin was to be open to air and she would often find him wearing one. She stated she left notes all over R1's room for what staff was to do for his skin care. She stated the staff was supposed to be doing an acetic acid treatment on his buttock and back. The facility told FM-A they did not have an order. FM-A called the nurse practitioner (NP) and told her R1's skin was getting worse, and she wanted the staff to follow the hospital recommendations. FM-A did not receive a response from the NP. She stated she took the acetic acid that he that hospital staff had used and started doing the cares herself. FM-A stated R1 was difficult to reposition, because of the dislocation to his left shoulder. She stated she would perform his repositioning by shifting him slightly with a pillow under one side of his buttocks to relieve pressure. She stated she asked staff to reposition him that way multiple times with no avail. FM-A asked an unidentified nursing assistant why R1 was wearing a pad and to please remove it and clean him as the pad was wet. The response FM-A received was, if he is wet, he did not need to be changed until the line on the pad turned blue. FM-A removed the pad herself and cleaned R1. Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his bottom and back had rashes all over that were bleeding from multiple open areas. She stated that the nursing department was aware because they would assist NA-C to change R1 and clean him when he was incontinent. R1 would cry whenever the skin on his back was touched. NA-C would sometimes find R1 in an incontinent brief and sometimes not she stated there were not specific instructions on that. She stated if staff did not put an incontinent brief on R1 they would have entire bed changes due to either urine or feces. Upon interview on 7/10/24 at 4:41 p.m. R1's orthopedic surgeon stated, the condition of R1's skin when he returned to the hospital from the facility was neglect. He stated please read all the hospital wound notes from his hospital discharge summary on 6/26/24 to his re-admission note on 7/8/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A had called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would investigate that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that the daughter wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff makes observations and reports concerns to her or refers the residents directly to the wound care. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated R1 did not admit with any wounds. She stated a few days after admission R1's daughter was asking about using acetic acid on his back however he did not have any rash or redness. RN-C stated she was not aware of the documented wounds on the hospital discharge. Acetic acid was listed on the discharge medication list and RN-A stated she thought that was maybe from a catheter he may have had. RN-A did not find out exactly what the acetic acid was recommended for. She stated the wounds were more than likely overlooked because there were no orders attached to them. RN-C was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out, did not seen R1 on that date and R1 was discharged on [DATE]. RN-A did not observe R1's skin directly during his stay. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had what appeared to be a couple of open blisters that had popped on two of R1's toes. He stated due to shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.