STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Care Center	55 Tenth Street Southeast Wells, MN 56097

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 0684 Level of Harm - Minimal harm or potential for 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** 39998 Based on interview and document review, the facility failed to comprehensively assess and monitor for change in condition following computer tomography with contrast dye to ensure appropriate and prompt treatment for 1 of 1 residents (R1) who was at risk for acute renal failure. Additionally based on observation, interview, and record review the facility failed to comprehensively assess, monitor, and treat wounds for 1 of 1 residents (R2) reviewed for non-pressure skin concerns. Findings include: R1's quarterly minimum data set (MDS) dated [DATE], indicated R1 had intact cognition and was dependent on staff for all dressing, toileting, personal hygiene, transfers, and mobility with wheelchair. Further identified R1 had diagnoses that included hemiplegia following a cerebral vascular accident (CVA), heart failure, renal (kidney) failure, diabetes mellitus (inability to regulate blood sugars), dementia, and morbid obesity. The MDS also identified R1 was at risk for pressure ulcers. R1's care plan dated [DATE], identified R1 had a provider order for life sustaining treatment (POLST) which include a do not resuscitate (DNR) and do not intubate (DNI) but did accept intravenous, oral, and intramuscular antibiotics. R1's care plan identified R1 was at risk for infections; had a self-care deficit requiring staff assistance; was resistive to care at times; had behavior problems toward staff; was at risk for falls; at risk for constipation; high risk for respiratory infections; on antidepressant medications; on anticoagulant (blood thinning) therapy; potential nutritional problem; an ulcer between 3rd and 4th toes; at risk for pain; high risk for skin breakdown; bladder incontinence; and at risk for potential abuse and neglect. R1's care plan did not identify management and/or risk of congestive heart failure or renal failure A physician order dated [DATE], identified R1 to drink 5 six to eight ounce glasses of water daily in preparation for a dye study to protect the kidneys. R1's Medication Administration Record (MAR) for [DATE] indicated on [DATE] an order was entered to encourage resident to drink at least ,d+[DATE] eight-ounce glasses of water daily in preparation for a dye study to protect his kidneys. The MAR did not contain any monitoring of oral fluid intake. The MAR also noted, and order started on [DATE] and discontinued on [DATE], to monitor VS two times a day; if O2 sat not maintained above 90% or fever develops patient needs to be seen. The MAR also identified an order entered on [DATE] to monitor for vitals two times a day for infection. This order entry identified R1 had an elevated temperature of 99.3 degrees (F). (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's record did not identify a physician was notified of an elevated temperature. R1's physician order dated [DATE], included weight one time daily for congestive hear failure. The order did not identify parameters in which the physician was to be notified for weight gain/weight loss. R1's daily weight log indicated R1 weighted 325 pounds on [DATE] and 334.5 pounds on [DATE] which was an increase of 9.5 pounds in a month with no documentation of physician notification of the increased weight and no evidence of further assessment of the weight gain to identify if the gain was related to fluid or nutritional related. R1's progress notes identified the following: [DATE] and [DATE], indicated R1 was out for appointments and returned with diagnoses of recurrent renal cell carcinoma with level two tumor thrombus (tumor extension into a vessel). [DATE] at 12:15 p.m., sent a physician request form to provider to request Mucinex and (as needed) prn neb [nebulizer]. [R1] present cough with mucus and complains of chest pain. COVID was negative. [DATE] at 2:03 p.m., family member (FM)-A would like [R1] watched closely to see if he needs an antibiotic. Mucus clear and does not have a fever. [DATE] at 3:10 p.m., received orders for DuoNebs (inhaler) and Mucinex (loosens congestion) prn and monitor VS (vital signs) and needs to be seen if fever or [oxygen] sats (saturations) below 90%. [DATE] at 5:30 a.m., temp. (temperature) 100.1 [degrees F]; oxygen sats 90% when lying down and 95% when sitting up on room air. Cough very loose. 7:39 a.m., called daughter and she wanted provider contacted. R1 was swabbed for RSV (respiratory syncytial virus) and FLU (influenza). 7:16 p.m., R1 tested negative for RSV, FLU, and COVID. [DATE] at 11:19 p.m., updated provider and received order for Zpak (used to treat bacterial infections). [DATE] at 11:45 a.m., R1 does not have as frequent of a cough and cough is not as moist and congested, afebrile (no fever). [DATE] at 8:11 a.m., writer reported to the nurse that she thought resident was full of fluid and needed to go to the hospital. [DATE] 11:31 a.m., resident awake since 4am [4:00 a.m.]; at 7 am R1 asked to lie down in bed and indicated not feeling well; temperature 99.3 [F], did not want breakfast, had chills, lungs [sounds] slightly diminished in bases. Documentation did not indicate provider was notified of change in condition and no further progress notes on [DATE]. [DATE] at 5:38 a.m. R1 awake at 1a.m., taken CPAP (continuous positive airway pressure machine to treat sleep apnea) off and refused to allow it back on, oxygen sats 93% on room air. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 10:35 a.m., [R1] assessed as he seems to be worse; audible wheezing and wet non-productive cough. O2 (oxygen) sats ,d+[DATE]% on room air. R1 stated he feels like shit and just might die. R1 had been eating and drinking minimally. Family in agreement to sent to ED. [DATE] at 7:14 p.m. R1 going to ICU (intensive care unit). R1's kidneys are shutting down and there is acid in his blood. R1's hospital Admission Note dated [DATE] at 11:23 p.m., identified R1 transferred to higher level of care hospital due to severe Acute Kidney Injury (AKI) and concern for need of urgent dialysis (filters waste and excess fluid from the blood). The Admission Note further indicated the etiology for R1's AKI differential includes mainly contrast [dye]-induced, and R1's cough and dyspnea are likely consequences of the fluid overload caused by the renal [kidney] failure. R1's death certificate indicated R1 died on [DATE], in the hospital due to acute and chronic kidney failure. During an interview on [DATE] at 5:00 p.m., FM-A identified R1 had at CT with dye contrast on both [DATE] and [DATE] and was told that R1 should have adequate fluid before and after the procedures to prevent kidney damage but, was not aware of the fluid order that was written on [DATE], and did not know if the facility was monitoring it. FM-A further identified R1 had a CT scan with dye on [DATE] and because of the findings, was asked to return for a second CT scan on [DATE] and R1 was already feeling sick by then. Reported R1 became really sick by the weekend (two days after the CT scan). FM-A asked RN-C to send him to the emergency department for evaluation but was told by RN-C that R1 did not have a fever, and they would not do anything for him until R1 developed one. FM-A stated during a visit on [DATE], a facility nurse (unsure which one) reported R1 was better and decided to wait one more day to have R1 seen by a provider. The next day, a different nurse called and stated R1 needed to be sent to the ED for evaluation and treatment. FM-A indicated she expected facility staff to be monitoring R1 more closely than they were. During an interview on [DATE] at 12:15 p.m., nursing assistant (NA)-A identified working with R1 the days prior to R1's hospitalization . On those days, R1 was wheezing a lot but was told R1 had a cold or something. NA-A was not aware R1 had any wounds or pressure areas for R1. During an interview on [DATE] at 9:30 a.m., NA-B identified R1 was more rude and disrespectful then normal for a couple of days before he went to the hospital. NA-B stated he was not feeling well, was more wheezy, appetite had decreased, not sleeping well, and was hard for us [staff] to get him to eat or drink anything. NA-B further identified she notified nursing staff and thinks they were checking on him more frequently but was not sure what the nurses were doing for R1. NA-B indicated staff were not monitoring R1's fluid intake or urine output. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:41 p.m., NA-C identified the nurses did not communicate to any of the staff about any need to increase R1's fluids and did not know that R1 should have had fluid intake monitored before and after the CT scan, and did not know that the CT scan could have put R1's health at risk further. R1 got sick with cold symptoms right after the CT scan. On [DATE], NA-C reported to RN-B that R1 was full of fluid, chest was full, stomach felt like rubber and was tight. RN-B told her the ED would not do anything for R1 because R1 was already on an antibiotic and nebulizer treatments. NA-C did not know whether RN-B further assessed R1 or not but in the morning of [DATE], R1 looked even worse and further described R1 was full of fluid, chest was rattling, having a hard time breathing, and appeared in a lot of pain. NA-C further reported that R1 told her that he had never felt that bad. NA-C then reported to RN-A and then RN-A assessed R1 and sent him to the ED. During an interview on [DATE] at 1:40 p.m., licensed practical nurse (LPN)-C indicated if a resident is on a physician ordered fluid intake or restriction, it should be on the MAR and would be measured and monitored but did not know of any resident's that the facility had been monitoring for fluid intake or restriction within the past few months. If there is a change in condition, the nurse should immediately assess and document in the progress notes that the nurse notified the family and provider of the change. LPN-C denied working with R1 during the days prior to his hospitalization so was not sure of R1's condition. During an interview on [DATE] at 9:40 a.m., LPN-B identified being familiar with R1's cares but did not know he was to be monitored for fluid intake and did not know anything about R1 having CT scans done. LPN-B further identified R1's cough did not get any better so notified family and they requested antibiotics, the physician was notified and ordered antibiotics and did infection monitoring on R1 every shift (included monitoring temperature, pulse, respirations, pain, and oxygen level) but although R1's vital signs were stable, R1 did not get any better and one of the RN's from the office sent R1 to the ED, R1 was hospitalized , and died . During an interview on [DATE] at 11:32 a.m., social service designee (SSD) indicated [nurse] charting could be better so everyone could know what is happening with the residents. During an interview on [DATE] at 3:05 p.m., registered nurse (RN)-A indicated not seeing R1 for a week prior to [DATE] and was asked to assess R1 for change of condition. RN-A noted R1 to have respiratory wheezing that was audible immediately entering the doorway and was dusky in color, with R1 stating he felt like he was going to die. RN-A notified family and arranged for ED transfer. RN-A also indicated an order was entered into the computer as encourage to drink instead of drink and no documentation was entered for tracking how much fluid R1 had consumed prior to or after the CT scans. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:45 p.m., the director of nursing (DON) indicated she received and transcribed R1's order for on [DATE] but instead of drink five ,d+[DATE] ounce glasses of water a day prior to the CT scan, transcribed the order as encourage five ,d+[DATE] ounce glasses of water a day and verified there was a difference in the interpretation of drink and encourage. The DON also stated she should have transcribed the order exactly as written, monitored the amount of fluids R1 had consumed, and communicated that amount to the provider that ordered the CT scan. The protocol for recognizing a change in condition is the nursing assistants (NA)'s inform the nurse and then nurse is to do an assessment of vital signs, oxygen level, lung sounds for respiratory, overall condition. If needed, the nurse would call the family to see if the resident should go in [clinic or ED] to be evaluated. If not, we would call or fax the doctor. The DON indicated R1 had a big change in condition on [DATE]-[DATE], when R1 developed a fever and lung sounds slightly diminished. We [facility nurse] got an order for nebulizer and Mucinex and he should have been monitored daily. The DON indicated vital signs were put in R1's MAR but lung sounds, or edema is not routinely checked unless the nurse felt it was something that needed to be done. The DON further identified R1 asked to go to the ED on [DATE] but R1 seemed to be the same as the day before so did not send him. The DON confirmed there was no documentation about R1's condition change until the next day ([DATE]) when R1 transferred to the ED. The DON stated she would have expected to see more [progress] notes than there were. R2 R2's face sheet dated [DATE], identified diagnoses of presence of right artificial hip joint (replacement of artificial parts for bone), and infection and inflammatory reaction due to internal right hip prosthesis (infection and inflammatory reaction that occurs around a joint replacement implant). R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had some cognition issues, no behaviors, independent with activities of daily living, and used a walker for mobility. R2's care plan dated [DATE], identified potential for skin breakdown. Interventions included weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations. R2's care plan did not identify any specific areas of skin concern. R2's physician notification form with approved order dated [DATE], identified R2 had an open wound on back of right hip that measured 2.0 cm x 1.0 cm. looked like a pressure sore from hip being pressed on side of recliner. Orders to clean and cover with mepilex (name brand of a foam absorbent dressing) until resolved. R2's progress note dated [DATE], identified R2 took off mepilex and noted drainage coming from gluteal fold. Serosanguineous drainage, wound edges intact, wound bed is reddish surrounding yellow/whitish in the middle of the wound. Measurements are 1.5 cm x 1.0 cm x upper part of the wound 0.8 cm depth and lower part is 0.5 cm depth. Cleansed, applied mepilex with hydrogel. R2 had no pain with the only complaint being itchiness. At 10:42 a.m., R2 stated he did not want a big dressing on his wound. Informed R2 he had more drainage at night and the bigger foam should help. Refused hot pack prior to dressing change. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's skin observation tool dated [DATE], identified a skin abnormality to right gluteal fold, type of wound was pressure stage III with measurements of 1.5 cm x 1.0 cm x depth of 0.5 cm and 0.8 cm. Applied hydrogel and mepilex after cleansing. R2's progress note dated [DATE] at 8:30 a.m., identified there are no wounds on buttocks or gluteal fold. Only wounds are on right hip area. The lower wound is located at the top of an old hip surgery incision, area is a hole which the wound bed is located at the base of the hole and the skin up the edges of the hole and top of the hole are normal color, intact skin with no maceration. Wound bed which only covers the base of the hole measured 1.0 cm x 1.5 cm and 0.1 cm depth. 85% red beefy tissue and 15% yellow slough. The other wound which is located about 1XXX,d+[DATE].5 inches above the other wound is 0.5 cm x 1.0 cm and 0.2 cm depth with yellow/pink wound bed. R2 did not have the wounds covered and stated he took it off because it bothers him and makes him itch. Noted an area of serous drainage on pants about the size of an orange. Will fax MD-A for change in treatment as there is too much drainage for silver hydrogel to be effective. At 11:14 a.m., order obtained to change treatment to calcium alginate to wound bed, after cleansing with wound cleanser apply skin protectant to surrounding skin and cover with mepilex daily. R2's physician notification form with approved order dated [DATE], identified R2 continues to have a large amount of drainage to wound on right outer buttock. May we change to calcium alginate after cleansing with wound cleanser and skin protectant to surrounding skin and cover with mepilex. Response was ok to wound treatment changes. R2's skin observation tool dated [DATE], identified open area on right buttocks still has small pinpoint opening below skin bubble that sticks out. Dressing was saturated with sanguineous (blood mixed with yellow liquid) fluid. No redness or signs of infection. No measurements provided. R2's record did not identify weekly skin evaluations with measurements on [DATE]. R2's skin observation tool dated [DATE], identified wound care being done to right hip region. No measurements, type of wound or drainage provided. R2's progress note dated [DATE] at 9:40 p.m., identified changed dressing to ulcer on buttocks. Continues to be the same, not healing but not worse. R2's skin observation tool dated [DATE], identified pinpoint open area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's progress note dated [DATE], identified dressing change to right hip area after a warm pack for 15 minutes. Small amount of drainage with no odor. R2's skin observation tool dated [DATE], identified pinpoint area that drains serous fluid on right hip has 0.4 cm high skin growth next to open area. No measurements or type of wound provided. R2's record did not identify weekly skin evaluations with measurements on [DATE], and [DATE]. R2's progress note dated [DATE] at 11:36 a.m., identified wound on right hip is no longer open, is fully covered with normal color skin and no drainage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated [DATE] at 12:15 p.m., identified area on right hip that was resolved is now open again and measured 0.2 cm x 0.3 cm x 0.3 cm water blister noted below open area. Moderate amount of serous drainage from area. Will inquire with family if they would like to take R2 to wound clinic as this was closed and now is open again and took a long time to heal. Family requested to continue treatment at facility. At 2:32 p.m., upon inspection of wound again noted that wound is 2.5 cm depth and about the size of the wooden end of a Q-Tip. R2's weekly skin observation dated [DATE], identified location was healed surgical scar on right hip/buttock with unknown etiology. Impression was worsening. Slough tissue and unable to visualize wound base due to minimal opening at top layer of skin. Moderate amount of yellow, tacky drainage with no odor. Depth measured 5.2 cm. Scar tissue around wound macerated and irregular. No suspected infection or inflammation present. Orders for CT of hip. Cover with absorbent dressing. MD-A does not feel packing the wound is needed currently. R2's progress note dated [DATE] at 10:15 a.m., identified wound is directly on the healed surgical scar from right hip revision. No peri wound redness, no pain or discomfort. Wound has very small opening at surface of epidermal layer. Able to probe Q-Tip into wound 5.2 cm depth but may be deeper. Unable to determine if wound tracts or undermines and unable to measure length and width due to small opening. Drainage is yellow and tacky. Packed with one fourth inch packing strip and covered with absorbent bordered dressing. Notified family and they are willing to get treatment and be seen at a wound clinic. Will contact MD-A for wound dressing change and wound clinic referral. At 12:25 p.m., spoke with MD-A to get referral for dressing order and wound clinic appointment. MD-A felt that this may involve the right hip prosthesis, and the first step should be a right hip CT. if there is prosthesis involvement, dressings are irrelevant at this time. Family aware. R2's progress note dated [DATE] at 11:01 a.m., identified area on buttocks still open 0.25 cm round with serosanguineous drainage, dressing changed. R2's progress note dated [DATE] at 11:05 a.m., identified MD-A examined wound on right hip by palpation and movement and discussed getting the CT scan. The physician visit note dated [DATE], identified the biggest concern was R2's hip wound and concern for an underlying infected hip replacement. R2 denied pain in that area interestingly. Area over the right hip shows a depressed area that is red, somewhat irritated, with an open area in the center that medical director (MD)-A was unable to express any purulent (thick, milky discharge that typically indicates an infection) material out of but does appear as though it has been draining. Possibly a draining sinus. Ordered at computed tomography (CT) scan of pelvis and hip to observe how deep the area of infection over the right hip was. Nursing staff stated it has been draining and this is a concern given R2's history of infected prosthetic. Certainly, prudent to look at a referral to orthopedic department for their thoughts. If R2 does have an infected right hip replacement that is not going to heal without removal, spacer, antibiotics, etc. this would likely result ultimately in R2 not really doing well at all. R2's CT with IV contrast dated [DATE], identified diagnoses of septic arthritis (painful infection in a joint), arthritis pyogenic hip (serious painful infection of joint often caused by bacteria). A small quantity of fluid is seen along the lateral incision within the proximal superficial subcutaneous tissue (layer of skin) of right thigh measured approximately 5.4 cm x 3.2 cm x 4.4 cm in size. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated [DATE] at 5:04 p.m., identified MD-A reviewed CT results. Fluid collection increased in size and ordered Keflex and doxycycline. Also, arginaid ordered. At 5:53 p.m., changed dressing to right hip. Light tan colored drainage noted on old mepilex. No signs of infection noted to area. R2's physician notification form dated [DATE], identified MD-A reviewed the CT results per radiology and it appeared the fluid collection has increased in size some from previously. MD-A recommended these findings be reviewed by orthopedic team that worked on R2. In the interim, start R2 on an antibiotic. Keflex 500 mg three times per day for 10 days and doxycycline 100 mg twice daily for 14 days. R2's physician notification form dated [DATE], identified wound on right buttock/old surgical scar continues to close over and fill with yellow, tacky fluid. Depth almost at 6 cm. May we add one fourth packing strip to wound with current orders and wondering if R2 should be seen by orthopedics. Reply was ok for packing of wound and recommended being seen by orthopedics to determine need for additional imaging and intervention. R2's weekly skin observation dated [DATE], identified location as healed surgical scar right hip/buttock with unknown etiology. Unchanged. Slough tissue present, moist. Very small opening with deep tract. Unable to visualize base. Large amount of purulent drainage with no odor. 0.1 cm x 0.1 cm x 5.8 cm depth. Indurated, scar tissue on peri wound. No infection suspected and no inflammation present. Cover with absorbent dressing. Sent fax to MD-A about packing wound. No evidence of healing, continued to drain large amount of tacky, yellow fluid. R2's progress note dated [DATE] at 6:09 p.m., identified fax sent to MD-A for order to pack right buttock wound with one fourth inch packing, as it continues to close over the tiny opening and fill with thick, tacky yellow drainage. Wound measured 6+ cm depth. Also questioned if follow-up with orthopedics was needed. R2's care plan dated [DATE], identified potential for skin breakdown. Has an open area on right hip. Interventions included treatment to open area on right hip as ordered by doctor, pack with packing after cleansing and cover with dressing daily, use only a continuous strip and leave a tail of ,d+[DATE] inches on outer side of wound to prevent packing getting left in wound. R2's skin observation tool dated [DATE], identified skin abnormality to right trochanter (hip), type is listed as other. Measurement 1.0 cm x 0.5 cm x 5.0 cm depth. Currently just covering wound with dressing per provider, pending an updated wound care order. R2's progress note dated [DATE] at 12:48 p.m., identified an orthopedic appointment for right hip had been made. During an interview on [DATE] at 11:22 a.m., licensed practical nurse (LPN)-A stated the nurse would check every resident's skin when they had a bath. The nurse would assess skin issues, bruises, dressings that are in place. For new skin issues the doctor, director of nursing (DON), and family are notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:30 a.m., LPN-B stated she had measured the length and width of R2's wound but not the depth on [DATE] after he had a bath. R2 did not currently have a dressing in place on his right hip wound. Registered Nurse (RN)-A had been measuring the depth. They were waiting for new orders from the doctor for packing the wound. During an interview on [DATE] at 11:39 a.m., RN-A stated she had taken over wound management the week of [DATE]. During an observation on [DATE] at 12:50 p.m., LPN-B and RN-A applied enhanced barrier precautions (EBP) prior to entering R2's room. R2 had been seated on the edge of his bed and stood up with a walker upon LPN-B and RN-A entering the room. LPN-B placed a clean towel over R2's overbed table and moved the garbage close to the overbed table. LPN-B removed needed wound care supplies from R2's closet and placed on towel. RN-A described the process for packing the wound with a tail to LPN-B. RN-A stated R2 had a CT scan last week. The wound would close over with fluid. The packing is to keep the wound open and wick out the fluid. The wound opening is the size of a Q-tip and does not have pain with it. The wound has been an on-going issue since ,d+[DATE]. RN-A lifted up R2's skin as the wound site was not visible without lifting the skin up with a hand. RN-A pointed out that proud flesh dimpled skin was at the end of the right hip surgical scar and the opening to the wound was not really visible. RN-A took took the wooden end of a Q-tip and placed it inside the wound opening and moved the Q-tip around. RN-A stated the wound felt boggy against the Q-tip. Removed Q-tip and measured the Q-tip with red-tinged drainage on it at 4.8 cm depth. Red liquid dripped from the wound down R2's leg. RN-A used a new Q-tip, after measuring out packing for the wound, and began to insert packing in the wound bed. R2 made noises and winced during this process. RN-A stated it was very difficult to pack the wound as it was such a tiny opening. Packed the wound with a tail hanging out and placed a mepilex over the area. Both nurses removed EBP when care was complete. During an interview on [DATE] at 1:39 p.m., LPN-B stated she was unsure how long it would take a boil to heal. Pressure sores occur from not having blood circulate to an area from a point that has pressure on it and did not feel that R2's wound was from pressure. Wounds should be measured a minimum of once a week and if a wound is not healing or does not have any change to it, the doctor should address every one to two weeks. During a phone interview on [DATE] at 12:50 p.m., MD-A stated if he had been aware that the 'boil' area that was being treated was on the right hip surgical site he would have ordered a CT sooner and consulted with R2's surgeon. One of the reasons MD-A ordered the CT scan was because he was under the impression that this was a new wound that had popped up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:05 a.m., RN-A stated she had first observed R2's hip wound on [DATE]. Prior to observing the wound, RN-A was under the impression that R2's wound was a boil. The charge nurses are in charge of the day-to-day wound treatments and RN-A would complete a weekly skin wound assessment that would include assessing for changes, notifying the doctor for wound treatments and updating with changes, notifying family as needed. RN-A had completed wound training with licensed nursing staff within the past year but did not include nursing assistants (NA)'s in the education. Medical doctor (MD)-A would have to be notified and requested to look at wounds during his monthly rounds if a wound needed to be looked at. RN-A had addressed with MD-A the extent of R2's wound on [DATE] and that is when the CT was ordered. MD-A was not aware that R2 still had a wound on his right hip. Moving forward MD-A and family will be informed when wounds heal and the site will be monitored for a week afterwards. RN-A was completing the weekly wound assessments in the interim until the facility determined who would be in charge of them. During an interview on [DATE] at 10:36a.m., DON stated a wound resource binder is located at each nursing station. Wounds should have a weekly comprehensive assessment completed. DON was unable to articulate the amount of time a treatment should be completed before re-evaluation but if there was no change for a while would reach out to MD-A to request new treatment orders. There is no protocol for monitoring a healed wound and it would just be part of the nurses responsibility to assess weekly on bath days. The braden assessment is completed to determine a residents risk for pressure ulcers and pressure reducing mattresses and wheelchair cushions are interventions that would be put in place. MD-A would address wounds on residents whenever necessary. DON would go with on rounds and have handwritten notes of items that needed to be addressed and tell MD-A while in the room with the residents. DON did not have any wound care audits or confirmatory training paperwork on specific wounds with nursing staff completed, any education was only verbal. DON could not recall if she had assessed R2's wound at the initial evaluation. DON did not feel that a boil would remain from September until April and had only assessed the wound when she was working as the floor nurse. There had not been any discussion or concern that the wound could be infected and/or have something to do with his right hip prosthesis even though R2 admitted to the facility with a diagnosis of infection and inflammatory reaction from the right hip prosthesis. Treatment for wounds are determined by review of the nurse resource manual, review from DON or RN-A and the request faxed to MD-A with what orders the facility would like for treatment. The expectation is that wounds are measured, documented, complete assessment and weekly review completed and addressed with MD-A on monthly rounds or as needed for wound worsening or healing and needing new treatment orders. The DON was in charge of completing and comprehensively reviewing weekly wounds but currently RN-A had begun completing them in the interim. The goal is to have the assistant director of nursing (ADON) complete them (after orientation) and DON would be the back-up. The facility Wound Treatment Management policy revised ,d+[DATE], identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Change of Condition and Assessments Policy and Procedure last reviewed [DATE], indicated the policy establishes standardized procedures for registered nurses (RNs) to assess and manage changes in condition among residents. The goal is to ensure timely detection, documentation, and intervention for any significant alteration in a resident's baseline status, safeguarding resident health and well-being. The policy defines change in condition as major decline or improvement in[TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 39998 Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and provide interventions to prevent pressure ulcer development, promote healing, and prevent deterioration for 1 of 3 residents (R3) who had pressure ulcers. The facility's failures resulted in harm when R3 developed a stage 2 pressure ulcer (PU) that deteriorated to a stage 3. Findings include: STAGING Staging of a PU/PI is performed to indicate the characteristics and extent of tissue injury, and should be conducted according to professional standards of practice. Determining whether damage to the skin and underlying tissue is a PI or PU depends on the staging of the damaged tissue. Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable UP/PI. R3's face sheet dated 4/23/25, identified diagnoses of edema (swelling caused by excess fluid). R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had no memory issues, did not reject cares, was dependent on staff for putting on and taking off footwear, R2 was at-risk for pressure injuries but did not have any. R3's care plan dated 3/25/25, identified R3 had a whirlpool bath weekly and required 1-2 staff to assist with bathing. The care plan identified a potential for skin impairment dated 10/13/23, identified interventions of Braden risk assessment, keep skin clean and dry, report any signs of skin breakdown, weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate and any other notable changes or observations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's podiatry evaluation dated 12/17/24, identified there was a small stage II ulceration to the right medial 4th toe. An offloading pad/dressing was applied. Keep the right foot dry in the shower and sponge bathe for now. Offload the area, keep dressing intact. If dressing falls off apply iodine, gauze and kling daily. Return to clinic in 3-4 weeks or sooner if problems arise. An addendum to the note on 12/17/24, identified R3's family did not want to transport R3 to the clinic and preferred the facility to treat the wound. Therefore, requested the nurse dressing daily, (but) wait to removal of initial dressing for two weeks. Then cleanse the ulcer daily and apply iodine, gauze, kling and paper tape. Keep the foot dry in the shower and sponge bathe until the ulcer is healed. Call the office with any questions of if the ulcer is getting worse or not healing for an appointment or go to the nearest hospital. Review of R3's progress notes dated 12/17/24 through 12/31/25 did not identify the dressing was left in place for two weeks as ordered. According to R3's treatment administration record the order for daily wound care dated 1/1/25 was discontinued on 1/2/25; R3's record did not include an assessment and/or documentation the wound had healed. During an interview on 4/23/25 at 1:39 p.m., licensed practical nurse (LPN)-B stated she could not remember if she discontinued the treatment on 1/2/25 but recalled that a dressing had been in place between the 3rd and 4th toes. They were told to monitor and after a couple of days to take the dressing off and discontinue the order. LPN-A stated when the order was discontinued on 1/2/25, the area did not appear healed. The area was scabbed over but not macerated. R3's toes were always puffy and so was her foot so ace wraps were used. R3 had a weekly bath and the NA's (nurse aides) got her feet in there to let them soak. LPN-B observed her skin after the bath but had not looked between the toes where the UP/PI was located. R3's bath skin assessment dated [DATE], identified a handwritten note that stated toe in parenthesis. R3's record did not identify a wound assessment was completed on the pressure ulcer between the 3rd and 4th toes of right foot between 12/17/24-4/21/25. R3's podiatry evaluation dated 4/22/25, identified stage III pressure ulcer to the medial right 4th toe, with maceration, no signs of infection. Debrided the ulcer at visit. Orders included to cleanse ulcer daily with saline damp gauze, dress daily with iodine, gauze, kling, and paper tape. Keep dry in the shower. Follow-up in the office in four weeks, call with questions or concerns. Add one package of Arginade per day. R3's progress note dated 4/22/25 at 9:01 a.m., identified podiatry was in house and ordered right medial 4th toe ulcer to cleanse daily with saline damp gauze, apply iodine, gauze, kling, and paper tape. Keep dry in the shower and follow up in four weeks. Add one packet of Arginade daily. At 9:59 a.m., spoke with family member (FM)-B in regards to the pressure injury worsening and the risks involved with wounds of the sort and difficulty of healing. Daughter requested to continue treating at facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's care plan dated 4/23/25, identified pressure ulcer on the medial aspect of right 4th toe related to immobility and edema. Interventions included to measure length, width, and depth where possible, document wound perimeter, wound bed and healing progress. Report improvements and declines to medical doctor. Due to difficulty of visualizing the wound for proper assessment, do dressing change and assessment when lying in recliner or bed. If unable to get right toe gauze to stay in place, apply lambs wool between 4th and 5th toes of right foot instead but it is important to cushion with one or the other. R3's weekly wound observation tool dated 4/23/25, identified pressure ulcer stage III to right 4th toe webbing acquired at facility. Wound had begun as a stage II. Wound tissue was moist with 100% slough (dead tissue presents soft, yellow, or white) present. No odor or drainage present. Wound measured 0.3 centimeters (cm) x 0.4 cm x 0.2 cm depth, depth approximate due to slough covering wound and unable to see base of wound. Surrounding skin is macerated (moist) and erythematosus (red). 4+ edema on top of right foot, fluid filled thin skin, 3+ edema in right mid-calf to knee. Inflammation is present with redness and discomfort at wound site. Treatment included to cleanse the ulcer with saline damp gauze, apply iodine, gauze, cling, and secure with paper tape. Keep dry in the shower. Updated order included that iodosorb (iodine gel primarily used to clean wounds and promote healing) could be applied to wound bed and lambs wool in between toes if gauze does not stay in place. Do not wrap multiple toes together to avoid added pressure. R3's progress note dated 4/23/25, identified right foot 4th digit wound assessed and dressing completed. Wound is in the web of fourth and fifth digit, difficult to dress. Notified podiatry of difficulty dressing and ease of unintentional removal of dressing with sock, ace wraps, and slippers on/off. Do not wrap toes together as this could compromise wound be adding additional pressure. Additional orders received for wounds and tentative appointment scheduled. Dressing changed to bedtime so foot is not dependent and wound would be easier to visualize. During an interview on 4/23/25 at 11:18 a.m., R3 was sitting in her wheelchair with her feet on the floor and wearing slippers. R3 stated she had her toes looked at on 4/22/25 by podiatry and they saw a sore on her toe. R3 thought she had the sore for awhile. R3 did not think the nurse had changed the dressing today. During an interview on 4/23/25 at 11:22 a.m., licensed practical nurse (LPN)-A stated skin is checked weekly after showers. The nurse will look at bruises, open skin, and dressings. LPN-A reviewed R3's medical record and did not see anything identified as a pressure ulcer. During am interview on 4/23/25 at 11:28 a.m., nursing assistant (NA)-B stated R3 had the toe wound since 4/18/25. The dressing is not on right now since R3 just had a bath. NA-B would notify the charge nurse for any wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 4/23/25 at 1:14 p.m., registered nurse (RN)-A entered R3's room to complete wound care. R3 was sitting in a wheelchair with her feet dependent on the floor. R3 stated the wound does not hurt. RN-A removed the ace wrap that was on R3's leg from toes to calf. There was +4 pocketed edema on the top of right foot. No dressing was on the pressure ulcer to remove. The 4th toe was red and the wound is located inside on the web of the toe in between the middle toe and fourth toe and going up a little of the 4th toe. It measured 0.3 cm x 0.4 cm. unable to determine depth as the wound was covered in a white substance. RN-A stated she could smell an odor during the dressing change. R3 stated it tickled but did not hurt. RN-A explained all of R3's toes had a large amount of edema and were pressed together and difficult to separate to see between. During an interview on 4/23/25 at 3:44 p.m., NA-D stated she discovered R3's toe on 4/18/25. The wound was between the toes. The toes were really red, swollen, and warm to touch. NA-D had not noticed it before. The nurse put triple antibiotic ointment on the wound and NA-D reported the area in the shift to shift report and told the oncoming staff about it. During a subsequent interview on 4/24/25 at 8:42 a.m., NA-B stated R3's sore had been there but it had not been open like it was currently. It opened again on 4/18/25. NA-B described the wound as a scab prior to 4/18/25. During an interview on 4/23/25 at 5:06 p.m., RN-B could not recall a pressure ulcer on R3's 4th toe. RN-B stated most of the wound treatments are done on the day shift and if a treatment is required the TAR would reflect it. During an interview on 4/24/25 at 9:05 a.m., RN-A stated a stage II pressure ulcer presenting with a scab over it would not be considered healed and would be troublesome as it would be eschar tissue. RN-A took over the wound treatments for the facility the week of 4/15/25, and had not been aware of the pressure ulcer until the podiatry noted it on 4/22/25 during their rounds. During a follow-up phone interview on 4/29/25 at 1:56 p.m., RN-A verified that R3's pressure ulcer is between the third and fourth toes, not the fourth and fifth toes as was documented. During a phone interview on 4/29/25 at 8:44 a.m., medical doctor (MD)-B stated the stage II pressure ulcer is the same location as the stage III pressure ulcer. The wound is the same width and diameter but appeared a little bit deeper on examination 4/22/25 compared to 12/17/24, when MD-B last saw it. There were no dressings on the wound prior to MD-B's examination. MD-B's expectation was that the facility would follow the order to not get the foot wet. The water just gets trapped between the toes due to the size of her toes. MD-B had not had any communication with the facility on R3's pressure ulcer in between 12/17/24 and 4/22/25. During an interview on 4/24/25 at 10:36 a.m., director of nursing (DON) stated wounds should be assessed at a minimum weekly and measurements included. If a wound was healed it would be documented in the progress notes, weekly wound assessment or the skin assessment tool. There was not a protocol in place to monitor a wound for any specific amount of time after it healed, only that the floor nurses should be aware of the healed wound and lay eyes on the location on weekly bath assessments. It was determined that R3's pressure ulcer had healed in January, but no documentation on the wound being healed. If the wound had a scab over it, the wound would be considered unstageable and not healed. The nurses were to communicate to the NA's that R3's right foot was not to get wet. It is the expectation that nurses look between resident toes on bath days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility Wound Treatment Management policy revised 4/2025, identified to promote wound healing of various types of wounds, the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include lack of progression towards healing, changes in wound characteristics, and changes in resident goals and preference. The facility Foot Care Skin Integrity policy dated 4/2025, identified the residents receive proper treatment and care to maintain mobility and good foot health. The risk assessment will include a comprehensive assessment to identify additional risk factors or conditions that increase risk for impaired foot skin integrity. Medical conditions will be managed and interventions implemented in accordance with professional standards of practice to prevent complications of medical conditions. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any foot ulcers, or any changes in a residents medical condition.