STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Lea Senior Living	115 North Lyndale, Rr 2 Box 49 Mabel, MN 55954

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on observation, interview, and record review the facility failed to ensure physician notification of skin injury that required treatment for 1 of 3 residents (R1) reviewed for pressure ulcers. The findings include: R1's face sheet printed 3/25/24, included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes. High blood sugar [glucose] can injure nerves throughout the body.), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone) stage 2, non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment, R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer (partial thickness loss of dermis [The inner layer of the two main layers of the skin] presenting as a shallow open ulcer with a red or pink wound bed, without slough. May present as an intact or open/ruptured serum filled blister.) MDS did not identify any other skin concerns such as other infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care, application of ointment/medications other to feet, and application of dressings to feet. R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.). (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 3/9/24, documented registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored and quite raised, hard and not fluid filled. More so resembled a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed. It does not appear R1 typically has prolonged pressure to this outer area of his leg. Director of nursing [DON] noted to be notified of injury at this time as RN was unable to find documentation of area. Wound appeared to be 1-2 days old. Wound left dry and covered with padded bandage to protect. R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm. Added to care plan, doctor and family notified. In review of R1's record between 3/9/24 to 3/18/24, it was not evident the physician was notified of R1's left lateral knee wound. Additionally, there was no indication of a physician ordered treatment in that time frame. During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m., physician gave an order for the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, included It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of time and contributed to the pressure. Physical examination included: On the right lateral heel, there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, He [R1] needs repositioning every 2 hours Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily. R1's March 2024 treatment administration record (TAR) identified the aforementioned treatment plan that was identified in the physician note; the knee dressing identified a start date of 3/19/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicated with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound appeared dark black in color about a quarter or larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain. New dressing was applied at this time as ordered. RN-A noted left heal to be soft and spongy at this time. During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A stated when a skin alteration was found on a resident, a progress note should be made, and the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included. During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A indicated, progress note for R1 identified leg wound on 3/9/24 but provider had not been notified of wound until 3/18/24, although documentation on skin integrity rolling log identified facility acquired on 3/11/24 with measurements of 0.7 cm x 0.8 cm deep tissue injury. CM-A stated, unfortunately the process for [R1]'s leg wound had not been followed properly. During an interview on 3/25/24 at 3:11 p.m., director of nursing (DON) stated body audits are to be completed on the floor weekly by the nurse assigned to the resident. DON also indicated the nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON identified R1's wound found in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, and could not say that the provider had been informed, nor could not recall if she had been informed. DON confirmed, the wound nurse should have been informed and weekly documentation should then have been initiated. Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician. Facility policy titled Notification of Change in Resident Health Status, updated 2/8/23, stated: The resident's physician and resident's legal representative will be notified of a change in resident status when the following occur: a) An accident involving the resident which results in injury and has the potential for requiring physician intervention b) A significant change in the resident's physical, mental, or psychosocial status for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications c) a need to alter treatment significantly, for example a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on interview and document review the facility failed to revise the care plan that addressed goals and interventions for new diagnoses of nonthrombocytopenic pupura for 1 of 1 resident (R2) who developed substantial bruising. Findings include R2's admission record indicated R2 had diagnoses that included chronic pain and other nonthrombocytopenic purpura (purple, red, or yellowish-brown spots or patches develop under the skin due to inflammation, damaged blood vessels, or an underlying health condition). R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 did not have cognitive impairment, was independent with oral hygiene and eating, and was dependent with toileting, dressing, personal hygiene, and mobility. R2 was at risk for pressure ulcers and no other skin problems identified. R2's care plan dated 4/6/23, included R2 has a potential for impairment to skin integrity related to immobility, and incontinence. Interventions included: keep skin clean and dry. Observe skin during cares. Report any changes to nurse. (Care plan did not include risk of bruising and or monitoring.) R2's Weekly Body Audit dated 1/1/24, identified no alterations of skin. Overall summary identified bruising noted throughout at various stages of healing. R2's progress note dated 1/4/24, at 11:36 a.m., directed to add diagnosis of senile purpura (bruising that occurs in the elderly without any major external impact) for easy bruising. R2's Weekly Body Audit dated 1/15/24, resident is bed bound, resting mainly on left side and stomach. She is totally dependent on staff to meet her needs. Lacked any description of skin alterations. R2's progress note dated 1/28/34, at 1:05 p.m., documented nursing assistant (NA) noticed two new bruises on resident left knee and thigh. Nurse called director of nursing (DON). R2's progress note dated 1/29/24, at 10:52 p.m resident due for body audit this shift per treatment administration record (TAR). It is noted that one was performed yesterday. Nurse felt this needed to be done with 2 nurses present as resident had multiple bruises on various areas of body and various stages of healing. R2's progress note dated 2/4/24, at 1:44 p.m., R2 showed nurse fingertip that blood sugar was drawn on that morning (left hand middle finger), entire fingertip was purple bruised. Measured 2.5 centimeters (cm) x 1.5 cm. R2 stated she was nervous to why she was bruising so easily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated 2/14/24, at 4:57 p.m.documented, hospital transfer related to large hematoma to right upper arm and is going by ambulance to be evaluated in emergency room [ER]. Resident was having severe bruising lately and labs have not indicated any cause. Due to new finding, resident agreed to be evaluated further. Nurse called local ambulance to have transported. Nurse left message for family. Mass was measured by wound nurse and DON prior to transport. Writer indicated, R2 left facility at 5:17 p.m. R2's progress note dated 2/15/24, at 12:31 a.m., writer documented, R2 returned from ER at 11:44 p.m. via ambulance. Education provided on hematoma's. R2's progress note dated 2/23/24, at 10:49 p.m., writer documented, nurse noticed [R2] was slurring her words and noted left leg was swollen. Noted that from hip down entire extremity had 3 plus pitting edema. Behind [R2]'s back of the knee the skin was orange and the rest was yellow. Nurse recommended resident to go to ER but resident refused. DON and provider notified. R2's progress note dated 2/24/24, at 9:38 a.m., indicated R2 transferred to the hospital related to noted change in condition with confusion. Left lower extremity and posterior knee area swollen, slightly warm, skin yellow in color and pitting edema plus 4. Bruising noted throughout entire body. DON notified. R2's progress note dated 2/24/24 at 4:43 p.m., documented, call from hospital reported R2 admitted to hospital with hemoglobin low at 5.1 and appears to have internal bleeding. During an interview on 3/26/24, at 3:05 p.m. clinical manager (CM)-A, stated she was the main person for the facility that created the nursing care plans. She had put the diagnoses for nonthrombocytopenic purapura (rash occurs when small blood vessels burst, causing blood to pool under the skin. They appear as small, reddish-purple spots just beneath the skin's surface) in the computer for R2 and had not updated the care plan. CM-A indicated she was responsible for wounds, infection control, Minimum Data Set (MDS) assessments and care plans. CM-A was unable to articulate who was monitoring and or assessing interventions for effectiveness and updating care plans accordingly. CM-A stated, I guess if I haven't updated the care plans, no interventions were put in. The new diagnosis for [R2] was put in the computer by me on 1/4/24 in the diagnosis area, I should have put in a care plan for risk for bleeding and bruising. During an interview on 3/26/24, at 3:48 p.m. director of nursing (DON) stated the care plan should be updated as new diagnosis and new interventions are needed for care. DON indicated she was not aware R2's care plans had not been updated and would have expected they would have been. DON indicated she was now aware the current process for care planning and monitoring interventions for effectiveness was not being done accurately and the facility needed to evaluate and implement a new system for care plans. Facility document titled Person Centered Care Plan revised 10/2017 indicated; COMPREHENSIVE PERSON-CENTERED CARE PLANS: 1. Developed within 7 days after completion of the comprehensive MDS Assessment. Reviewed and revised annually, quarterly, with a significant change in status and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Contain measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being Other Areas to address on the plan of care are: Skin Integrity Alterations or Risk for: -Pressure reducing mattresses/cushions -Turning/repositioning schedule -Treatments -Wound Clinic Referrals - Podiatry Referrals - Adaptive equipment like Geri-sleeves - Foot boards/heel protectors/wedges - Alternating pressure pads. - Potential for bruising/bleeding (e.g., medications like Coumadin/injections)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45843 Based on observation, interview and document review, the facility failed to complete pressure ulcer risk assessment, failed to comprehensively assess and monitor pressure ulcers, notify physician, and follow physician orders to prevent and/or mitigate the risk of new ulcer development or deterioration for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: 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. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. R1's face sheet included diagnoses of chronic right heart failure, acute respiratory failure, type 2 diabetes with diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes), type 2 diabetes mellitus with foot ulcer, pressure ulcer of sacral region (the portion of your spine between your lower back and tailbone) stage 2 non-pressure ulcer of other part of right foot with fat layer exposed. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and was dependent on facility staff for toileting, bathing, dressing, transfers and mobility. R1 was at risk for pressure ulcers, had one unhealed stage 2 pressure ulcer. MDS did not identify any other skin concerns such as other infections of the foot, diabetic foot ulcers, or open lesions on the foot, nor did it identify any other skin concerns present during assessment. Skin treatments included pressure ulcer care, application of ointment/medications other to feet, and application of dressings to feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan revised on 9/20/23, identified R1 had a pressure injury on left buttock, diabetic ulcer on right great toe, injury on left great toe and moisture associated skin damage (MASD.) Interventions included -Administer treatments as ordered and observe for effectiveness, -Encourage off loading every hour and encourage to turn, reposition at least every 2 hours, more often as needed or requested, -notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily cares. Notify family and medical practitioner of any new area of skin breakdown or worsening in status of current area. R1's care plan did not include any revisions to R1's skin condition after 9/20/23. R1's physician orders for skin treatments included the following: -Skin Prep to either heel as needed (PRN) for protection (1/18/23) -Reposition side-to-side in bed every two hours. Waffle cushion when up in recliner or wheelchair (start date 5/25/23) -Skin assessment weekly on Mondays (start date 7/3/2023) -Bilateral (both) buttock cares: wash and dry, apply Calmoseptime (may hold in place with viva towel), only cleanse the soiled top layer off with incontinence, and apply new as needed two times a day (start date 7/10/23) R1's physician assistant visit (PA) dated 2/26/24, indicated R1 had a chronic wound on right foot. PA talked to R1 and family about hospice; with R1's weight loss and respiratory failure and heart failure, I do expect that he could die within the next 6 months. R1 thought hospice would be a good service for him but he would first like to see the wound clinic to have his foot checked on before officially considering hospice. R1's medical doctor visit note dated 2/27/24, indicated reason for visit was for routine check-up. There has been general deterioration lately and discussion has been started regarding potential hospice placement. Note identified the diabetic ulcer on right foot, family considering hospice admission. The note did not indicate any other areas of impaired skin integrity. Although R1's noted overall decline in condition as documented by physician visits on 2/26/24 and 2/27/24 related to medical diagnosis. R1's record did not include a comprehensive assessment that included tissue tolerance to pressure over bony surfaces and/or evaluation of the appropriateness of R1's care planned pressure alleviating interventions that had not been revised with new interventions to prevent and/or mitigate the risk of new pressure ulcer development or deterioration since 9/20/23. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Weekly Body Audit dated 3/4/24, identified R1 had skin alteration. Alterations that were identified included areas of redness to buttock, no further description on location on buttocks, etiology of redness, measurement of redness, and no treatment plan was included. R1's progress note dated 3/7/24, documented right heel suspected deep tissue injury 0.5 cm x 0.6 cm dark spot. Facility Skin Integrity log form (form is not in individual resident records) dated 3/2024, identified on 3/7/24, facility identified right heel facility acquired stage 2 caused by pressure . 0.5 cm x 0.6 cm. Treatment was offloading boot. Form indicated care plan was updated, doctor and family notified. A Non-emergent Fax Communication with Provider dated 3/7/24, included R1 has a deep tissue area [right] heel measure 0.5 x 0.6 - Heel protector bootie placed. No open area. The section titled Provider Response was blank. R1's progress note dated 3/9/24, documented registered nurse (RN) and nursing assistant (NA) noted old appearing bandage to left lower leg, lateral aspect, below knee. The bandage was peeling off and had a small amount of dried blood that was now very brown and hardened. Under the bandage was a wound of unknown cause. It had the appearance of possible impact wound and/or pressure injury. It was irregular round area approximately larger than a quarter. Measurements not obtained at this time. Wound was deep red and purple mix with a dark purple mix with dark brownish center that appears to have been open and now healing over with a new layer of skin. There was no drainage currently. The area appeared to be discolored, raised, hard and not fluid filled resembling a bruise. Possibly area of impact from being bumped. R1 has been quite deconditioned with recent poor health, therefore has not been common for him to leave the bed recently, if at all. R1 insists on keeping several items in the bed with him at all times, along with several remotes. R1 denied pain when area was assessed, there is no indication that R1 typically has prolonged pressure to this outer area of his leg. Director of nursing (DON) notified of injury at this time as RN was unable to find documentation of area. Wound was 1-2 days old. Wound left, dry, and covered with padded bandage to protect. After new skin impairments were identified on 3/4/24 (buttocks), 3/7/24 (right heel-suspected stage 2 pressure ulcer), 3/9/24 (left lateral knee-deep tissue injury) it was not evident weekly comprehensive assessments and ongoing monitoring were completed. R1's Skin Integrity log for the Left lateral knee dated 3/11/24, indicated the wound was facility acquired abrasion Measured 0.7 cm x 0.8 cm. Added to care plan, doctor and family notified. Care plan lacked any documentation related to this wound and indicated had not been updated since 9/20/23. R1's Weekly Body Audit dated 3/11/24, identified R1 had skin alteration. Areas of alterations included but were not limited to right heal suspected deep tissue injury and lower left lateral leg- skin abrasion. Heels firm with dark spots/discoloration. No further descriptions, measurements of impairments, and no treatment was included. (continued on next page)

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	245536	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Lea Senior Living	115 North Lyndale, Rr 2 Box 49 Mabel, MN 55954

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's physician assist visit note dated 3/11/24, indicated reason for visit was R1's condition; nurses note an overall decline. R1 was still planning on going to the wound clinic on 3/14/24. He was noted to recently have a small pressure wound on right heel, and pressure offloading boot is now in place on the right heel. Physical exam included: small 1 cm scabbed area on the right lateral heel with pressure-offloading in place on the right heel. The note identified the right foot diabetic ulcer of right foot (toe), pressure injury of right heel stage 2; moderate calorie malnutrition. Nutritional supplements are being given. Continue with wound cares and pressure offloading for the right foot wounds. The wound identified on R1's left lateral knee on 3/9/24 was not addressed in the physician visit note. In review of R1's medical record between 3/9/24 to 3/19/24 did not identify R1's left leg wound was comprehensively assessed, monitored, nor were there any treatments ordered and applied until 3/19/24, 10 days after the PU was identified. R1's Skin integrity log for the right heel dated 3/13/24, identified the stage 2 pressure ulcer measured 0.5 cm x 0.6 cm with no further assessment. R1's Weekly Body Audit dated 3/18/24, no assessment completed During an interview on 3/25/24 at 12:51 p.m., family member (FM)-A indicated she had come in for a visit around 3/9/24 noted the leg wound when she was putting lotion on R1's legs and he yelled in pain when she got close to the wound that was covered with a bandage with no date on it. FM-A stated she later noted what appeared to be the same bandage in place on the wound a week later, she brought it to the physician's attention on 3/18/24. Physician had lifted the bandage and put the same bandage back on around 8:30 a.m. Physician had ordered the dressing to be completed daily around 3/18/24. However, later the same day R1 was sent to ER in late afternoon around 2:30 p.m. for breathing concerns and returned from the hospital between 8:30p.m. and 9:30 p.m. and the dressing had not been changed. R1's physician assistant (PA) visit dated 3/18/24, indicated R1 decided to cancel wound clinic appointment because he did not have enough stamina to travel the distance. Hospice order was provided. It was noticed over the last coupe of days that he has a new wound over his left lateral leg. This is presumably from pressure. He has a reacher that he holds himself and keeps in his bed, and his [family member] wonders if perhaps the reacher got underneath him for a period of time and contributed to the pressure. Physical examination included: On the right lateral heel, there is a small area of redness, about 0.5 cm in diameter, non-blanching and the overlying skin appeared to be intact. Left lateral knee there appeared about a 2 cm in diameter with skin breakdown and black necrotic area in the middle with some moist serous drainage on the overlying from dressing. The note indicated PA ordered Arginaid wound protein supplement, He [R1] needs repositioning every 2 hours Additional treatment orders included, continue skin prep daily to the right heel wound with pressure offloading cushion. For the leg wound that is deep tissue injury, we will trim calcium alginate or Aquacel [non-stick antimicrobial wound dressing] to fit the wound and apply this to the wound bed daily. Cover with bordered foam dressing and change daily. In the future, skin issues can be managed by hospice . R1's hand written Physician Orders dated 3/18/24 included the following: -Arginaid wound supplement daily (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Every two hour repositioning -Continue Skin prep daily to right lateral heel and pressure alleviating cushion -Left lateral knee deep tissue injury: trim calcium alginate (or Aquacel) to fit wound daily and apply over wound bed then cover with bordered foam dressing change daily. Although the physician's ordered R1's skin treatments on 3/18/24, R1's treatment administration record (TAR) identified a start date of 3/19/24 for the left lateral knee deep tissue injury treatment and the right lateral heel. There was no indication these treatments were completed on 3/18/24 as ordered. The pressure relief boot on right foot when in bed and in recliner for deep pressure injury to heel had a start date of 3/20/24 even though the reducing intervention was initiated on 3/18/24 as ordered. The record further identified between 3/1/24 to 3/19/24 there was no indication PRN Skin Prep was applied to either of R1's heels for protection (order start date of 1/8/23). R1's progress note dated 3/20/24, documented, R1 was admitted to hospice on 3/20/24. R1's Skin integrity log for the right heel dated 3/20/24, identified wound increased in size from 0.5 cm x 0.6 cm on 3/13/24 to 0.7 cm x 0.8 cm R1's progress note dated 3/23/24, documented, 3.5 cm x 1.0 cm open area left popliteal area (back part of the leg of the knee joint). No further description of the wound was included. Wet to dry dressing applied. (Wet to dry dressing was not in accordance with physician order dated 3/18/24). During an observation on 3/25/24 at 1:28 p.m., registered nurse (RN)-A was providing wound cares and noted wound on coccyx area and stated this area was pressure related that was non-blanchable. There was small open areas in the same area that were not measured. Left lower area below the knee had a gauze dressing wrapped around the leg that was not dated. RN-A indicated it was not an expectation the dressing be dated and was not able to articulate how long the wrong dressing according to treatment orders had been on. The gauze was dry and adhered to the wound. RN-A sprayed the gauze with wound cleanser to moisten the gauze and carefully and slowly started unwrapping the dressing. Despite R1 being medicate with narcotic pain medication R1 cried out in pain and displayed facial grimacing as RN-A removed the dressing. The leg wound appeared dark black in color about a quarter or larger with bright red skin surrounding the wound. When RN attempted to touch R1's left leg during wound care R1 again cried out in pain. New dressing was applied at this time as ordered. RN-A noted left heel to be soft and spongy at this time. R1's TAR for dates between 3/19/24 to 3/24/24 identified the left lateral knee dressing change was completed according to physician orders except for on 3/22/24, when the recorded entry was 3 indicating R1 refused and on 3/24/24 when the recorded entry was 7 indicating R1 was sleeping. Weekly Body Audit dated 3/25/24, identified R1 had skin alteration on coccyx which was described as reddened but blanchable, skin breakdown beginning, calmoseptime cream applied with brief changes reposition every 2 hours. Lower leg rear (pressure injury 2 centimeters (cm) x 2 cm black eschar tissue. Very painful when touched. Surrounding skin reddened. Dressing changed as ordered. Left heel soft and spongy boot placed at this time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 11:58 a.m., licensed practical nurse (LPN)-A stated she documented the leg injury for R1 on the 3/11/24 body audit but did not notify the doctor of the injury. LPN-A stated she had faxed the provider about a deep tissue injury on his right heel on 3/7/24 and thought she had provided information about the leg wound on that same fax as she recalled the wound on leg the same day but no information about the leg wound was located on the fax to the provider. LPN-A reported nurses on the floor have not been completing comprehensive skin assessments weekly and she would not consider the document titled, weekly body audits as comprehensive skin assessments. LPN-A stated when a skin alteration was found on a resident, a progress note should be made, that included location, description of the wound, measurements, drainage, status and treatments. Then the provider should be faxed the information. LPN-A stated the nurses on the floor do not always follow the protocol, herself included. During an interview on 3/26/24 at 9:41 a.m., clinical manager (CM)-A reviewed the weekly body audits in conjunction with weekly skin integrity logs and stated they did not always match. CM-A also indicated R1's progress note identified leg wound on 3/9/24, however the skin integrity log identified the leg wound was facility acquired deep tissue injury on 3/11/24, and the physician was not notified of the wound until 3/18/24. CM-A stated, unfortunately the process for [R1]'s leg wound was not followed properly. CM-A indicated, body audits were to be completed weekly by nursing staff and they were to inform management of new wounds. CM-A also stated, the weekly skin audits that had been completed on [R1] would not be considered comprehensive as they did not include skin alteration details, measurements and or locations. Further indicated, there was no description of wound other than measurements noted on the Skin Integrity log forms, and found it difficult to determine healing of wound other than measurements. CM-A stated she recognized the need for better documentation on wounds. Her expectation was nurses on the floor wound know to monitor for infection. CM-A stated she was responsible for updating skin care plans for residents however had not updated R1's care plan with any changes since 2023 even though the Skin Integrity rolling log indicated the care plan had been updated with both the new heel and new leg wound interventions. During an interview on 3/25/24 at 3:11 p.m., director of nursing (DON) stated body audits were to be completed weekly by the nurse assigned to the resident. DON stated the body audits are comprehensive skin assessments. DON stated if the body audits are not completed in the medical record, she would not be able to determine if they had been completed. DON reported she was unable to locate 5 weekly body assessments in R1's record. DON verified the weekly skin audits that had been completed for R1 did not appear to be comprehensive because skin alterations were identified at times but missing details including wound descriptions, wound measurements, and locations. DON also stated the nurse on the floor should be informed of any skin alterations immediately and should then be notifying the DON, the family, and the provider by the end of their shift. The nurse on the floor should be measuring the wounds and describing the wounds in a progress note. DON stated R1's wound identified in progress note on 3/9/24 did not have a comprehensive assessment completed on that date, could not say that the provider had been informed, and could not recall if she had been informed. The wound care nurse, clinical manager (CM)-A should have been informed and weekly documentation should have than been initiated. DON was unsure if bruising and or rashes are being monitored or assessed as wound nurse only documents on open wounds. DON indicated she was aware that staff education was needed as policy had not been followed for comprehensive skin assessments. Facility's policy titled, Weekly Skin Assessment and Documentation Process, updated 1/20/23, indicated Skin Ulcers and Non-Ulcers will be assessed and documented weekly by the facility wound nurse. Policy did not address comprehensive skin assessment protocol. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled, Skin Management Protocol, undated, indicated. All treatment orders included in these protocols requires a physician's signature. Wound Notification Standards a) Notify DON and Wound Nurse of new Skin Alteration or Skin Ulcer. b) Complete Incident Report in Risk Management (Point Click Care) and Skin Sheet (paper). c) All Skin Sheet(s), Non-Ulcer or Ulcer Assessment will be updated Weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. e) The community must remove a mechanical lift sling once transfer is completed. Slings may not be left under a resident at any time when not actively transferring. a) If the Skin Ulcer or Non-Ulcer has not made improvements after the first two weeks, the community must notify the residents physician.