STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265764	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Dilworth	9645 Big Bend Blvd Saint Louis, MO 63122

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals and needs, desire to be discharged , the resident's capacity for discharge, including caregiver support availability, capacity, and capability to perform required care, and failed to involve the resident, family member, and the interdisciplinary team (IDT) in developing a discharge plan, with interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition to the post-discharge setting and reduce factors leading to preventable readmissions. The facility failed to document and include the evaluation of the resident's discharge needs and failed to discuss the results of the evaluation with the resident and family, and incorporate it into the discharge plan, which is a part of the comprehensive care plan. The facility failed to discuss with the resident, and the family member, and document the implications and/or risks of being discharged to a location that is not equipped to meet the resident's needs and attempt to ascertain why the resident chose to return home, failed to document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed, failed to document that despite being offered other options that could meet the resident's needs, the resident refused those other more appropriate settings, and failed to determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The facility failed to identify changes in the resident's conditions, which impacted the discharge plan, and warranted revisions to interventions. The facility failed to identify post-discharge needs for nursing services for wound care, possible modifications to the home, and activities of daily living (ADL) assistance. The resident was discharged to home, alone, without required home health care services, and without education or instructions of how to care for the coccyx/sacral wound. Five residents were sampled, and problems were identified with one (Resident #5). The census was 149. Review of the facility's policy for Discharge of a Resident, affecting the Social Services Department, revised 7/2022, showed: -Purpose: A recapitulation of the resident's stay at the facility will be part of the permanent medical record when the resident is discharged from the facility; -Responsibility: It is the responsibility of the assigned Social Worker to document a discharge summary; -Policy: A discharge summary must be documented for a resident that discharges without an anticipated return to the facility; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Practice: -The discharge summary will include but is not limited to the following: -Statement of reason for admission to the facility; -Reason for discharge; -Psychosocial concerns or special arrangements regarding the resident's condition; -Resident's response to the discharge plan; -Resident/family involvement, including any advance notice of the discharge and notification of the right to appeal a Medicare or Medicare Advantage discharge; -Date and time for the discharge; -Discharge destination and transportation arrangements; -The discharge summary is a permanent part of the medical record. Review of the facility policy's for Discharge/Transfer of a Resident, revised 12/2022, showed: -Purpose: To provide guidelines when discharging or transferring a resident to another health care residence, another bed within the residence, or when leaving against medical advice; -Responsibility: It is the responsibility of all departments to see that the resident's transfer/discharge plans are complete and appropriate. For residents who receive care covered by Medicare A, it is their responsibility to see that the resident has utilized his/her Medicare A benefits to the fullest within the guidelines established by CMS; -Policy: Bethesda communities comply with federal regulations to permit each resident to remain in the community, and not transfer or discharge the resident unless the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the community; -Non-emergency discharges, initiated by the community, return not anticipated: -Document the reasons for the transfer or discharge in the resident's medical record, and in the case of necessity for the resident's welfare and the resident's needs cannot be met in the community; -Contents of the transfer/discharge notice must include: -The reason for transfer or discharge; -The effective date of transfer or discharge; -The location to which the resident is transferred or discharged ; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An explanation of the right to appeal the transfer or discharge; -Orientation for transfer or discharge must be provided in a form and manner that the resident can understand and documented to see that a safe and orderly transfer is affected; -Assist with transportation arrangements and any other arrangements as needed; -Assist with any appeals as desired by the resident; -When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would be endangering the health or safety of the resident or other individuals in the facility; -The physician shall document medical reasons for transfer or discharge in the medical record, when the reason for transfer or discharge is for any reason other than nonpayment of the stay or the community ceasing to operate; -Anticipated Discharges: -Obtain physicians' orders for discharge and instructions or precautions for ongoing care; -A member of the interdisciplinary team completes relevant sections of the Discharge Summary; -The nurse caring for the resident at the time of discharge is responsible for seeing that the Discharge Summary is complete; -A recap of the resident's stay that includes the diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; -A final summary of the resident's status; -Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter); -A post-discharge plan of care that is developed with the participation of the resident to adjust to his or her new living environment; -Education for discharge must be provided and documented to see that a safe and orderly transfer occurs, in a form and manner that the resident can understand. Depending on the circumstances, this education may be provided by various members of the interdisciplinary team; -The nurse/designee will assist with transportation arrangements and any other arrangements as needed; -The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Specific to rehabilitation and therapy center for discharge to home or another facility: -Discharge planning will be established and discussed through the Utilization Review meeting and the discharge date established when the report indicates plateauing and/or the resident has met goals; -If necessary, rehabilitation services will make a home visit prior to discharge to assess physical environment, making recommendations as necessary; -Once the resident has utilized his/her Medicare A benefits to the fullest within the guidelines established by CMS, it is the responsibility of the discharging residence to notify the resident of the determination of discharge in writing, within 48 hours prior to discharge, that the resident has met his/her established rehabilitative goals and/or that the qualifying medical necessity for a skilled stay in a Medicare A bed has been met or exhausted and the need for discharge planning is eminent; -The Social Service Staff/Designee will obtain the signature of the resident/resident representative on the notice as stated above; -The residence will keep the copy of the notice in the medical record in the Social Services section; -The resident/resident representative will be given the original notice; -The Social Worker will consult with resident/resident representative regarding discharge plans and their choice of Home Health Care and durable medical equipment (DME) provider and alert the IDT to upcoming discharge via email; -Nursing will obtain physician orders including any Home Health Care, DME providers or equipment, and medications to be sent home with resident; -Social Services will send a Discharge Notification letter with attached discharge orders to the resident's Primary Care Physician via fax, mail, or electronically; -A copy of the Discharge Notification letter and the fax confirmation, if applicable, will be placed in the medical record; -Day of discharge: -Nursing will assist to pack belongings (reference Inventory sheet to be sure all belongings are sent with the resident); -Nursing will send medications with the resident per contract pharmacy policy and procedures; -Complete the discharged Resident Medication Transfer Record. Print only the necessary discharge information. Have resident/resident representative sign the form. Make a copy of the form and give the original to the resident; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fax the signed discharged Resident Medication Transfer Record to the pharmacy. Place the copy and fax confirmation in the medical record; -Nursing will prepare resident for discharge; -Nursing will complete a Discharge/Transfer progress note, complete and print Discharge Instructions, and have the resident/resident representative sign and date the Discharge Instruction sheet and receive a copy; Discharge to home: -Social Worker will consult with Resident/Resident Representative regarding discharge plans and choice of home health care and DME provider that is certified; -Nursing will obtain a physician order including any home health care of DME and medications to be sent home with resident. Nursing will notify Social Services that the discharge order has been obtained; -Nursing will obtain order from physician; -Social Worker will arrange/assist with transportation as necessary; -Social Services and Nursing will provide pertinent medical information. Review of the facility's policy for Return to Home, affecting all Nursing, Social Service, and Rehabilitation (Rehab) Staff, revised 5/2023, showed: -Purpose: All residents returning home from The Rehab and Therapy Center should be at the highest possible level of function in order to promote a safe return home and reduce the risk of injury or re-hospitalization; -Responsibility: It is the responsibility of all Nursing, Social Service, Dietary and Rehab staff to promote that all residents achieve their maximum level of function prior to discharge from the Rehab and Therapy Center; -Policy: All residents will be observed for a designated amount of time prior to discharge from the Rehab and Therapy Center to a home setting to see that they are able to function at and maintain the highest level of independence that they achieved during their rehab stay; -Practice: -Within one week of admission, the Interdisciplinary team will set care plan goals with resident and/or family based upon their prior level of function; -Interventions will be implemented by IDT members to help resident achieve these goals during their stay; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is communicated to the resident and their family, that the resident will be observed for a designated period of time to monitor they are safe to return home; -Therapy will provide Nursing with recommendations that indicate what ADLs the resident is able to perform independently and what ADLs the resident requires assistance with. Nursing will encourage the resident to perform all ADLs as independently as possible and only provide assistance when necessary; -The resident will be provided with the appropriate DME to use during their therapeutic stay, in order to achieve the highest level of independence, in the Rehab Center. However, DME brought from home is preferred if that is what the resident will be using upon return to home; -The resident's room will be adapted to simulate the home setting as much as possible while maintaining safety. Example: the resident's bed will remain at the height of the bed at home; -When it is determined that the resident has met all goals or plateaued in therapy and at their highest level of function, therapy will set a last covered day for therapy; -An indicator will be placed next to the resident's name plate on the room to indicate that the resident is in the return to home phase of rehab. The return to home phase of rehab includes not only ADL independence tasks but could include disease knowledge and management if applicable. The indicator will alert staff that the resident will be discharging soon and should be encouraged to be as independent and knowledgeable as possible to promote a safe return home. This will also be communicated to the resident and their caregivers; -Nursing staff is responsible for documenting in the resident's medical record, their ability to perform ADL tasks to the highest level of function, the amount of assistance or cues required as well as education and response to learning as applicable; -Nursing and Therapy staff will review documentation and residents level of function to verify that the resident is maintaining their highest level of function. If a decline is noted, discharge plan will be re-evaluated to see if additional services are required. Review of Resident #5's undated facility face sheet (first page of a medical record with the resident's demographics, medical diagnoses, family contacts, and physician contacts) showed: -No admission date; -Diagnoses of: -Diabetes mellitus with insulin use; -Chronic (long-term/ongoing) congestive heart failure (CHF, heart unable to pump enough blood to meet the body's needs); (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Permanent atrial fibrillation (an arrhythmia/irregularity in heartbeat); -Atherosclerotic heart disease (plaque buildup inside of arteries of the heart); -Transient ischemic attack (TIA, a brief neurological dysfunction caused by blocked or reduced blood flow to a part of the brain); -Cerebral infarction (stroke) without residual deficits; -Major depressive disorder; -Chronic kidney disease stage 3 (moderate kidney damage with loss of half the kidney's function, causing high blood pressure, anemia, and bone disease); -Peripheral vascular disease (PVD, a narrowing of the blood vessels that restricts blood flow and mostly occurs in the legs); -Hypothyroidism (low thyroid hormone production, resulting in slowing the speed of the life-sustaining chemical activity/metabolism of the body); -Gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows back into the esophagus, also called acid reflux); -Inappropriate diet and eating habits. Review of the resident's undated Care of Resident Profile (CORP, plan of care) report, showed: -Resident's goal was to return home after short term rehabilitation; -Resident received significant medications: antidepressants, diuretic (water pill), antiplatelets (blood thinner), hypoglycemics (lower blood sugar) and anticonvulsants (prevent seizures); -Required one person assistance with transfers, use of front wheeled walker with ambulation, bed mobility, bathing, grooming and dressing; -Resident at risk for falls due to weakness: -Ensure personal items are within reach; -Make frequent rounds to ensure safety; -Goal-To reduce the risk factors that contribute to fall risk and to minimize injury related to falls throughout this review period; -Resident always wore protective briefs to protect clothing and dignity: -Staff to assist with changing when soiled; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to assist with peri-care as needed and requested; -Goal-To maintain the current level of continence, remain clean and dry, and minimize the risk of skin breakdown through this next review period; -Resident required no assistance with eating and the goal was to improve/maintain current nutritional status: -Was on a pureed diet (no reason for pureed diet given); -Required encouragement to eat meals and drink fluids; -Staff to monitor meal intake and report anything below 50% to the nurse; -Resident was diabetic and required sliding scale insulin; -Goal-To manage diabetes through good food choices and monitoring of blood sugar; -Received a routine antidepressant, for diagnosis of depression: -Staff to monitor for unwanted side effects such as mood swings, or aggressive behaviors; -Goal-To maintain a stable mood with reduced anxiety and be free of unwanted side effects; -Staff to check skin daily, during care, and inform the nurse of any skin issues: -Staff to reposition frequently; -Staff to let the nurse know if there were any new areas of redness or skin impairment; -Standard pressure reducing mattress and wheelchair cushion in place; -Goal-To reduce the risk factors that could contribute to skin impairment or optimize wound healing through next review period; -Resident had a pressure wound on the coccyx (no date): -Staff to monitor area for signs and symptoms of infection and alert the nurse of any changes; -Staff to keep the dressing clean, dry, and intact; -Staff to ensure the low air loss mattress (LAL, a medical-grade mattress that helps prevent and treat pressure ulcers by using air cells to distribute body weight and circulate air to keep skin dry) was working, before helping the resident into bed; -The resident was at risk for bleeding due to anticoagulant use: -Monitor for any signs of bleeding and notify my nurse immediately; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal-To minimize my risk for bruising and bleeding related to these medications through the next review period; -Resident was at risk for pain due to recent hospital stay: -Resident had pain medication and non-pharmacological interventions to help relieve pain; -Goal-To maintain a comfort level that does not interfere with ADLs through the next review period; -Persons who participated in developing this plan: There were no electronic or handwritten signatures, signifying who or whom wrote this plan of care. -No documentation of the resident's learning disability, due to a mild intellectual impairment, and no further documentation of detailed discharge planning. Review of the resident's nurse admission electronic checklist assessment, dated 10/16/24, with no time of admission, showed: -Living situation, listed as independent at home; -No evident barriers to learning; -Resident used wheelchair for mobility; -Skin integrity, localized abnormality (no additional information provided); -Preventative skin care, barrier cream (a topical product that creates a physical barrier between the skin and moisture/irritants from loss of bowel/bladder control); -Edema location, generalized (generalized edema-fluid accumulates throughout the entire body); -History of fall last three months; -Weak gait (walk); -Independent with ADLs, but required one person partial/moderate assistance to: -Move from a bed to chair transfer; -To go from lying to sitting on side of the bed; -To go from sitting on side of the bed to lying; -To safely move from a bed to chair transfer; -To go from sitting to standing; -Transfer on and off the toilet; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-To roll left to right in bed; -Transfer in and out of a car; -To pick up an object. Review of the resident's Social Worker (SW) E note, dated 10/17/24 at 10:07 A.M., showed the SW was familiar with the resident as the resident was at the facility not long ago. The resident lived alone, and his/her goal was to return back home, once he/she was done with therapy. Review of the resident's physician's assessment, dated 10/17/24 (no time), showed: -The resident had a history of severe aortic valve stenosis (a heart valve disease that occurs when the aortic valve becomes so narrow that it cannot fully open, thereby reducing blood flow from the heart to the body), permanent atrial fibrillation, diabetes, and coronary artery disease (CAD, the coronary/heart arteries narrow or become blocked); -The resident re-admitted to the hospital after a recent discharge to home, from rehabilitation services at the facility, because he/she fell the next day, on 10/12/24, at home; -The resident was seen that morning, up in the chair, and the resident said he/she was not ready to go home (referring to his/her discharge from the facility to home on [DATE]), got dizzy and fell; -Past medical history showed the resident had a learning disability, due to a mild intellectual impairment; -Impression/Plan: -Chronic coccygeal wound; -Wound care team to follow while at facility. Review of the resident's physiatry (specializing in maximizing physical function, through physical therapy, to foster independence and improve quality of life) Nurse Practitioner (NP) A history and physical evaluation, dated 10/17/24 at 8:53 A.M., showed: -Chief complaint: Mobility deficit (a disability that limits a person's ability to move) and ADL deficits, secondary to frequent falls; -The resident had been getting short of breath and dizzy and was hospitalized for falls; -The hospital diagnosed the resident with CHF exacerbation (a worsening or flare-up of a pre-existing chronic condition), which was the likely cause of the resident's dizziness and shortness of breath; -The resident had a [NAME] procedure (a minimally invasive surgery that implants a device in the heart to reduce the risk of stroke) for his/her diagnosis of atrial fibrillation; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-New order given to nurse to start hydroxyzine twice daily again, for three days, then change to as needed; -Chronic coccygeal wound: -Wound care team to follow while at f

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	265764	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Dilworth	9645 Big Bend Blvd Saint Louis, MO 63122

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pressure ulcer treatments as ordered and failed to notify the physician when the ulcer developed drainage and a foul odor, shortly before the resident was discharged . The resident was discharged to home, alone, without home health registered nursing care services, and without education or instructions of how to care for the coccyx/sacral wound. Five residents were sampled, and problems were identified with one (Resident #5). The census was 149. Review of the facility policy for Skin Integrity, Assessment, and Prevention of Wounds/Other Skin Conditions, revised on 9/2022, showed: -Purpose: -To prevent avoidable skin breakdown and pressure injuries; -Provide guidelines for the treatment of impaired skin; -Provide guidelines for documentation. -Policy: -All residents will be assessed for the risk of skin breakdown; -Risk factors identified will be evaluated; -Interventions will be developed and implemented to minimize or stabilize risk; -Interventions will be care planned. -Assessment: -The admitting nurse will complete a head-to-toe skin assessment and Braden risk assessment (an assessment tool used to determine a resident's risk for developing pressure ulcers) to determine the absence, or presence, of any existing skin impairment or risk for skin impairment and document accordingly; -If there are existing impairments, implement appropriate interventions, including notification of the physician and obtaining treatment orders; -If there are no existing impairments, document there are none; -For residents who do not already have skin impairment, utilize the Braden score to assist in identification of preventative measures; -Document these measures on the resident's care plan; -Severe risk: Braden of less than 9; (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-High risk: Braden of 10-12; -Moderate risk: Braden of 13-14; -Mild risk: Braden of 15-18; -The Braden Scale is to be completed: -On admission; -Weekly for the first four weeks after admission; -Quarterly; -Significant change in condition. -Examples of other risk factors, which should be considered, are: -Previous history of pressure injuries; -Diagnoses such as diabetes, thyroid disease, congestive heart failure, peripheral vascular disease, and cardiovascular disease; -Poor intake of protein; -Resident's refusal of care and treatment. -Prevention: -Residents at risk should be monitored; -An individualized turning and positioning schedule is advised and must be communicated to the Certified Nurse Assistant (CNA), to reduce pressure and aid in providing comfort; -Keep residents clean and dry to minimize skin exposure to moisture from urine and feces; -Apply a moisture barrier product to provide protection from incontinent episodes; -Note any limitations in mobility or activity; -For residents who are at severe risk, additional pressure reducing devices should be considered; -For residents who are at severe risk, skin care preventative measures are in place, such as skin prep, Cavilon cream, or other protective ointment; -Consult the dietitian for nutritional concerns; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Offer supplemental nutrition such as fortified foods, vitamin and mineral supplements when applicable, and monitor, evaluate and document; -CNA will report any abnormal findings to a nurse; -Abnormal findings will be assessed by a licensed nurse and appropriate interventions and documentation completed by that nurse; -All assessments, interventions, and outcomes must be documented in the medical record. Review of the facility's policy for Treatment of Pressure and Non-Pressure Injuries, Staging and Documentation, revised on 10/2023, showed: -Purpose: To provide guidelines for use in wound assessment, treatment, and documentation. -Policy: -The Wound Product Selection Guide will be used as guidelines to determine appropriate treatments; -A physician's order is required for all wound treatment. -Practice: -General Principles of Wound Care: -Before choosing an intervention or treatment, it is important to identify the type of wound; -Keep the wound clean; -For wet wounds add absorbent dressing; -For dry wounds add moisture; -Protect wound with the appropriate dressing; -Protect periwound (the outside skin area surrounding the wound) with products to prevent maceration (skin softening and break down because of prolonged exposure to moisture) with products such as skin prep (protective wipes, that form a protective barrier film, which help to shield the skin from moisture and friction), Cavilon cream (a transparent skin protectant that creates a protective barrier from bodily fluids, friction, and adhesives) or zinc oxide (topical ointment to protect and treat the periwound area); -Interventions should be taken to reduce edema (swelling) and pressure, such as off-loading (reduce or eliminate pressure) the heels and repositioning; -Individualize a turning schedule; -Evaluate mattress type and add specialized mattress if indicated; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessment and Documentation: -Any wound is to be assessed by a licensed nurse or licensed practitioner; -Weekly documentation, at least, of the wound location, stage (a classification system used to categorize the severity of a wound based on the depth of tissue damage and the extent of tissue loss), size, odor, undermining (the wound area that lies beneath the wound opening is larger than the hole or entrance of the wound; like a cavity or cavern), tunneling (when a chronic wound forms a channel or tract that extends from the skin's surface into deeper tissue), exudates (the fluid that leaks out of blood vessels into a wound), necrotic tissue (dead or dying tissue in a wound, prevents healing, can appear dry, black, leathery, or discolored, swollen, and smelly), presence or absence of granulation tissue (new connective tissue that forms in a healing wound and is red, bumpy, and moist), periwound, and wound edge description; -Location: Describe the precise location of the wound in anatomical terms; -Staging: -Suspected deep tissue injury-persistent non-blanchable (when pressure applied to the reddened skin area, the area does not turn lighter color, or blanch, indicating a problem with capillary blood flow to the area) deep red, maroon, or purple discoloration; -Stage I pressure injury-non-blanchable erythema (reddened skin) of intact skin; -Stage II pressure injury-partial skin loss (damage to the epidermis/top layer of skin, and possibly the dermis/second layer of skin, but not the subcutaneous tissue (layer of fatty tissue underneath the skin), appearing as a shallow, open wound, with red or pink base, or an intact or ruptured serum-filled blister) with exposed dermis; -Stage III pressure injury-full-thickness (wound that extends past the top two layers of skin) loss of skin in which adipose (fat) tissue is visible, granulation tissue may be visible, slough (white, yellow, tan, gray or green dead tissue) or eschar (layer of dead, hardened tissue that forms over a wound, appearing as a dry crust of scab) may be visible but does not obscure the depth of tissue loss, undermining and tunneling may be present, but there is no exposed/visible fascia (a thin layer of connective tissue that surrounds and supports every organ, muscle, bone, and nerve in the body), tendon (a fibrous connective tissue that attaches a muscle to a bone or other structure), ligament (a band of connective tissue that connects bones to other bones), cartilage (a flexible, tough, connective tissue that protects bones and joints, and gives structure to parts of the body like the ears and nose), muscle or bone; -Stage IV pressure injury-full thickness skin and tissue loss with exposed, or directly palpable, fascia, bone, tendon, muscle, cartilage in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining, and/or tunneling often occur; -Unstageable-When the wound bed is covered by slough and/or eschar, not allowing the true depth to be visualized. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Size: -Measure the wound in centimeters (cm), including the length, width, and depth; -Measure from the healed margins to the healed margins; -Use clock coordinates to measure and document any tunneling or undermining. -Odor: -Describe the odor of the wound as none, mild, or foul, after cleaning. Color: -Describe the color of the involved area, and wound bed, in terms of color such as pink, red, yellow, white, black, or brown and estimate percentage of colors; -Surrounding Tissue (periwound): Assess the tissue surrounding the wound and document the involved areas, such as inflammation, maceration, wet wound edges, tenderness, warm or cool to touch, skin turgor (ability of the skin to return to its original shape after being pinched or pulled), hypertrophic (overgrown), callused, thickened, or any other finding; -Drainage: Describe the type, amount, and color of the drainage; -Pain: -Describe pain related to the wound; -Incorporate interventions to reduce pain in the care plan; -Document interventions and outcomes in the medical record. -Monitoring of wounds: -Weekly wound rounds will be made by the Director of Nursing or designee to assess all wounds (pressure and non-pressure); -Monitor wounds for signs and symptoms of infection such as purulent exudates, periwound warmth, swelling, induration (hardening), erythema, delayed wound healing, or increased pain or tenderness around the site; -Blood work with elevated white blood cells, bacteremia (bacteria present in the blood), sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection, and can lead to organ failure, shock, and death if not treated promptly) or fever, may signal an infection related to the pressure ulcer; -If any of the above symptoms develop, intervene appropriately, including notification of the physician and obtaining orders and update the plan of care as appropriate; (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the wound fails to show some evidence of progress toward healing within two weeks, the wound and resident's overall clinical conditions should be reassessed, and the treatment plan re-evaluated; -The decision to change, modify, or remain with the same treatment plan should be documented; -The rationale for continuing with the same treatment should be well documented; Documentation: -It is critical that all caregivers document their observations and activities. For example, CNAs are critical to the process by reporting abnormal skin observations, documenting nutrition and hydration, turning and positioning, peri-care, etc.; -Nurses also have a variety of documentation responsibilities as indicated throughout and are critical to the process of documenting interventions that have been taken to avoid pressure injuries; -The definition of Avoidable means that the resident developed a pressure injury, and the facility did not do one or more of the following: -Evaluate the resident's clinical condition and pressure injury risk factors; -Define and implement interventions consistent with resident's needs and goals, and consistent with recognized standard of practice; -Monitor and evaluate the impact of the interventions; -Revise the interventions as appropriate. -Document presence or absence of skin impairment of any kind on admission, transfer, and discharge. If present, describe the condition or wound thoroughly; -Skin condition should be assessed within two hours of admission, re-admission or return from LOA and documented; -The residents' skin conditions are to be documented at least weekly; -Documentation encompasses, at a minimum, all assessments, interventions, including prevention measures taken, monitoring of nutrition and hydration, and interventions taken to address underlying diseases that might impact risk for skin breakdown or wound healing; -Documentation is key to show that everything is being done to prevent those avoidable pressure injuries and heal pressure injuries. Review of Resident #5's undated facility face sheet (first page of a medical record with the resident's demographics, medical diagnoses, family contacts, and physician contacts), showed: -No admission date; (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses: -Diabetes mellitus with insulin use; -Chronic (long-term/ongoing) congestive heart failure (CHF, heart unable to pump enough blood to meet the body's needs); -Permanent atrial fibrillation (an arrhythmia/irregularity in heartbeat); -Atherosclerotic heart disease (plaque buildup inside of arteries of the heart); -Transient ischemic attack (TIA, a brief neurological dysfunction caused by blocked or reduced blood flow to a part of the brain); -Cerebral infarction (stroke) without residual deficits; -Major depressive disorder; -Chronic kidney disease stage 3 (moderate kidney damage with loss of half the kidney's function, causing high blood pressure, anemia, and bone disease); -Peripheral vascular disease (PVD, a narrowing of the blood vessels that restricts blood flow and mostly occurs in the legs); -Hypothyroidism (low thyroid hormone production, resulting in slowing the speed of the life-sustaining chemical activity/metabolism of the body); -Gastro-esophageal reflux disease (GERD, a digestive disorder that occurs when stomach acid flows back into the esophagus, also called acid reflux); -Inappropriate diet and eating habits. Review of the resident's nurse admission electronic checklist assessment, dated 10/16/24, with no time of admission, showed: -Skin integrity, localized abnormality (no additional information provided); -Preventative skin care, barrier cream (a topical product that creates a physical barrier between the skin and moisture/irritants from loss of bowel/bladder control); -Edema location, generalized (generalized edema-fluid accumulates throughout the entire body); -History of fall last three months; -Weak gait; -Living situation, independent at home; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Independent with activities of daily living; -Required one person partial/moderate assistance to move from a bed to chair transfer; -Required one person partial/moderate assistance to go from lying to sitting on side of the bed; -Required one person partial/moderate assistance to go from sitting on side of the bed to lying; -Required one person partial/moderate assistance to safely move from a bed to chair transfer; -Required one person partial/moderate assistance to go from sitting to standing; -Required one person partial/moderate assistance for toilet transfer; -Resident uses wheelchair for mobility; -Required one person partial/moderate assistance to roll left to right in bed; -Required one person partial/moderate assistance for car transfer; -Required one person partial/moderate assistance to pick up an object; -No evident barriers to learning. Review of the resident's nurse admission skin assessment, dated 10/16/24 at 7:08 P.M., showed: -Skin color, general: Usual for ethnicity; -Skin temperature: Warm; -Skin moisture, general: Dry; -Skin turgor, general: Elastic; -Skin integrity, general: Localized abnormality; -Mucous membrane color: Pink; -Mucous membrane description: Moist; -Preventative skin care: Barrier cream; -Sensory perception Braden: Slightly limited. Review of the resident's weekly nurse skin flowsheet, showed: -10/16/24 at 7:08 P.M.: (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident re-admitted to the hospital after a recent discharge to home, from rehabilitation services at the facility, because he/she fell the next day, on 10/12/24, at home; -The hospital found the resident had positive orthostats (referring to orthostatic hypotension); -Cardiology, in the hospital, scheduled surgery for a transcatheter aortic valve replacement (TAVR, a minimally invasive procedure that replaces a diseased aortic valve with a new one, and is most often used in older adults who are not healthy enough for regular valve surgery), on 10/22/24, for severe aortic stenosis; -The physician documented the resident was seen that morning, up in the chair, and the resident said he/she was not ready to go home (referring to his/her discharge from the facility to home on [DATE]), got dizzy and fell; -Past medical history showed the resident had a learning disability, due to a mild intellectual impairment; -Medications listed, as received during the recent hospitalization: -Hydrophilic wound dressing (a sterile paste applied to wounds to absorb exudate and promote healing), to affected area twice daily (affected area not listed); -Physical examination: -Skin warm and dry with no rash or jaundice; -Impression/Plan: -Chronic coccygeal (tailbone area) wound; -Wound care team to follow while at facility. Review of the resident's physiatry (specializing in maximizing physical function, through physical therapy, to foster independence and improve quality of life) Nurse Practitioner (NP A) history and physical evaluation, dated 10/17/24 at 8:53 A.M., showed: -Chief complaint: Mobility deficit (a disability that limits a person's ability to move) and activities of daily living (ADL, basic self-care tasks performed independently to maintain daily life, like getting in and out of bed, chairs, or vehicles, dressing, bathing, toileting, mobility, and managing bladder and bowel functions) deficits, secondary (a result of) to frequent falls; -The resident had been getting short of breath and dizzy and was hospitalized for falls; -The hospital diagnosed the resident with CHF exacerbation (a worsening or flare-up of a pre-existing chronic condition), which was the likely cause of the resident's dizziness and shortness of breath; (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a [NAME] procedure (a minimally invasive surgery that implants a device in the heart to reduce the risk of stroke) for his/her diagnosis of atrial fibrillation; -The resident reported a poor appetite and said he/she just wanted tomato soup; -The resident lived in a home alone, with a Life Alert device (a device worn, with a button, that connects users to a monitoring center in the event of an emergency); -Gait-Not attempted at this visit; -The resident's assessment showed: -ADL and mobility dysfunction, secondary to frequent falls; -Deconditioning (the physical and mental changes that occur when someone is inactive for a period) and gait instability: The resident was at high risk for functional impairment without therapy; -The resident's full physical and occupational therapy (OT) evaluations were still pending. Review of the resident's weekly nurse skin flowsheet, showed: -10/17/24 at 7:50 P.M.: -Skin color general: Usual for ethnicity; -Skin temperature: Warm; -Skin moisture general: Dry; -Skin turgor general: Elastic; -Mucous membrane color: Pink; -Mucous membrane description: Moist; -Preventative skin care: Barrier cream; -Sensory perception Braden: Slightly limited; -Moisture Braden: Occasionally moist; -Activity Braden: Chairfast; -Mobility Braden: Very limited; -Nutrition Braden: Adequate (continued on next page)

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	265764	A. Building B. Wing	01/29/2025

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