

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Kettering Heights Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3313 Wilmington Pike Kettering, OH 45429	

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy interview, the facility failed to ensure resident records were provided timely upon request. This affected two residents (#97 and #101) of three reviewed for record requests. Facility census was 95. 1. Review of the medical record for Resident #97 revealed an admission date of 05/31/23 and discharge date of 10/15/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 13, indicating intact cognition. Review of the authorization to disclose health information dated 06/23/25 revealed a record request was made for the entire electronic nursing home chart from dates 05/28/23 to 10/15/24 by an attorney handling the estate of Resident #97. Review of the letter dated 06/24/25 revealed a records request for Resident #97 requesting the electronic nursing chart. A handwritten note on the letter stated, emailed 07/01/25. Review of email communication dated 07/30/25 from the Administrator to Medical Records (MR) #301 revealed an attorney for Resident #97 stated he requested records three times and was going to subpoena records. The Administrator requested MR #301 to contact him. Review of email communication dated 07/30/25 from MR #301 to the Administrator revealed a record request was received for a resident that was admitted when facility was Legacy (they recently were sold). The email stated they had received more requests. MR #301 reported she had not been instructed on what to do with records from the previous ownership and reported she had paper copies. She stated, I did not think we were supposed to send information that was before the facility was sold. The email also noted the attorney was now threatening subpoena for the records. Review of multiple email communications between facility staff and regional legal department staff dated 07/03/25, revealed staff asked if any direction was given from the previous company and stated if an official request or subpoena had been provided, the facility staff can produce the records. An email then stated to wait until they received the subpoena. A separate email stated, if they get exasperated and say they would just serve you with a subpoena, that's fine, it might actually light a fire under someone. Review of multiple email communications between facility staff and regional legal department staff dated 08/01/25 to 08/04/25 stated the facility heard from the previous ownership company stating they no longer manage these buildings. Staff was instructed to send the request to the regional legal department and proceed with gathering records to the law firm. Additional emails instructed staff to send records to legal department for them to prepare. Interviews on 08/11/25 from 2:48 P.M. to 3:10 P.M. with MR #301 confirmed she had not provided any medical records since 01/2025 when the new company took over ownership. MR #301 stated records had not been sent to Resident #97's estate attorney. She confirmed she received an email from the Administrator that the attorney was threatening to subpoena for records. MR #301 acknowledged Resident #97's attorney had waited over a month to receive records without results. 2. Review of the medical record for Resident #101 revealed an admission date of 01/10/24 and discharge date of 01/26/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of seven, indicating impaired cognition. Review of authorization to disclose health information dated 01/13/25 revealed a record request was made for all records by Resident #101. Review of the letter dated 07/29/25 revealed a records request for Resident #101 requesting the medical record. MR #301 revealed this was a subpoena for documents. Review of email communication dated 08/04/25 from regional legal staff to additional regional legal staff as well as MR #301 revealed the record request was valid and requested for documents to be prepared and files shared with legal to authorize release. Interviews on 08/11/25 from 2:48 P.M. to 3:10 P.M. with MR #301 confirmed she had not provided any medical records since 01/2025 when the new company took over ownership. MR #301 stated records had not been sent to Resident #101 or his attorney. She confirmed she was unaware and never saw the medical release request from 01/2025. MR #301 did not have knowledge or understanding of the requirement to provide records in a timely manner even when residents were admitted under a previous ownership name. MR #301 acknowledged the policy stated record requests should be provided within two business days upon written or oral request and confirmed the facility did not follow that policy/procedure. Review of policy titled, Access to Personal and Medical Records, dated 05/2017 revealed each resident had the right to access and or obtain copies of his or her personal and medical records upon request. It stated a request shall be submitted orally or in writing. Access shall be provided within 24 hours (excluding weekends and holidays and two business days for copies of the records. This deficiency represents non-compliance investigated under Complaint Number 2581293</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interviews, and policy review, the facility failed to timely notify the physician of signs and symptoms of dry gangrene toes and ankle which in turn resulted in delayed treatment. This resulted in actual harm when Resident #98's toes on the left foot began to show signs and symptoms of dry gangrene and the facility staff had not notified the physician in a timely manner. Resident #98 required a left above knee amputation (AKA) the same night he was sent to the hospital for acute limb ischemia and dry gangrene. This affected one (Resident #98) of three residents reviewed for wound care. Additionally, the facility also failed to ensure the accuracy of skin assessments. This affected two (#98 and #99) of three reviewed for skin assessments. The facility census was 95.1. Review of the medical record revealed Resident #98 was admitted to the facility on [DATE] and discharged [DATE] with the following diagnoses: non-sterni elevation myocardial infarction (a type of heart attack where a coronary artery is partially or completely blocked, reducing blood flow to the heart and causing damage to the heart muscle), sepsis due to Escherichia coli and Type II diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 had intact cognition. This resident was assessed to be moderate assistance with toileting and dressing with maximal assistance with bathing.</p> <p>Review of the skin assessment dated [DATE] revealed there was a small area on left lower shin and left toes.</p> <p>Review of the care plan initiated 12/05/24 for Resident #98 revealed skin checks to be completed weekly due to anticoagulants.</p> <p>Review of the skin assessment dated [DATE] revealed there were no skin issues. There were no other skin assessments completed in the medical record.</p> <p>Review of the Physician's note dated 12/30/24 revealed Resident #98 had ongoing chronic pain syndrome especially with neuropathy pain, and because of issues with lethargy and sleepiness, he will be a poor candidate for Neurontin or Lyrica, and with underlying diabetes, cannot be on NSAIDs. Physician noted: Skin-Warm and dry, no rashes, lesions, or unusual pigmentation, skin turgor normal.</p> <p>Review of shower sheets dated 01/10/25 noted no skin issues and 01/14/25 noted left foot and back of left ankle to be turning black and painful.</p> <p>Review of the Nurse Practitioner's (NP) #600 note dated 01/14/25 at 3:34 P.M. revealed the NP addressed abnormal laboratory results. Resident #98 complained of increased urinary frequency and requested a sleep aid. NP #600 ordered a urinalysis test to be completed. NP noted: Skin-Warm and dry, no rashes, lesions, or unusual pigmentation, skin turgor normal.</p> <p>Review of the nurse's notes dated 01/14/25 at 11:13 P.M. revealed Resident #98 had toes on left foot that looked gangrenous and were painful. Nurse placed a note in the doctor's book and stated she would pass it on to morning shift to notify the physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician's notes dated 01/16/25 revealed Resident #98 was having issues with worsening left toe wounds with necrosis and concerns for limb ischemia and concerns for gangrene of the toes with issues of pain control. Resident #98 was sent to the hospital for further workup and possible revascularization.</p> <p>Review of the hospital records dated 01/16/25 to 01/22/25 revealed Resident #98 received a left leg above the knee amputation due to dry gangrene of the left lower extremity on 01/16/25 through 01/17/25. Resident #98 was found to have an occlusion of left superficial femoral artery with blood flow to the left profunda. Contracture to the left lower extremity. The aspect of the foot was dusky purple red. The foot and ankle demonstrated two ulcerated lesions, 1.7 centimeters (cm) and 4.6 cm each in greatest dimension. Toes number one through four demonstrated red-purple dusky areas of skin discoloration that demonstrate sloughing of the skin. Within these dusky areas, there are areas of mummification. Sections through these areas revealed hemorrhagic and necrotic soft tissue. Resident #98 was discharged on 01/22/25 to a different rehabilitation facility.</p> <p>Interview with Administrator on 08/11/25 at 11:10 A.M. revealed gangrenous area was found on 01/14/25 and the physician was notified and saw Resident #98 on 01/16/25. The Administrator educated Registered Nurse (RN) #201 on 01/20/25 regarding notifying physician with high level change of condition.</p> <p>Interview with Nurse Practitioner (NP) #360 on 08/11/25 at 3:51 P.M. revealed NP #360 does not complete a head-to-toe assessment every time a resident is seen. NP #360 stated he does not always look in the doctor's book because the nurse manager tells him who he needs to see and why. NP #360 recalls Resident #98 and visiting him on 01/14/25 to review the resident's laboratory results. Resident #98 only complained of frequent urination and a urinalysis was ordered. NP #360 verbalized not being notified the night of 01/14/25 or on 01/15/25 of Resident #98's condition. NP #360 stated on 01/15/25, he was in the building because Wednesdays are his day to be in the facility. NP #360 was not sure but thought maybe the wound doctor was seeing Resident #98.</p> <p>Interview with Certified Nursing Assistant (CNA) #293 on 08/11/25 at 4:17 P.M. revealed CNA #293 does not remember Resident #98. CNA #293 was the employee who signed the shower sheets for 01/10/25 and 01/14/25.</p> <p>Interview with NP #360 on 08/12/25 at 8:24 A.M revealed dry gangrene usually takes weeks to turn into gangrene and shows signs and symptoms of becoming dry, shrinking, and turning black, related to poor vascular. NP #360 verbalized he was never notified of Resident #98's change of condition. NP #360 reviewed the chart, and the last skin assessment was completed 12/12/24 stating no skin issues. NP #360 stated he felt skin assessments should have been completed weekly on Resident #98 due to his condition and possibly facility policy. NP #360 verified the facility staff should have noticed Resident #98's gangrene toes.</p> <p>Interview with Wound Physician #601 on 08/12/25 at 8:39 A.M. revealed Resident #98 was never seen by Wound Physician #601 and facility never sent a consultation. Wound Physician #601 stated a gangrene foot is more of a vascular doctor consult than for wound.</p> <p>Review of facility policy, "Prevention of Pressure Injuries," dated April 2020, revealed a skin assessment should be conducted on admission, with each risk assessment, as indicated to the resident's risk factors and prior to discharge. The policy did not address if skin assessment should be completed weekly.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy, "Change in Resident's Condition or Status," dated February 2021, revealed the nurse will notify the resident's attending physician or physician on call when there has been a significant change in resident's physical/emotional/mental condition.</p> <p>2. Review of the medical record for Resident #99 revealed an admission date of 01/01/25 and discharge date of 01/14/25. Diagnoses included chronic non-pressure ulcer of the left foot with muscle involvement, Lobar pneumonia, atherosclerosis of arteries of extremities with intermittent claudication of the left leg, chronic obstructive pulmonary disease, diabetes, peripheral vascular disease, malnutrition, surgical aftercare following surgery of the skin and tissue, pressure ulcer of the sacral region stage four, rhabdomyolysis, heart failure, and recent COVID-19.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Resident #99 was dependent on staff for toileting and transfers and required partial and moderate assistance for walking 10 feet. The MDS stated Resident #99 admitted with a stage four pressure wound, a vascular wound, and a surgical incision.</p> <p>Review of hospital discharge information dated 01/01/25 revealed wound treatment recommendations for sacrum wound included cleanse with wound cleanser, pat dry and apply silverdene then silver alginate, cover with bordered foam dressing and change daily and as needed. A treatment order for a right elbow wound included cleanse with wound cleanser, pat dry and apply small piece of Xeroform, cover with bordered foam dressing and change daily and as needed.</p> <p>Review of the admission assessment dated [DATE] revealed the resident was admitted for post acute care with a left vascular foot wound and staples to left pelvic area. Assessment of the skin found the resident had a left heel documented as soft, a left foot dorsal open area measuring five inches by three inches by one centimeter was documented as a suspected deep tissue injury, a groin wound documented as upper left with 36 staples, and a sacrum pressure wound measuring six by five by one to two centimeters and labeled a stage four. It was also mentioned the resident was incontinent of bladder. The assessment included no mention of a right elbow wound.</p> <p>Review of the physician note dated 01/02/25 revealed the resident was seen in the hospital for left foot non-healing wound with excisional debridement and was placed on antibiotics. The physician note did not include any mention of a stage four pressure wound, surgical incision wound, or elbow wound.</p> <p>Review of the comprehensive skin evaluation dated 01/02/25 revealed Resident #99 had a vascular right dorsal foot wound measuring eight by nine by 0.1 and a sacrum pressure wound measuring six by five by two and was documented as a stage four pressure wound. The wound had small serosanguinous drainage with 70% slough and 30% eschar. The assessment was completed by the Director of Nursing (DON). The assessment did not include any information of a surgical wound of the groin with staples, a soft heel, or an elbow wound.</p> <p>Review of the wound Nurse Practitioner (NP) note dated 01/02/25 revealed a vascular right foot wound was assessed and dressing change completed. No other skin impairments were reviewed or assessed by the NP. The assessment included inaccurate location as wound was on the left foot.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the comprehensive skin evaluation dated 01/08/25 revealed the resident had a vascular right dorsal foot wound measuring nine by seven by 0.1 and a sacrum pressure wound measuring nine by five by 0.1 and was listed as a stage four. The assessment was completed by the DON.</p> <p>Review of the wound NP note dated 01/08/25 revealed a pelvis coccyx wound was assessed with measurements of nine by five by 0.1. The assessment stated the wound was unstageable with 100% slough. A treatment for santyl for enzymatic debriding with bordered gauze daily and as needed was recommended.</p> <p>Interview on 08/07/25 at 1:10 P.M. with Wound Nurse #345 revealed she began employment around 01/20/25. She revealed upon admission, a resident should have a full skin assessment completed by two staff with findings documented in the medical record. She revealed the wound NP would come to facility once weekly and could be reached for questions on days she was not onsite at the facility. Wound Nurse #345 verified all skin impairments shall be documented so they can be followed until healed including scratches, bruising, skin tear, pressure wounds, and surgical incisions.</p> <p>Interview on 08/07/25 at 2:15 P.M. with the DON and the Administrator confirmed the admission assessment for Resident #99 had four skin items marked, left foot dorsal wound, heel soft, surgical incision with 36 staples, and a pressure stage four to coccyx/sacrum. The DON confirmed she completed the second assessment the same day (01/02/25) that included two skin notations including the dorsal foot open wound and the stage four pressure sore to the sacrum. The DON reported the heel being soft would not need to go on a skin assessment as it had no treatment. The DON also reported she typically would not put surgical incisions as well as incisions with staples on a comprehensive skin assessment stating, "we don't always have dressings for surgical incisions." The DON verified staff would monitor incision sites each shift for signs of infection and also verified the facility had no evidence of orders or documentation to monitor areas and incision sites and confirmed no record of staff documentation of monitoring.</p> <p>Interview on 08/11/25 at 11:00 A.M. with the Administrator revealed the facility had identified non-compliance for skin and wounds and were back in compliance. The Administrator verified compliance meant wound assessments were completed according to nursing standards and per interview with the DON and Administrator on 08/07/25, the expectations for staff did not meet standards of practice. The Administrator confirmed staff should document any and all skin impairments including scratches, bruising, soft heels, and surgical wounds.</p> <p>Interview on 08/11/25 at 3:48 P.M. with Licensed Practical Nurse (LPN) #312 verified all skin impairments should be documented on the admission and weekly assessment no matter the size. He revealed he did not remember caring for Resident #99, but if a wound treatment was mentioned on hospital discharge paperwork, the facility should make a note if they did not see the skin impairment on facility admission skin exam and get clarification from medical provider. LPN #312 also stated the importance of documenting a soft heel due to higher risk of developing a pressure sore and stated it would need increased monitoring or interventions.</p> <p>Review of facility policy titled, Prevention of Pressure Injuries, dated 04/2020, revealed facility shall identify risk factors as well as interventions. Facility shall conduct a comprehensive skin assessment upon admission and as indicated.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 1306087 and 1306090.</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of hospital records, and policy review, the facility failed to ensure timely treatments and interventions were completed for a resident's pressure ulcer. This resulted in Actual Harm on 01/14/25 when Resident #99 was hospitalized with a pressure ulcer to the sacrum which deteriorated in condition and developed purulent drainage and necrotic tissue from a delay in treatment. This affected one (Resident #99) of three residents reviewed for wounds. The facility identified six residents (#8, #11, #51, #76, #83 and #92) with pressure ulcers. The facility census was 95. Findings include: Review of the medical record for Resident #99 revealed an admission date of 01/01/25 and a discharge date of 01/14/25. Diagnoses included chronic non-pressure ulcer of the left foot with muscle involvement, lobar pneumonia, atherosclerosis of the arteries of the extremities with intermittent claudication of the left leg, chronic obstructive pulmonary disease, diabetes, peripheral vascular disease, malnutrition, surgical aftercare following surgery of the skin and tissue, pressure ulcer of the sacral region stage four (full thickness skin and tissue loss, exposing or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone), rhabdomyolysis, heart failure and recent coronavirus (COVID-19). Review of the hospital referral information dated 12/09/24 to 12/30/24 revealed Resident #99 had a left chronic foot wound with vascular surgery consulted. On 12/19/24 a pre-procedure note stated a plan for debridement of the left foot and possible trans-metatarsal amputation. Hospital orders included Augmentin 875-125 milligrams (mg) tablet twice daily for cellulitis and a coccyx wound treatment order dated 12/18/24 for silver sulfadiazine (Silvadene) topical cream with instructions to cleanse with wound cleanser, pat dry and apply Silvadene then silver alginate, cover with bordered foam dressing and change daily and as needed. Review of the hospital discharge information dated 01/01/25 revealed wound treatment recommendations for the sacrum wound included orders to cleanse with wound cleanser, pat dry and apply Silvadene then silver alginate, cover with bordered foam dressing and change daily and as needed. Review of the baseline care plan dated 01/02/25 revealed Resident #99 had a history of an ulcer and rhabdomyolysis. An arterial ulcer was documented under the skin integrity section, while pressure ulcers and an option for other were left unmarked. The interventions and goals included a select all that applied question asking reasons for nursing services, other was marked off with a comment stating, physical deconditioning. Wound care and skin breakdown prevention were left blank. No skin related interventions were documented on the baseline care plan. Review of the admission assessment dated [DATE] revealed Resident #99 was admitted to the facility for post-acute care with a left vascular foot wound and staples to the left pelvic area. An assessment of the skin found the resident had a left heel documented as soft, a dorsal left foot open area measuring 5 inches by 3 inches by 1 centimeter (cm) was documented as a suspected deep tissue injury, an upper left groin wound with 36 staples, and a sacrum pressure wound measuring 6 by 5 by 1 to 2 centimeters (cm) and labeled as a stage four. It was also mentioned that the resident was incontinent of bladder. Review of the physician note dated 01/02/25 revealed the note did not include any mention of a stage four pressure wound or surgical incision wound. Review of the Braden scale (pressure ulcer risk) assessment dated [DATE] revealed Resident #99 was at risk for the development of pressure sores. Review of the comprehensive skin evaluation dated 01/02/25 revealed Resident #99 had a vascular right dorsal foot wound (though the admission assessment on 01/02/25 stated it was a left foot wound) measuring 8 by 9 by 0.1 deep with no measurement descriptors. The evaluation also noted a sacrum pressure wound measuring 6 by 5 by 2 deep, with no measurement descriptors, and was documented as a stage four pressure wound. It revealed a wound had small serosanguinous drainage with 70% slough and 30% eschar, but it was not specific to which of the two wounds the documentation was referring to. The assessment was completed by the Director of Nursing (DON). Review of the wound Nurse Practitioner (NP) #362 note dated 01/02/25 revealed a vascular right foot wound was assessed and the dressing change was completed. No other skin impairments were reviewed or assessed by the NP. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. Resident #99 was dependent on staff for toileting and transfers and required partial and moderate assistance for walking 10 feet. Further activity was not assessed due to safety concerns. The MDS indicated Resident #99 admitted with a stage four pressure wound, a vascular wound, and a surgical incision. Review of the comprehensive skin evaluation dated 01/08/25 revealed Resident #99 had a vascular right dorsal foot wound measuring 9 by 7 by 0.1 with no measurement descriptors, and a</p>		