STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366463	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue at Wooster	1700 East Smithville Western Road Wooster, OH 44691

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, staff interview and review of facility policy, the facility failed to implement treatment for a venous wound timely. This affected one resident (#56) of three residents reviewed for wounds. The facility census was 80. Findings include: Record review for Resident #56 revealed an admitted [DATE]. Diagnoses included intervertebral disc degeneration lumbarsacral and peripheral vascular disease (PVD). Review of the quarterly Minimum Data Set (MDS) assessment, dated 09/12/24, revealed Resident #56 was moderately cognitively impaired. Resident #56 had no impairment to the upper extremities and had impairment to both sides of the lower extremities. Resident #56 required substantial/maximum (staff) assistance for bed mobility, and partial/ moderate assistants for personal hygiene. Review of the skin/wound note dated 10/30/23 at 2:36 P.M., completed by Licensed Practical Nurse (LPN) #257 revealed Resident #56 was seen by wound care today. Resident #56 had a wound related to venous - chronic osteomyelitis (bone infection). right heel -planter surface. Further review revealed to apply adaptic, abdominal pad (ABD) and secure with kerlix daily and as needed (PRN). Review of the skin: non pressure ulcer area note dated 10/31/23 at 2:10 P.M., completed by LPN #257, revealed Resident #56 had a venous stasis ulcer to the right heel, first observed on 10/30/23. The area measured 3.1 centimeters (cm) by (x) 2.6 cm with undetermined depth. The wound bed was 60 % granulation and 40% scabbing The new treatment order included Adaptic/ABD/Kerlix every Monday, Wednesday and Friday. Review of a progress note dated 11/07/23 at 9:27 A.M., completed by Registered Nurse (RN) #311, revealed to cleanse Resident #56's right heel with normal saline (NS), pat dry, apply xeroform and wrap with kerlix on Monday, Wednesday, Friday and PRN. Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) for October 2023 revealed there was no treatment documented to Resident #56's right heel on either record. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR for November 2023 revealed an order with a start date of 11/07/24 to cleanse Resident #56's right heel with NS, pat dry, apply xeroform and wrap with kerlix on Monday, Wednesday, Friday and PRN every day shift for wound care. Further review revealed the treatment was not initiated until 11/08/23. Interview on 10/18/24 at 5:19 P.M. with LPN #257 confirmed Resident #56 was found to have a wound first observed on 10/30/24 to the right heel. LPN #257 confirmed he received orders on 10/30/23 for care and treatment of the wound but the order was not entered into the resident's electronic medical records until 11/06/23 for the nurses to see the order and administer the treatment. LPN #257 verified care for Resident #56's right heel wound was not initiated until 11/08/23 until 11/06/23. put into the electronic medical record (EMR) for the nurses to see the order and administer the treatment until 11/06/23 to start 11/07/23 then the wound care was not initiated until 11/08/23 (nine days after it was identified). LPN #257 revealed he forgot to put the order in the EMR. Review of the facility policy titled Skin Measurement and Assessment, revised August 2022, revealed upon admission or upon identification of a skin condition, the licensed nurse will document the area noted. The physician, Registered Dietitian, Wound Consultant, and responsible party will be notified of the new skin development and an order for the treatment will be obtained. Dressing changes/treatment are performed by the licensed nurse as per the physicians order and documented on the TAR. This deficiency represents noncompliance investigated under Complaint Number OH00157487.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, open and closed medical record review, resident, staff and Wound Care Certified Nurse Practitioner (WCCNP) interviews and review of facility policies, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention and treatment program to ensure residents' skin impairments were assessed, physician notification was made for treatment orders and treatment was initiated timely. Actual Harm occurred on 09/29/24 to Resident #54, who was at risk for developing pressure ulcers, when the facility identified the resident had impaired skin upon readmission from the hospital but failed to assess and describe the wound, failed to notify the physician for treatment orders and further failed to initiate any treatments until 10/11/24. Subsequently, on 10/14/24, the wound was described as a Stage III pressure ulcer (full-thickness loss of skin that extended to the subcutaneous tissue, but did not cross the fascia beneath it) on the sacral area and required excisional debridement. This affected three residents (#54, #82 and #71) of three residents reviewed for pressure ulcers. The facility census was 80. Findings include: 1. Record review for Resident #54 revealed an admitted [DATE] and a readmitted [DATE]. Diagnoses included rhabdomyolysis (breakdown of muscle tissue that released damaging protein into the blood), morbid severe obesity, saddle embolus (blood clot) of pulmonary artery and muscle weakness. Review of the nursing progress note dated 09/29/24 at 12:31 P.M., completed by Licensed Practical Nurse (LPN) #249, revealed Resident #54 arrived at the facility via emergency medical technician (EMT). Resident #54 was alert and oriented to person, place and time. Documentation included Resident #54 had a small open area to the left buttock. Wound nurse was notified at the time of the admission. The progress note provided no measurements or further description of the open area to Resident #54's left buttock or evidence of physician notification for treatment orders. Review of the Nursing Admission assessment dated [DATE] at 6:50 P.M., completed by LPN #249, revealed Resident #54 was admitted on [DATE] at 12:06 P.M. Resident #54 had an open area to the left buttocks. The document included no assessment of the wound, including measurements or further description of the wound, or physician notification for treatment orders. Review of the Braden Scale for Predicting Pressure Ulcers dated 09/30/24 at 1:19 A.M., completed by Registered Nurse (RN) #310, revealed Resident #54 was at mild risk for a pressure ulcer development. Review of the wound care note dated 09/30/24 at 7:45 A.M., completed by Wound Care Certified Nurse Practitioner (WCCNP) #320, revealed Resident #54 was seen for a right medial shin distal venous ulcer. Further review revealed no evidence the wound to Resident #54's left buttock was assessed or any treatments for the wound were ordered at this time. Additional review of Resident #54's medical record from 09/30/24 through 10/10/24 revealed no evidence the open area identified on 09/29/24 was further assessed or treatment initiated for the area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan, dated 10/03/24, revealed Resident #54 had potential for impaired skin integrity and pressure ulcer development related to morbid obesity and impaired mobility. Interventions included pressure redistribution mattress to the bed and refer to the facility wound nurse as needed. Review of the admission Minimum Data Set (MDS) assessment, dated 10/04/24, revealed Resident #54 was cognitively intact. Resident #54 had impairment to both sides of the lower extremities; used a wheelchair for mobility; was (staff) dependent for toileting, bed mobility and transfers; and required set up or clean up assistance with personal hygiene. Resident #54 was frequently incontinent of urine and always incontinent of bowel. The MDS indicated Resident #54 did not have a pressure ulcer, was at risk for pressure ulcers, and had one venous and arterial ulcer. Resident #54 had a pressure reducing device to the chair and bed. Review of the skin pressure ulcer wound note dated 10/11/24 at 3:00 A.M., completed by LPN #351, revealed Resident #54's gluteal cleft (the groove between the buttocks) was reddened and an order was added to apply cream every shift daily. Further review of the medical record revealed no evidence of further assessment of the area, including measurements and description, or physician notifications were made. Review of the Treatment Administration Record (TAR) for October 2024 revealed an order, with a start date of 10/12/24, was added for Triad Hydrophilic wound dress external paste, apply to left upper buttock topically every day shift. Review of the TAR confirmed the treatment was initiated 10/12/24. Review of the wound care note dated 10/14/24 at 9:16 A.M., completed by WCCNP #320, revealed nursing requested evaluation of a new, concerning area on the sacrum (the triangular bone at the base of the spine that connects the spine to the pelvis). The evaluation indicated Resident #54 had a full thickness Stage III pressure ulcer, measuring 1.1 centimeters (cm) in length by (x) 2.4 cm in width x 0.1 cm depth, and identified as a clustered wound. The wound bed was 70% granulation and 30 % slough. The evaluation further included the resident had the following contributing factors: resident was poorly compliant with offloading, incontinence and overall poor medical condition, making the presence of the wound unavoidable. Other factors contributing to the unavoidable wound included morbid obesity. As per the National Pressure Ulcer Advisory Panel (NPUAP) protocols, even though there is slough/eschar present, it does not obscure the extent of tissue loss. It is therefore acceptable to call this a stage III pressure wound with shallow granulation tissue with intervening slough. Excisional debridement was performed using a curette. The tissue debrided went down to subcutaneous tissue. Tissue removed included slough. Post debridement measurements were 1.1 cm. x 2.4 cm. x 0.2 cm. New orders were given to cleanse with normal saline (NS), apply silver alginate and bordered foam dressing every day and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/15/24 at 3:10 P.M. with Resident #54 revealed she was aware of the wound on her sacral area. Resident #54 stated after her admission to the facility, she returned to the hospital due to a blood clot in her lungs. Resident #54 stated she had the wound when she returned from the hospital, but dressings/treatment just started this week. Resident #54 stated staff asked her if she was aware of the wound when they turned her and provided incontinence care, but nothing was done until recently. Resident #54 reached her hand back to the dressing on her buttock area and stated, It was the same wound the dressing is on now, it's the same one I came back from the hospital with, in the crack of my butt. Concurrent observation revealed Resident #54 did not have a low air loss (LAL) mattress on her bed. Interview on 10/15/24 at 3:42 P.M. with State tested Nursing Assistant (STNA) #279 revealed she frequently worked with Resident #54 and confirmed the wound currently being treated on the resident's sacrum was the same area as the wound she readmitted to the facility with from the hospital. STNA #279 further stated the wound was not covered with a dressing until recently. Interview on 10/15/24 at 3:44 P.M. with STNA #265 revealed Resident #54 had the wound (pointing to the crease of the buttocks) since she readmitted from the hospital. STNA #265 stated, I saw it many times while providing care. Interviews on 10/16/24 between 11:20 A.M. and 1:58 P.M. with LPN #257 revealed he was the facility's wound care nurse. LPN #257 confirmed Resident #54 did not have a LAL mattress and further stated LAL mattresses were usually provided for residents if they had a Stage III pressure ulcer or multiple Stage II pressure ulcers. LPN #257 revealed he did not provide a LAL mattress unless the WCCNP ordered one, even though facility policy indicated one would be appropriate for Resident #54. LPN #257 revealed the expectation was for nursing to assess and measure an identified skin impairment and notify the physician and administration. LPN #257 denied he was made aware of the wound on Resident #54's buttocks until 10/14/24 (15 days after the initial identification). Observation on 10/16/24 at 11:20 A.M. of wound care for Resident #54, provided by LPN #257 and LPN/Unit Manager (UM) #324 revealed the open wound was located inside the crease, on the left side, of the buttocks (sacral) area. A telephone interview on 10/16/24 at 2:02 P.M. with WCCNP #320 confirmed he consulted with Resident #54 for wound care needs. WCCNP #320 confirmed he assessed Resident #54's wound to the right medial shin on 09/30/24 but was not told of any other wounds at that time. WCCNP #320 revealed the first time he was made aware of the wound on Resident #54's buttock/sacral area was on 10/14/24 (15 days after identification). WCCNP #320 then stated his documentation on 10/14/24 that the wound was unavoidable was incorrect. WCCNP #320 further stated he only documented unavoidable if the resident had a pressure ulcer that developed in house and Resident #54 readmitted with the wound. WCCNP #320 stated he would correct his documentation. WCCNP #320 confirmed the wound should have been treated at the time it was discovered on 09/29/24 to prevent the wound from worsening. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A telephone interview on 10/16/24 at 4:14 P.M. with LPN #249 revealed, when asked if the current wound being treated on Resident #54's buttocks/sacral area was the same wound she identified upon readmission, LPN #249 quickly stated, Yes. I don't know. I don't remember. I don't think I am going to be able to remember, that was two weeks ago. I am not going to be able to remember. LPN #249 revealed she notified LPN #257 of Resident #54's wound on 09/29/24 at 6:58 P.M. via text message and LPN #257 replied Ok thank you. LPN #249 verified she did not notify the physician of the open wound because she notified LPN #257. A follow-up interview on 10/17/24 at 11:23 A.M. with LPN #249, per request of UM #258, revealed she now recalled the location of the wound on Resident #54's buttock upon readmission from the hospital. LPN #249 stated she and STNA #279 completed a skin check for Resident #54 and the wound currently being treated was under the area she identified upon readmission. LPN #249 stated the area she observed was at the top of her butt, not the same area. LPN #249 pointed to the top of the buttock area, near the left hip, and stated it was right here. LPN #249 confirmed she did not measure the wound, notify the physician or get an order for treatment. LPN #249 stated she notified the wound care nurse, LPN #257, per protocol. A follow-up interview on 10/17/24 at 11:28 A.M. with STNA #279, per request of UM #258, confirmed she assisted LPN #249 with Resident #54's skin check when she returned from the hospital. STNA #279 stated, It's the same. She had that wound when she came back from the hospital. I saw it when she came back from the hospital, it's the same wound. It just got bigger and worse. I am not changing my mind, it's the same. Interview on 10/17/24 at 1:43 P.M. with UM #258 revealed if a wound was found on a resident, the nurse should chart the appearance of the wound, obtain measurements, notify the physician, get an order for treatment and notify the Director of Nursing (DON) and wound care nurse. UM #258 verified none of those were done for Resident #54 on 09/29/24, except notification to the wound care nurse. 2. Review of the closed medical record for Resident #82 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis. Review of the care plan dated 10/02/23 revealed Resident #82 had potential for impaired skin integrity and pressure ulcer development related to impaired mobility, bladder incontinence and colostomy status. Interventions included following the facility's policy and protocols for prevention and treatment of skin breakdown. Review of the progress note dated 12/05/23 at 4:48 P.M., completed by Registered Nurse (RN) #311, revealed the nurse was made aware the resident's heels were red and squishy. Skin prep was placed on bilateral heels and floated on a pillow. Also noted was an open area to the buttocks. This area was cleansed with NS and a patch was placed. Further review of Resident #82's medical record revealed no evidence of what type of patch was placed on the open wound on the resident's buttocks. Additionally, there was no evidence the wound was assessed, including measurements and description of the wound, and no physician notification was made of the wound for treatment orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a physician note dated 12/06/23 at 12:14 P.M., completed by Certified Nurse Practitioner (CNP) #322, revealed no identification or documentation of an open wound to Resident #82's buttocks or treatment ordered for the wound. Review of the nursing note dated 12/06/23 at 3:23 P.M., completed by LPN #238, revealed the nurse was informed the resident had a sore to the coccyx area by the STNA, after giving the resident a bed bath. The STNA stated it has a dressing on it but it's coming off. The nurse went to the room to assess the area and noted a partially covered area to the coccyx, with blood noted. The area was cleansed with NS and patted dry. The area measured approximately 10.0 cm x 12.5 cm. Skin prep applied. Review of a physician order, dated 12/06/23 at 3:27 P.M. and discontinued on 12/07/23, revealed to cleanse sacral wound with NS, pat dry, do not wipe, apply xeroform and CDD (clean dry dressing) two times a day (BID) and as needed (PRN). Review of the TAR revealed the treatment was not initiated. Review of a physician order, dated 12/07/23 at 9:37 A.M., revealed to cleanse sacral wound with NS, pat dry, apply medi-honey and foam dressing every day shift and as needed for wound care. Review of the TAR revealed the treatment was not initiated until 12/08/23. Review of the Pressure Ulcer Wound Record, dated 12/11/23, revealed Resident #82's wound was first observed on 12/06/23. The wound was an unstageable pressure area to the left buttocks, measuring 9.9 cm x 13.6 cm x undetermined depth. The note indicated debridement of the wound was done to reduce bacterial load and promote healing. Review of the significant change MDS dated [DATE] revealed Resident #82 was severely cognitively impaired; had impairment to one side of the upper and lower extremities; required substantial /maximum (staff) assistance with toileting and personal hygiene; partial/moderate (staff) assistance with bed mobility; and was dependent for transfers and wheelchair mobility. Resident #82 was at risk for pressure ulcers and had one unstageable pressure ulcer that was not present upon admission. Interview on 10/17/24 at 4:08 P.M. with LPN #257 verified Resident #82's wound was initially identified in the medical record on 12/05/23, but not assessed, an no notification was made to the physician for treatment orders. LPN #257 further confirmed a treatment order entered on 12/06/23 was not initiated and the treatment order entered on 12/07/23 was not initiated until 12/08/23 (three days after the initial identification of the wound). LPN #257 stated the initial assessment should have included measurements, a description of the wound appearance and any drainage. In addition to the physician, LPN #257 stated nursing was to inform him, as the wound care nurse, and the DON. LPN #257 stated, They don't always notify me either. I will hear on wound day, Mondays, about oh so and so has a wound. They don't always tell me. LPN #257 revealed on 01/01/24, he put out an in-service for nurses and stated, I put the in-service out because I was not getting notified, and neither was the doctor, of new wound issues so residents weren't getting treatments. LPN #257 revealed he did not recall why Resident #82's treatment order was not obtained or implemented timely. Interview 10/18/24 at 3:49 P.M. with UM #258 and LPN #312 confirmed the facility had no evidence Resident #82 received treatment for the wound identified on 12/05/23 until 12/08/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the nursing in-service, dated 01/01/24, revealed when the nurse is notified of a new wound on a resident and the wound care nurse is not available, the nurse must get an order for the treatment and do the treatment. Document where the wound is and notify the wound care nurse. Even on weekends, notify the wound care nurse of wounds and, if not sure, ask what treatment should be done. 3. Record review for Resident #71 revealed an admitted [DATE]. Diagnoses included Hodgkin lymphoma, severe protein calorie malnutrition, diabetes mellitus and anorexia. Resident #71 received Hospice services. Review of the Admission Assessment, dated 09/12/24 at 6:42 P.M., completed by LPN #239, revealed Resident #71 had no wounds noted to the sacral/coccyx area. Review of the admission MDS, dated [DATE], revealed Resident #71 was cognitively intact, occasionally incontinent of urine and always continent of bowel. Resident #71 was at risk for pressure ulcers, had no unhealed pressure ulcers and a pressure reducing device was in the chair and bed. Review of the care plan, dated 09/20/24, revealed Resident #71 had potential for impaired skin integrity and pressure ulcer development relate to severe protein calorie malnutrition, underweight and decreased endurance and mobility. Interventions included follow facility policies/protocols for the prevention/treatment of skin breakdown and refer to the facility wound nurse as needed. Review of the nursing progress note dated 09/29/24 at 6:10 P.M., completed by LPN #256, revealed the nurse was alerted to the resident complaining of pain on the bottom. The note further stated an open area was observed on the resident's coccyx measuring 2.5 cm x 1 cm, without depth. The wound bed was pink and pain with palpation. The note stated the resident felt pain in his bottom during transportation to an appointment and he felt the pain got worse and worse with every bump. Review of Resident #71's physician orders revealed an order dated 09/30/24 to cleanse sacrum wound with NS, pat dry, apply medi-honey and calcium alginate then cover with border foam every day shift Monday, Wednesday and Friday for wound care. Review of the wound care note dated 09/30/24 at 7:00 A.M., completed by WCCNP #320, revealed Resident #71 had a full-thickness Stage III sacral wound that measured 1.7 cm x 0.7 cm x 0.1 cm. The wound base was 60% granulation, 20% slough and 20% adipose with scant serosanguinous exudate. Additionally, the note stated even though there is slough/eschar present, it does not obscure the extent of tissue loss. It is therefore acceptable to call this a stage III pressure wound. Sharp/excisional debridement was performed using a curette. Review of the wound care note dated 10/14/24 at 9:45 A.M., completed by WCCNP #320, revealed sharp/excisional debridement was performed using a curette to remove slough. Review of the Nutritional assessment dated [DATE], documented by Registered Dietitian (RD) #323, revealed Resident #71 was underweight. Resident #71's skin was documented as intact. There was no evidence Resident #71 had been reassessed by RD #323 following the identification of the pressure ulcer on 09/29/24. Observation on 10/16/24 at 10:45 A.M. of Resident #71's room revealed the resident did not have a LAL mattress on his bed. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/16/24 at 11:20 A.M. with LPN #257 confirmed Resident #71 did not have a LAL mattress as an intervention to help aid the treatment and/or prevention of the resident's pressure ulcer, even though facility policy indicated one would be appropriate for the resident due to having a stage III pressure ulcer. Interview on 10/18/24 at 10:13 A.M. with RD #323 revealed she just copied and pasted information from Resident #71's previous nutritional assessment into the assessment dated [DATE]. RD #323 stated she was aware Resident #71 had a pressure ulcer, even though the assessment indicated the resident's skin was intact. RD #323 went on to state she had not locked the assessment yet; it was not completed, and she would not have done anything different to treat Resident #71's pressure ulcer. Interview on 10/18/24 at 11:13 A.M. with the Administrator revealed he would have expected the Dietitian to assess Resident #71 to determine if interventions were needed at the time the pressure ulcer was first identified. Review of the facility policy titled Skin Measurement and Assessment, revised August 2022, revealed upon admission or upon identification of a skin condition, the licensed nurse will document the area noted. If a resident develops or is admitted with a wound, an assessment is performed, and the wound is measured and assessed for the wound characteristics. During assessment of the wound, documentation will address the following: the type of wound, the stage of the wound, a description of the wound's characteristics, and a description of dressings and treatment. The physician, RD, Wound Consultant, and responsible party will be notified of the new skin development and an order for the treatment will be obtained. Dressing changes/treatment are performed by the licensed nurse as per the physician's order and documented on the TAR. Review of the facility policy titled, Pressure Ulcer Prevention and Intervention, revised January 2023, revealed to notify the physician and responsible party of any changes in skin condition. All the mattresses provided to each resident are pressure-redistributing. Additional pressure support may be implemented per resident assessment as needed. Stage three and four and unstageable pressure ulcers included evaluation for specialty mattress or bed, alternating air mattress, low air loss. Document all findings in the medical record. Review of the facility policy titled, Nutrition and Wound Management, revised May 2023, revealed residents with pressure wounds will be assessed for optimal nutrition intervention. Nursing notifies dietitian/designee as soon as a pressure wound of any stage is identified. Nutrition assessment to determine interventions included protein and calories consumed as necessary, usual fluid intake, calorie, protein and fluid needs, use of supplements, tolerance and acceptance, medication review, vitamin and mineral use and labs per orders. Recommendations are made to improve intake and promote healing. This deficiency represents noncompliance investigated under Complaint Numbers OH00158050 and OH00157487.