STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375229	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ranchwood Nursing Center	824 South Yukon Parkway Yukon, OK 73099

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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 - Immediate jeopardy to resident health or safety 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** On 09/16/25 at 2:02 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation related to the facility's failure to assess and identify a wound for Resident #128. This likely resulted in an infected diabetic foot ulcer which caused the resident to be admitted to the hospital and resulted in a right below-knee amputation.On 09/16/25 at 2:15 p.m., regional director was notified of the IJ and provided the IJ template.On 09/17/25 at 8:25 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Plan Of Removal 09/16/2025:What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur. Resident #128 was discharged . Skin assessment for current residents in house will be completed by 09/16/25 at 11:59 p.m. Weekly skin assessments will be documented in the TAR. DON/designee will provide education to all clinical staff on completion of weekly skin assessments and on the addition of skin assessments to the TAR by 11:59 p.m.Involvement of Medical Director. The Medical Director has been notified of IJ status on 09/16/25.Involvement of QA. An Ad Hoc QAPI meeting was held on 09/16/25 with the Medical Director, Facility Administrator, and Director of Nursing to review the plan of removal. Director of Nursing will track, trend, and analyze audit results and forward results of audits monthly to QAPI Committee for review and/or action.Who is responsible for the implementation of the process? The Administrator/designee will be responsible for the implementation of the new process. The new process/system will be started on 09/16/25 and no licensed staff will be able to return to work until they complete the above stated education.A review of skin assessments, dated 09/16/25, showed all residents in the facility had a head-to-toe skin assessment performed.A review of in-services provided for staff on 09/16/25 and 09/17/25, showed staff were educated on documentation, identification, and notification of wounds.On 09/17/25 after interviews with facility staff, review of skin assessments, and review of in-services, the immediacy was lifted, effective 09/17/25 at 8:34 a.m., when the remainder of staff received in-service training. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to assess and identify a new wound to prevent hospitalization for an infected diabetic ulcer for 1 (#128) of 5 sampled residents reviewed for wounds. The infected diabetic ulcer led to the resident having a right below-knee amputation.The DON identified 109 residents resided in the facility.Findings: A Skin Data Collection policy, dated 07/01/18, showed a licensed nurse would collect data during weekly skin evaluations. A quarterly assessment, dated 05/06/25, showed Resident #128's cognition was intact with a BIMS score of 15. The assessment showed diagnoses of diabetes mellitus and renal failure. The assessment showed no pressure ulcers or skin issues and the resident required supervision for activities of daily living. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A skin assessment, dated 06/24/25, showed Resident #128 had no skin issues. An interdisciplinary progress note, dated 07/07/25, showed Resident #128 was observed to be drowsy, with a persistent desire to lie down and sleep. The note showed due to the resident's altered mental status and inability to engage coherently; the resident was transported to the hospital. An emergency room note, dated 07/07/25, showed Resident #128 presented from the nursing home for evaluation of increased confusion. The note showed on arrival the resident was mildly hypotensive but responded well to IV fluids. The note showed there was concern for a possible infected right foot diabetic ulcer. The note showed the resident was admitted to the hospital for further management with podiatry consultation. An emergency room note, dated 07/07/25, showed final diagnoses of altered mental status, sepsis, diabetic foot ulcer, and hypoglycemia for Resident #128. The note showed the plan to be admitted to the hospital. A wound culture report, dated 07/12/25, showed culture collected from the right foot ulcer on 07/08/25 and resulted in growth of methicillin-resistant Staphylococcus aureus. A hospital physician's note, dated 07/13/25, showed a diabetic ulcer on the right plantar was first assessed 07/07/25. A hospital discharge note, dated 07/15/25, showed an assessment and plan for a diabetic foot ulcer to include wound care, patient to remain completely touch down weight bearing to right lower extremity per podiatry, and vancomycin (IV antibiotics) with dialysis on Monday, Wednesday, and Friday through 09/02/25 and flagyl (antifungal) through 08/19/25. A physician's order, dated 07/15/25, showed to: Cleanse right plantar foot with soap and water, normal saline or wound cleanser. Pat dry. Pack wound with Dakins soaked gauze. Cover with dry gauze. Wrap with kerlix and secure with tape. Wrap with Ace bandage. Perform daily on day shift and as needed. An admission skin assessment, dated 07/16/25 at 8:04 a.m., showed the Resident #128 had a skin issue of dry skin. The skin assessment showed no diabetic ulcer to the resident's right foot. A progress note, dated 07/17/25 at 4:00 a.m., showed a head-to-toe assessment of a dry dressing to the right foot. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A treatment record, dated 07/15/25 through 07/21/25, showed daily wound care to the resident's right plantar foot was not performed on 07/15/25 and 07/21/25 due to resident being in the hospital. The record showed the daily wound care was not performed on 07/16/25 and 07/18/25 due to the resident had been out to dialysis. A progress note, dated 07/21/25 at 10:20 a.m., showed the resident was confused and unable to appropriately answer questions. The note showed Resident' #128's fingerstick blood sugar was 57. The resident was sent to the emergency room for evaluation and treatment. An emergency room note, dated 07/21/25, showed the Resident #128's family stated the right diabetic foot ulcer was worsening and they were unsure if the nursing home was performing wound care as prescribed. The note showed the family stated the resident had become increasingly confused for the past couple of days, prompting the nursing home to send the resident to the hospital for further evaluation. The emergency room note, dated 07/21/25, showed the resident's right plantar diabetic ulcer appeared grossly infected. The note showed to cefepime (antibiotic) was added to the IV vancomycin (antibiotic) and flagyl (antifungal) due to worsening infection. The note showed wound care team consulted and the resident was admitted to the hospital for further evaluation. A podiatric surgery consultation, dated 07/21/25, showed ulceration #1 right plantar measurements 1.5 cm x 1.5 cm x 0.9 cm. The note showed debridement performed at bedside with wound measurements post debridement of 4.5 cm x 1.6 cm x 1.1 cm. A vascular surgery consultation, dated 07/26/25, showed a non-healing right foot wound and the resident will need either a below the knee or above-the-knee amputation. A postoperative note, dated 07/29/25, showed a right below-knee amputation procedure. On 09/15/25 at 1:35 p.m., the resident's family member stated the resident was taken to the emergency room on [DATE] when a wound was found on the resident's right foot. The family member stated the wound was so deep the bone was almost visible, and the wound was not found until that day in the emergency room. The family member stated the resident was treated for a wound infection in the hospital for several days and then sent back to the nursing home. The family member stated the resident was sent back to the nursing home for less than a week before having to be readmitted to the hospital. The family member stated the last hospital admission resulted in an amputation of the right foot, then the resident was admitted to a hospice house until their passing on 08/06/25. The family member stated a nurse at the nursing home was not taking adequate care of the resident's wound. The family member stated they had called the nursing home and were told an investigation had been conducted related to the resident's wound and changes had been made and staff had been terminated. On 09/15/25 at 2:15 p.m., the regional director stated there were no incident reports related to this resident other than a fall that did not require a state report. On 09/15/25 at 2:57 p.m., the DON reported the issues with skin assessments not being completed accurately had been addressed and the employee had been terminated. The DON reported the resident's wound to the right foot was not documented before the emergency room visit on 07/07/25. The DON reported the resident's last skin assessment before 07/07/25 was completed on 06/24/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 09/16/25 at 3:04 p.m., the DON reported the charge nurses were supposed to conduct weekly skin assessments on all residents. The DON reported they were working on a process to ensure skin assessments were conducted every week.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure a discharge summary was completed for 1 (#129) of 5 sampled residents reviewed for discharge from the facility. The administrator identified 109 residents resided in the facility.Findings: A quarterly assessment, dated 01/01/25, documented Resident #129 had diagnoses which included paraplegia and anxiety. The assessment showed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The assessment showed the resident was independent with eating and personal hygiene. A social services discharge note, dated 03/21/25, documented resident #129 was discharged from the facility. There was no discharge summary located in the resident's medical record. On 09/17/25 at 10:12 a.m., the corporate nurse consultant reported a discharge summary was not completed for Resident #129.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on observation, record review, and interview, the facility failed to accurately assess a resident for smoking safety/privileges for 1 (#32) of 2 sampled residents reviewed for smoking assessments. The administrator identified 15 residents who smoked. Findings: On 09/09/25 at 9:45 a.m., Resident #32 was observed in their room lying in bed. An unidentified staff member was asked by the surveyor to verify if Resident #32 was in the second bed by the window. The staff member stated, yes, and upon looking in on the resident, stated to the resident, you know the drill, give it to me. The resident was observed to hand the staff member their vape, which was held in the resident's hand under their blanket. The staff member reported the resident's smoking/vaping privileges were suspended at one time and staff were supposed to keep the resident's smoking supplies. The staff member stated the resident's family continued to bring the resident vapes and they had several stored in a large baggie, locked in the medication cart. On 09/11/25 at 1:42 p.m., Resident #32 was observed outside in the smoking area/patio with other residents. The resident was observed to be smoking a cigarette independently. A Resident Smoking policy, dated 08/01/22, showed residents who wished to smoke would be evaluated for their ability to safely do so. The policy showed the care plan would be updated quarterly and as necessary to document changes in the resident's smoking status. A quarterly assessment for Resident #32, dated 06/16/25, showed the resident has a BIMS of 15, which indicated the resident was cognitively intact. The assessment showed the resident required substantial to maximal assistance with activities of daily living and ate independently. A care plan for Resident #32, dated 07/02/25, showed the resident tried to keep their vape and other smoking supplies in their pockets or hidden in their chair. The care plan showed the resident accused staff of harassment and theft when they removed smoking supplies from the resident's possession. A physician order, dated 07/12/25, showed Resident #32 would have their smoking privileges suspended due to non-compliance of smoking policies and procedures. The physician order documented a diagnosis of psychosis. A smoking assessment for Resident #32, dated 09/08/25, showed the resident may smoke unsupervised in designated smoking areas and must request smoking materials from staff. On 09/10/25 at 10:15 a.m., the corporate director was asked if there was a smoking assessment for Resident #32 prior to 09/08/25. The corporate director stated they would check. No further assessment prior to 09/08/25 was provided. On 09/11/25 at 1:45 p.m., the ADON was asked about the physician order of 07/12/25, which showed smoking privileges were suspended. The ADON stated they thought the order was written just prior to the resident going out for a psych eval and that may have been part of the reason the resident was sent out. The ADON was asked about the smoking assessment completed on 09/08/25, and if the order should have been changed or discontinued. The ADON stated they did not know and would check with the DON. On 09/11/25 at 3:13 p.m., the DON reported the physician order which suspended Resident #32's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoking privileges was correct and still active. The DON reported the smoking assessment was not correct, as the resident should not be smoking or have any smoking privileges at all, due to not following facility policies.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, and interview, the facility failed to develop and implement a comprehensive care plan for a. anxiety disorder for 1 (#70) of 5 sampled residents reviewed for unnecessary medication, and b. smoking for 1 (#16) of 3 sampled residents reviewed for smoking.The DON identified 15 residents in the facility were smokers.The DON reported 109 residents resided in the facility.Findings:1. A care plan policy, dated 02/12/20, showed it was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Resident #70's physician's order, dated 03/20/25, showed the resident was to receive, sertraline (antidepressant) 50 mg one time daily for anxiety disorder and unspecified depression.duloxetine hcl (serotonin and norepinephrine reuptake inhibitor) 30 mg one by mouth every 12 hours for anxiety disorder and unspecified depression, andXanax (benzodiazepines) 0.25 mg one by mouth at bedtime for anxiety disorder.A quarterly assessment, dated 08/14/25, showed Resident #70's cognition was intact with a BIMS score of 15. The assessment showed a diagnosis of anxiety disorder and the use of antianxiety medication.A care plan, dated 09/09/25, showed no goals or interventions for Resident #70's anxiety disorder.On 09/17/25 at 12:32 p.m., the regional nurse consultant stated the resident's anxiety diagnoses should have been included in the care plan.2. A Resident Smoking policy, dated 08/01/22, showed the resident's care plan would include the resident's smoking designation (Supervised/Unsupervised) and include the amount of assistance the resident was to receive during smoking.A physician's order for Resident #16, dated 03/18/25, showed supervised smoking as needed for nicotine dependence. An annual assessment, dated 08/09/25, showed severe cognitive impairment with a BIMS score of 07. The assessment showed tobacco use and a diagnosis of nicotine dependence. A smoking risk assessment, dated 09/08/25, showed cigarette use. The assessment showed Resident #16 may smoke independently or with setup assistance and may request smoking material from staff. A care plan, dated 09/09/25, showed no goal or interventions related to smoking. On 09/17/25 at 11:10 a.m., the regional nurse consultant stated smoking should have been included in the resident's care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to: a. revise and update the care plan for Resident #32 when their smoking privileges were suspended, andb. include the resident's legal guardian in the development and review of the care plan for Resident #76. The administrator identified 109 residents resided in the facility. Findings: 1. On 09/09/25 at 9:45 a.m., Resident #32 was observed in their room lying in bed. An unidentified staff member was asked by the surveyor to verify if Resident #32 was in the second bed by the window. The staff member stated, yes, and upon looking in on the resident, stated to the resident, you know the drill, give it to me. The resident was observed to hand the staff member their vape, which was held in the resident's hand under their blanket. The staff member stated the resident's smoking/vaping privileges were suspended at one time and staff were supposed to keep the resident's smoking supplies. The staff member reported the resident's family continued to bring the resident vapes and they had several stored in a large baggie, locked in the medication cart. On 09/11/25 at 1:42 p.m., Resident #32 was observed outside in the smoking area/patio with other residents. The resident was observed to be smoking a cigarette independently. A quarterly assessment for Resident #32, dated 06/16/25, showed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The assessment showed the resident required substantial to maximal assistance with activities of daily living and ate independently. A care plan for Resident #32, dated 07/02/25, showed the resident tried to keep their vape and other smoking supplies in their pockets or hidden in their chair. The care plan showed the resident accused staff of harassment and theft when they removed smoking supplies from the resident's possession. The care plan did not address the resident's smoking privileges had been suspended due to non-compliance of smoking policies and procedures. A physician order, dated 07/12/25, showed Resident #32 would have their smoking privileges suspended due to non-compliance of smoking policies and procedures. The physician order documented a diagnosis of psychosis. On 09/11/25 at 3:13 p.m., the DON reported the physician order which suspended Resident #32's smoking privileges was correct and still active. The DON reported the resident's care plan should have been updated to reflect the resident was not supposed to smoke and does not have smoking privileges. 2. On 09/10/25 at 2:52 p.m., Resident #76's guardian stated they had attended only one care plan meeting, held in March 2025, and that meeting was attended by the social worker only. The guardian stated they had not been invited to the most recent care plan meeting held on 08/22/25. A quarterly assessment, dated 8/15/25, showed Resident #76 has a BIMS of 10, which indicated their cognition was moderately impaired. On 09/15/25 at 9:40 a.m., the social services director stated they conducted the 08/22/25 care plan meeting alone. The social services director stated they forgot to invite the resident's guardian and there was no documentation to show the guardian had been contacted or participated in the meeting.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to: a. ensure incontinent care was provided for 1 (#100), and b. ensure showers were provided for 1 (#127) of sampled 8 residents reviewed for activities of daily living.The DON identified 109 residents resided in the facility.Findings:1. A progress note showed Resident #127 was admitted to the facility on [DATE] and discharged on 04/24/25. Review of bath sheet forms for Resident #127 showed the resident received showers on 04/16/25, 4/20/25 and 04/23/25. There was no documentation to show showers were provided from 04/03/25 to 04/16/25. On 9/10/25 at 2:45 p.m., an unidentified charge nurse stated there was a shower list displayed at the nurse's station indicating the room numbers and the days showers were scheduled. The charge nurse stated once showers were complete, the charge nurse signed off on the sheet. The unidentified charge nurse acknowledged sometimes showers were missed if staff did not show up to work. On 9/10/25 at 4:00 p.m., CNA #1 stated residents sometimes refused showers. Residents were encouraged to shower by discussing the importance of hygiene and if they continued to refuse, it was reported to the charge nurse. CNA #1 stated there was enough staff to provide showers. 2. On 09/11/25 at 10:01 a.m., Resident #100 was observed in bed during a wound care observation. The resident's brief was observed to be soaked with urine, and the resident had a foul odor of urine. The resident's hair was observed to be greasy and unwashed. A care plan, dated 08/05/25, showed Resident #100 was incontinent of bowel and bladder. The care plan showed an intervention was to check and change the resident and keep them clean and dry. An annual assessment, dated 08/09/25, showed Resident #100's cognition was severely impaired with a BIMS score of 07. The assessment showed the resident was frequently incontinent of urine and required partial to moderate assistance with activities of daily living. The assessment showed diagnoses of chronic obstructive pulmonary disease, diabetes mellitus, and dementia. On 09/11/25 at 10:16 a.m., Resident #100 stated they had not received a brief change or a bath. On 09/11/25 at 10:18 a.m., CNA #2 stated they had not been able to perform incontinent care for Resident #100 during this shift. On 09/17/25 at 12:33 p.m., the regional nurse consultant reported incontinent care should be offered to this resident frequently, at least every two hours.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Statement of Deficiency:Based on record review and interview, the facility failed to notify the resident's legal guardian of a change in the resident's condition and treatment for 1 (#76) of 1 sampled resident reviewed for notification. The administrator identified 109 residents resided in the facility. Findings: A facility policy Change of Condition, dated 02/13/23, read in part, Patient families, guardians, or other appropriate people are to be contacted when there is a significant change in the patient's condition or health status. A quarterly assessment for Resident #76, dated 08/15/25, showed a BIMS of 10, which indicated the resident was moderately cognitively impaired. A physician's order dated 08/20/25 showed the resident was to receive Ceftriaxone 2 g, intravenous. There was no documentation to indicate the legal guardian was notified. On 09/10/25 at 2:52 p.m., Resident #76's legal guardian stated they were not notified when the resident was diagnosed with a UTI and the need for IV antibiotic treatment on 08/20/25. On 09/11/25 at 10:00 a.m., the DON reported the resident's guardian should have been notified of the resident's diagnosis and antibiotic treatment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement a baseline care plan to provide effective and person-centered care for 1 (#126) of 1 sampled resident reviewed for baseline care plans. The administrator identified nine residents admitted to the facility in the previous 30 days. Findings:A Care Plan - Process policy, dated 03/27/23, read in part, The interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process.Initiate a Baseline Care Plan and complete within forty-eight (48) hours of admission based on the physician's orders and nursing evaluation.The Baseline Plan of Care facilitates care until the comprehensive Care Plan is developed. Resident #126 was admitted to the facility on [DATE]. A baseline care plan, dated 09/03/25, showed Resident #126 had diagnoses which included infection and inflammatory reaction due to internal right knee prosthesis, diabetes, hypertension, urge incontinence, and atrial fibrillation. The baseline care plan showed the resident was mildly cognitively impaired and would receive physical therapy to improve function, as well as antibiotic IV therapy. The baseline care plan did not address the resident's incontinence, ADL assistance required, the resident's fall risk, or the resident's wound vac. On 09/08/25 at 1:30 p.m., Resident #126's family member stated the resident had fallen out of bed the previous night on 09/07/25. The family member reported the resident had a new surgical wound to the right leg, as well as a wound vac in place, and did not know what the facility was doing to prevent falls. On 09/09/25 at 11:45 a.m., Resident #126's family member stated the resident had fallen again the previous night. The family member reported staff had told them they would put the bed in the lowest position and get a fall mat for the resident's bedside. The family member stated the resident did not have an injury related to the fall. On 09/10/25 at 9:36 a.m., Resident #126's family member stated since the time of the resident's admission on e week ago, they had issues with finding the resident soaking wet. The family member reported they were at the facility the previous day at 11:45 a.m. and walked with the resident to physical therapy. The family member reported they returned at 6:15 p.m. and found the resident in their recliner, soaking wet with urine up to their neck. The family member stated the resident was in the same pull-up and clothes they had been in earlier in the day. On 09/11/25 at 10:13 a.m., the DON was asked about the resident's baseline care plan, which did not show the resident was at risk for falls, although the resident had recently had surgery to the right leg and had a wound vac in place. The DON reported the resident's fall risk and wound vac should have been included on the baseline care plan. The DON reported ADL assistance, including toileting or incontinent care, should have been included on the baseline care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375229	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ranchwood Nursing Center	824 South Yukon Parkway Yukon, OK 73099

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure care plan interventions were implemented to promote the healing of a pressure ulcer for 1 (#100) of 7 sampled residents reviewed for pressure ulcers. The DON identified 13 residents in the facility had pressure ulcers.Findings: On 09/09/25 at 11:03 a.m., Resident #100 was observed lying on their back in bed. The resident was observed with a gauze bandage on the left foot. The resident's heels were observed on the mattress and not offloaded.On 09/11/25 at 9:25 a.m., Resident #100 was observed in bed lying on their back. The resident's heels were on the mattress and not offloaded.On 09/11/25 at 11:33 a.m., the ADON entered Resident #100's room to provide wound care. The resident was in bed lying on their back and heels were not offloaded. The ADON performed wound care to the left heel per physician's orders. The ADON exited the room after the wound care was performed, and the resident's heels were not offloaded and no pressure relieving devices were in place.On 09/17/25 at 12:08 p.m., Resident #100 was observed in bed; no pillow was observed under their heels. A Prevention of Pressure Ulcers/Injuries policy, dated 07/01/18, showed residents would receive care to maintain skin integrity and prevent pressure ulcers/injuries. The policy showed pillows used to support the entire lower leg may effectively raise the heel from contact with the bed.A quarterly assessment, dated 07/16/25, showed Resident #100's cognition was moderately impaired with a BIMS score of 12. The assessment showed two stage III pressure ulcers that were not present on admission. The assessment showed skin and ulcer/injury treatments:pressure reducing device for bed and chair, pressure ulcer/injury treatment, andapplication of dressing to feet.A physician's order, dated 08/26/25, showed to cleanse the stage III pressure wound of the left heel with normal saline or wound cleanser, pat dry, apply A & D to peri wound, apply hydrogel to wound bed, cover with border island dressing, wrap with gauze roll, and secure with tape.A wound physician's note, dated 09/03/25, showed a stage III pressure wound of the left heel, full thickness, with a duration of greater than 110 days. The note showed the wound size was 1.2 X 0.8 x 0.1 cm. The note showed measurements were exactly the same as the previous visit. The note showed given improvement in the wound with a decrease in ulcer area of 7.7 percent. The note showed the objective was to heal and maintain, and the approach was close monitoring and off-loading.A care plan, dated 09/08/25, showed a stage III pressure ulcer wound to the left heel. The care plan showed an intervention to float the heel when in bed.On 09/17/25 at 11:08 a.m., the regional nurse consultant stated if it was documented in the care plan to offload the resident's heels, then the heels should be offloaded.On 09/17/25 at 12:06 p.m., CNA #3 stated Resident #100's should have had a pillow under their heels to offload them for the pressure ulcer.