STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415082	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Healthcare Community	546 Main Street Coventry, RI 02816

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. 37158 Based on record review and staff interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 2 residents reviewed with pressure ulcers (a localized injury to the skin and/or underlying skin usually over a boney prominence), Resident ID #1. Findings are as follows: According to the State Operations Manual, Appendix PP Guidance to Surveyors for Long Term Care Facilities, revised 2/3/2023 states in part, A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A facility must .Identify whether the resident is at risk for developing or has a PU/PI upon admission and thereafter .Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors .If a PU/PI is present, provide treatment and services to heal it and to prevent .It is important that each existing PU/PI be identified, whether present on admission or developed after admission .Any new PU/PI suggests a need to reevaluate the adequacy of prevention measures in the resident's care plan. When assessing the PU/PI itself, it is important that documentation addresses: - The type of injury (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of injury; - The PU/PI's stage; - A description of the PU/PI's characteristics; - The progress toward healing and identification of potential complications; - If infection is present; - The presence of pain, what was done to address it, and the effectiveness of the intervention; and - A description of dressings and treatments . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the resident was admitted to the facility in March of 2024 with diagnoses including, but not limited to, a Stage 2 pressure injury (shallow open ulcer) to the buttocks, adult failure to thrive and pneumonia. Record review of the nursing progress notes revealed a note dated 4/1/2024, authored by Licensed Practical Nurse, Staff A, which states in part, .Skin/Wound : New changes in Skin Integrity resident has redness, non-blanchable [Stage 1 pressure injury-observable pressure related alteration of intact skin reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device] on right .heel encouraged heel to be elevated . During a surveyor interview on 4/25/2024 at 9:44 AM with Staff A, she acknowledged that the resident had a Stage 1 pressure injury identified by her on 4/1/2024. When asked if she had notified the provider of the pressure injury, she could not say. Additionally, she was unable to explain why a treatment was not implemented for the resident's pressure injury. Record review of the weekly skin checks dated 4/12/2024 and 4/19/2024 indicated the resident had a pressure injury to his/her right heel. Additionally, no further description of the wound was documented. Record review of the physician's orders failed to reveal evidence of a treatment to the resident's Stage 1 pressure injury to his/her right heel. During a surveyor interview on 4/25/2024 at 11:55 AM with the Director of Nursing Services, she revealed that she was unaware of a pressure injury to the resident's right heel. Additionally, she was unable to provide evidence that a treatment was implemented when the pressure injury was first identified.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who need respiratory care, are provided such care, consistent with professional standards of practice relative to 1 of 1 resident reviewed receiving oxygen therapy, Resident ID #2. Findings are as follows: Record review revealed the resident was admitted to the facility in October of 2023 with diagnoses including, but not limited to, traumatic brain injury, anxiety and s/he was diagnosed with Influenza (Flu) A virus on 4/18/2024. Record review of a nursing progress note dated 4/19/2024 at 5:44 AM revealed the resident called 911 stating that s/he did not feel well and needed to go to the hospital. The resident was subsequently transferred to a local acute care hospital and returned to the facility that same day, 4/19/2024. Review of the hospital continuity of care document dated 4/19/2024, revealed a chest x-ray was completed and was negative. Additionally, the document revealed recommendations included, O2 [oxygen] via NC [nasal cannula] 1-2 L [liters] to maintain sats [oxygen saturation-a measurement of the percent of oxygen in the blood, a normal reading for most people is 95-100%]. Record review revealed a physician's order dated 4/19/2024, Pt [patient] on 2L O2 via N/C, wean O2 to keep sats > [greater than] 91%, pulsox [pulse oximetry-an electronic device that measures the saturation of oxygen levels carried in your blood] qs [every shift] x 5 days. Record review of the April 2024 Medication Administration Record (MAR) revealed the oxygen order was transcribed to start and end on 4/19/2024. Therefore, was no longer an active order after 4/19/2024. Additionally, the resident's O2 level that was documented within this order on 4/19/2024 (night shift) as 90%. Record review of the nursing progress note dated 4/20/2024 at 10:57 AM, revealed the resident had fallen onto the floor and s/he was in distress, with increased anxiety, a rapid heart rate and excessive sweating. The resident's oxygen tubing was observed on the floor, wrapped in his/her clothing. Further assessment revealed the resident's oxygen saturation level was 86% at the time, the resident was placed back on his/her oxygen and given a nebulizer treatment and his/her oxygen saturation level increased to 90%. The provider was contacted and ordered to have the resident transferred to an acute care facility. The nurse called 911, upon EMS arrival, they assessed the resident and the resident refused to be transferred to the hospital for further evaluation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with Licensed Practical Nurse (LPN), Staff B, she revealed that she was the nurse taking care of the resident on 4/20/2024. She revealed that she contacted the on-call provider to report the resident's fall and her assessment. She also revealed that she called EMS and when they arrived the resident refused to be transferred to the hospital. She further revealed that she and other staff continued to assess the resident frequently throughout the shift and to ensure the resident kept his/her oxygen on. During frequent checks of the resident, s/he was maintaining saturation levels of 90-92 % on oxygen and s/he was more relaxed and comfortable towards the end of the shift. Record review revealed a subsequent order dated 4/20/2024 for a neurological assessment (sensory response and motor strength tests to evaluate functions associated with the spinal nerves), vital signs and oxygen saturation levels every shift for the unwitnessed fall on 4/20/2024. Additional review of the MAR revealed the following oxygen saturation levels documented on 4/20/2024 which failed to indicate if the resident was receiving oxygen or not: -7-3 shift: 90% -3-11 shift: 90% -11-7 shift: 88% Further review of the record revealed the following oxygen saturation levels: -4/20/2024 at 6:42 AM, 90% (room air) -4/20/2024 at 2:35 PM, 94% (room air) -4/20/2024 at 3:35 PM, 90% (Oxygen via NC) -4/20/2024 at 9:04 PM, 90% (Oxygen via NC) -4/21/2024 at 2:29 AM, 88% (Oxygen via NC) During a surveyor interview on 4/25/2024 at 10:18 AM with LPN, Staff C, she revealed she and the nurse she was training were taking care of Resident ID #1 on 4/20/2024, during the 11-7 shift. Staff C revealed that frequent checks were made throughout the night and the resident was assessed to be alert and oriented, comfortable, and not short of breath. Towards the end of the shift, the resident had a fall and sustained swelling to his/her chin. Upon assessment after the fall, his/her oxygen saturation level was 80% on 2 L of oxygen. Additionally, Staff C was asked by this surveyor if she was aware of the resident's documented oxygen saturation level of 88% taken during her shift. She revealed that she was not aware of his/her prior oxygen level as the nurse that she was training did not inform her and Staff C further revealed that she would have contacted the provider prior if she had known. Lastly, she revealed 911 was called and the resident was transferred to an acute care hospital. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the subsequent nursing progress note dated 4/21/2024 at 1:50 PM, indicated that the resident was admitted to the local hospital and currently intubated (a medical procedure where a tube is inserted into the body for ventilation). The resident was diagnosed with acute respiratory failure and needed to be transferred to the only trauma hospital in the state. Record review of a nursing progress note dated 4/22/2024 at 2:19 PM revealed the resident has been diagnosed with Pyothorax (a condition that occurs when there is a build-up of pus or fluid in the chest cavity). During a surveyor interview on 4/25/2024 at 11:18 AM with the Registered Nurse Practitioner, Staff D, she revealed she was unaware that the oxygen order was no longer active after 4/19/2024. Additionally, she would expect that nursing would have called the provider if the resident's oxygen saturation level was less than 91%. During a surveyor interview on 4/24/2024 at 4:10 PM with the Director of Nursing Services, she acknowledged the oxygen order was transcribed incorrectly, with a start and stop date of 4/19/2024 and not for the full 5 days as ordered. Additionally, she revealed she would expect that the provider would have been notified when the resident's oxygen saturation level was 90% and below.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 7 of 8 residents reviewed receiving Coumadin (an anticoagulant medication that is used to prevent harmful blood clots from forming or growing larger), Resident ID #s 1, 4, 5, 6, 7, 8 and 9. Findings are as follows: 1. Record review revealed Resident ID #1 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, atrial fibrillation (an irregular heartbeat often causing blood to flow inadequately through the heart) and long-term use of anticoagulants. Record review revealed a physician's order dated 3/27/2024 for Coumadin 0.5 mg [milligrams] by mouth at bedtime for treating/preventing blood clots. Give with 1 mg tablet to equal 1.5 mg. Record review of a laboratory report dated 4/8/2024 indicated the resident's INR (international normalized ratio-a blood test that measures how long it takes for your blood to clot and the results are used when dosing Coumadin) was elevated with a result of 4.5 (an INR between 2.0 and 3.0 is the therapeutic range for patients receiving Coumadin therapy. An INR greater than 3.0 poses a higher risk of bleeding). Further review at the bottom of the document revealed a hand-written order signed by the Registered Nurse Practitioner (RNP), Staff D, to Hold Coumadin 4/8 + 4/9 Recheck .INR on 4/10. Record review revealed a nursing progress note dated 4/8/2024 at 2:44 PM which states, HOLD coumadin 4/8 and 4/9 re-check .INR on 4/10. Further review of the record failed to reveal evidence of an order to hold the Coumadin on 4/8/2024 and 4/9/2024. Record review of the April 2024 Medication Administration Record (MAR) revealed the Coumadin 0.5 mg was signed off as administered on 4/8/2024. Additional record review of a nursing progress note dated 4/10/2024 at 2:58 AM, indicated the resident had an unwitnessed fall in his/her bedroom. Additionally, the on-call provider was contacted and ordered the resident to be sent to an acute care hospital for an evaluation due to the fall and that the resident was on Coumadin therapy. Further record review revealed a progress note dated 4/10/2024, authored by RNP, Staff D, which states in part, .Returned from ER [emergency room] visit, review of discharge instructions .past medical history of a-fib on Coumadin .[resident] was sent to the hospital after an unwitnessed fall .[S/he] had an elevated INR of 10.7 [critically high value, indicating the blood is taking a long time to clot and there is a high risk for bleeding] in ER ,d+[DATE]] and was given Vitamin K [a medication used to assist in normalizing an excessively elevated INR] 2.5mg PO [by mouth]. Instructed to hold Coumadin x 48 hrs [hours] and recheck INR on 4/12 . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor interview on 4/25/2024 at 11:07 AM with RNP, Staff D, she acknowledged that she ordered to hold the resident's Coumadin on 4/8/2024 and 4/9/2024, and she was unaware that the resident had received Coumadin on 4/8/2024. During a surveyor interview on 4/25/2024 at 11:50 AM with the Director of Nursing Services (DNS), she acknowledged that the order to hold Coumadin was not transcribed and that the medication should have been held on 4/8/2024, as ordered. During a surveyor interview on 5/1/2024 at 12:06 PM with Registered Nurse, Staff G, she acknowledged that she received an order on 4/8/2024 to hold the resident's Coumadin on 4/8/2024 and 4/9/2024. Additionally, she was unable to explain why she did not transcribe to hold the Coumadin 0.5 mg order. 2. Record review revealed Resident ID #4 was admitted to the facility in November of 2022 with diagnoses including, but not limited to, atrial fibrillation and long-term use of anticoagulants. Record review revealed a progress note dated 4/1/2024, authored by RNP, Staff F, states in part, . Assessment and Plan .NEW ORDER increase Coumadin to 4.5 mg NEW ORDER: repeat INR .1 week . Record review revealed a physician's order dated 4/1/2024 for Coumadin 4.5 mg by mouth in the evening for 7 days. Further review of the order revealed the Coumadin start date was entered as 4/1/2024 at 8:00 PM and the Coumadin stop date was entered as 4/8/2024 at 7:59 PM, which was 1 minute prior to the 8:00 PM scheduled administration time on 4/8/2024, indicating a transcription error. Further record review of the April 2024 MAR failed to reveal evidence of the scheduled order for an INR on 4/8/2024. Additional record review failed to reveal evidence that the Coumadin was administered to the resident on 4/8/2024, resulting in a missed dose. Record review revealed an INR was completed on 4/9/2024, resulting in an INR of 2.0. Record review of a provider progress note dated 4/9/2024, states in part, .INR reviewed Assessment and Plan .NEW ORDER Coumadin 5.0 mg po once a day thru end of 4/15 Recheck [INR] on 4/16 . Record review revealed a physician's order dated 4/9/2024 for Coumadin 5 mg by mouth in the evening until 4/15/2024. Further review revealed an INR was completed on 4/16/2024 with an INR result of 2.5. Record review of the laboratory report dated 4/16/2024 revealed a handwritten order at the bottom of the report, signed by RNP, Staff D which reads, Reviewed cont [continue] current dose of coumadin (5 mg po daily) Recheck .INR in 1 week . Record review revealed a physician's order dated 4/16/2024 for Coumadin 5 mg by mouth in the evening . until 4/22/2024. Further review of the order revealed the Coumadin start date was entered as 4/17/2024 at 6:00 PM and not 4/16/2024 and the Coumadin stop date was entered as 4/22/2024 at 10 AM, which was 8 hours prior to the scheduled administration time of 6 PM, indicating a transcription error. Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered on 4/16/2024 and 4/22/2024, resulting in 2 missed doses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor interview on 5/2/2024 at 1:24 PM with Licensed Practical Nurse (LPN), Staff H, she was unable to explain why the resident was not administered his/her Coumadin on 4/8/2024, suggesting the order may have fallen off of the MAR. Additionally, she could not explain why the INR order was not transcribed on 4/8/2024. 3. Record review revealed Resident ID #5 was admitted to the facility in August of 2022 with diagnoses including, but not limited to, atrial fibrillation and prosthetic heart valve (an artificial valve that is implanted to replace their native heart valve). Record review revealed a physician's order dated 3/27/2024 for Coumadin 5 mg by mouth in the evening for 5 days. Further review of the order revealed the Coumadin start date was entered as 3/27/2024 at 6:00 PM and the Coumadin stop date was entered as 4/1/2024 at 5:59 PM, which was 1 minute prior to the 6:00 PM scheduled administration time, indicating a transcription error. Record review of a progress note dated 4/2/2024 and authored by RNP, Staff F, states in part, .Assessment and Plan .INR -2.0 NEW ORDER: increase coumadin to 5.5 mg once daily x 7 days and repeat .INR .7days . Record review of the physician's orders failed to reveal a Coumadin order for 4/2/2024. Additional record review revealed an order for Coumadin 5 mg by mouth in the evening for 7 days with a start date of 4/3/2024 instead of 4/2/2024 and an incorrect Coumadin dose of 5 mg instead of Coumadin 5.5 mg daily, indicating a transcription error. Record review of a provider progress note dated 4/10/2024 and authored by RNP, Staff F, states in part, . Assessment and Plan .INR -2.1 NEW ORDER: increase coumadin to 5.5 mg once daily x 7 days and repeat . INR .7 days . Record review of a nursing progress note dated 4/10/2024 and authored by LPN, Staff B, states, INR reported, orders obtained to continue with 5 mg po qd [daily], recheck INR 4/17. Record review revealed an order with a start date of 4/10/2024 for Coumadin 5 mg in the evening until 4/16/2024, instead of Coumadin 5.5 mg daily, indicating a transcription error. Record review of the provider progress notes, revealed a note dated 4/24/2024 and authored by RNP, Staff F, states in part, .Assessment and Plan .INR -2.6 NEW ORDER: c/w coumadin 5.5 mg once daily x 7 days and repeat .INR .7 days . Record review revealed two orders for Coumadin with a combined total dose of Coumadin 5.5 mg daily, with a start date of 4/24/2024 and a stop date of 4/29/2024, indicating the order was incorrectly transcribed for 6 days instead of the ordered 7 days. Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered on 4/1/2024, 4/2/2024 and 4/30/2024, indicating the resident missed 3 doses. Additional review of the MAR revealed the Coumadin 5 mg was signed off as administered daily, instead of the ordered 5.5 mg dose from 4/3/2024 through 4/16/2024, resulting in the resident receiving the incorrect dose of Coumadin for 14 days. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a surveyor interview on 5/2/2024 at 2:40 PM with RNP, Staff F, after reviewing her written progress notes dated 4/3/2024 and 4/10/2024 and the transcribed orders with her, she revealed the orders were transcribed incorrectly, and she would have expected Resident ID #5 to receive Coumadin 5.5 mg daily as ordered on 4/3/2024 and 4/10/2024. 4. Record review revealed Resident ID #6 was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, atrial fibrillation. Record review revealed a physician's order dated 4/27/2024 at 9:24 AM to repeat INR today and hold the Coumadin until INR was rechecked. Record review revealed a physician's order dated 4/27/2024 to obtain an INR. Record review failed to reveal evidence of the INR results on 4/27/2024. Further record review failed to reveal evidence of a physician's order to obtain an INR on 4/28/2024 or INR results for 4/28/2024. Record review failed to reveal a Coumadin order for 4/27/2024 and 4/28/2024. Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered on 4/27/2024 and 4/28/2024, resulting in 2 missed doses. During a surveyor interview on 5/2/2024 at 2:36 PM with the DNS, she was unable to provide evidence of the ordered INR results for 4/27/2024. 5. Record review revealed Resident ID #7 was admitted to the facility in June of 2021 with a diagnosis including, but not limited to, atrial fibrillation. Record review revealed a physician's order dated 4/18/2024 at 6:05 PM for Coumadin 4 mg by mouth in the evening until 4/25/2024. Further review of the order revealed the Coumadin start date was entered incorrectly for 4/19/2024, instead of 4/18/2024, indicating a transcription error. Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered to the resident on 4/18/2024, resulting in a missed dose. 6. Record review revealed Resident ID #8 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, acute embolism (a foreign substance that moves in the blood stream until it blocks a vessel) and thrombosis (blood clot). Record review revealed a physician's order dated 4/2/2024 for Coumadin 4 mg by mouth in the evening for 6 days. Further review of the order revealed the Coumadin start date was entered incorrectly for 4/3/2024 at 6:00 PM, instead of 4/2/2024, indicating a transcription error. Further review of the orders revealed an order dated 4/9/2024 for Coumadin 4 mg by mouth in the evening for 6 days. Further review of the order revealed the Coumadin start date was entered as 4/9/2024 at 6:00 PM and the Coumadin stop date was entered as 4/15/2024 at 5:59 PM, which was 1 minute prior to the 6:00 PM scheduled administration time, indicating a transcription error. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered on 4/2/2024 and 4/15/2024, resulting in 2 missed doses. 7. Record review revealed Resident ID #9 was admitted to the facility in June of 2023 with a diagnosis including, but not limited to, atrial fibrillation. Record review revealed a physician's order dated 4/15/2024 to hold Coumadin on 4/15 and 4/16/2024, obtain the INR on 4/17/2024. Record review of the laboratory report dated 4/17/2024 revealed a handwritten order at the bottom of the report, signed by RNP, Staff F, which reads, 1. Hold coumadin today 2. Repeat .INR tomorrow [4/18] . Record review revealed a physician's order dated 4/18/2024 for Coumadin 3 mg by mouth in the evening. Further review of the order revealed the Coumadin start date was entered incorrectly as 4/19/2024 instead of 4/18/2024, indicating a transcription error. Record review of the April 2024 MAR failed to reveal evidence that the Coumadin was administered on 4/18/2024, resulting in a missed dose. During a surveyor interview on 5/2/2024 at 2:36 PM with the Administrator, Director of Nursing Services, Regional Director of Clinical Services and VP of Clinical Services, when the above-mentioned findings were reviewed, they acknowledged that the above-mentioned Coumadin and INR transcription errors resulted in significant medication errors.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review and staff interview it has been determined that the facility failed to maintain medical records for each resident that are accurately documented, in accordance with accepted professional standards and practices for 1 of 3 residents reviewed for skin observations, Resident ID #2. Findings are as follows: Record review revealed the resident was admitted to the facility in October of 2023 with diagnoses including, but not limited to, traumatic brain injury, anxiety and s/he was diagnosed with Influenza (Flu) A virus on 4/18/2024. Record review revealed a weekly skin assessment dated [DATE] indicating a new small open [area] to coccyx area was identified. During a surveyor interview on 4/24/2024 at 3:23 PM with Registered Nurse, Staff E, she acknowledged that she was the nurse that completed the skin assessment report, however she revealed that the resident did not have an open area and she had documented this in error. During a surveyor interview on 4/25/2024 at approximately 11:30 AM with the Director of Nursing Services, she revealed that Staff E documented an open area to the resident's coccyx in error on 4/19/2024. Additionally, she was unable to explain why the resident's medical record was inaccurate.