STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425147	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hilton Head	120 Lamotte Drive Hilton Head Island, SC 29926

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43322 Based on review of facility policy, record review, and interview, the facility failed to accurately document Resident (R)510's advance directives, for 1 of 2 residents. Specifically, R510 had orders and signed documentation requesting Do Not Resuscitate (DNR), however R510's Care Plan documented Full Code. Findings include: Review of the facility policy titled, Advance Directives and Advance Care Planning with a reviewed date of [DATE], documented, Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive . Procedure 15. Documentation in the Minimum Data Set (MDS) should reflect the appropriate advance directives . 16. Do Not Resuscitate (DNR) - . all Life Care Centers of America's residents receive full resuscitative measures unless a DNR is written in the resident's medical record and is identified in the resident's advance directive . The following procedures are to be enforced: c. DNR order is flagged appropriately on the resident's chart to alert staff as to status. f. The DNR order is incorporated into the resident's care plan . Review of R510's Face Sheet revealed R510 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia, hyperlipidemia, and erythematous condition. Further review of the Face Sheet revealed R510's code status was documented as Do Not Resuscitate/Comfort Measures Only. Review of R510's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R510 had a Brief Interview for Mental Status Score (BIMS) of 3 out of 15, indicating R510 had severe cognitive impairment. Review of R510's Physician Orders revealed an order with a start date of [DATE] which documented Do Not Resuscitate/Comfort Measures Only. Review of R510's Hard Chart (binder containing paper copies of medical records) revealed a document titled SC Physician Orders for Scope of Treatment dated [DATE], revealed code status of R510 was DNR, comfort measures only. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R510's Hard Chart revealed a document titled SC Emergency Medical Services dated [DATE] indicated R510's code status was DNR. Review of R510's Hard Chart revealed a written order dated [DATE], which documented, Resident's son request DNR/Comfort Measures Only. Review of R510's Baseline Care Plan signed on [DATE], indicated Advance Directives: Full Code. Review of R510's Care Plan initiated on [DATE], revealed, Resident has Advance Directives . CPR - Full Code, with a goal indicating, Resident's Advance Directives will be honored. Intervention in this Care Plan with a date initiated of [DATE], revealed, Code status will be reviewed on a quarterly basis and PRN (as needed). Another intervention with a date initiated of [DATE] and a revision date of [DATE], revealed, Resident has decided to remain a Full Code. During an interview on [DATE] at 2:17 PM, Licensed Practical Nurse (LPN)1 stated, Her family never came back to complete the admission process. I didn't do her care plan. If something were to happen and we did the opposite of what was documented, it would not be good. During an interview on [DATE] at 2:26 PM, the Director of Nursing (DON) stated, She has dementia and is a wanderer. When a patient is first admitted they will automatically be full code, until we verify their code status. If the family is not present, then we have to wait until we can confirm. The staff doesn't follow the care plan when it comes to advance directives. If someone is coding, we run and get the hard chart to verify the status. Care plans get updated quarterly and as needed. The care plan should have been updated immediately when the DNR was verified. During an interview on [DATE] at 3:08 PM, Registered Nurse MDS Coordinator (RN)1 revealed, At that time we had a care plan meeting with the family, the family decided to do the DNR. The care plan meeting was done on Monday. Baseline, I do within 48 hrs. If the family is not available, we make a note of that. Quarterly, Annual and as needed, significant change. Advance directives should be updated immediately, this was my mistake.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42424 Based on observation, interview, record review, and review of facility policy, the facility failed to revise Resident (R)4's Care Plan to reflect refusal of Activities of Daily Living (ADL) care in a timely manner, for 1 of 3 residents reviewed for Care Plans related to ADL Care. Findings include: Review of the facility policy titled Comprehensive Care Plans and Revisions last revised on 08/22/23 revealed, The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Procedure includes: the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery this can include; additional interventions on existing problems; updating goal or problem statements; adding a short-term problem, goal, and interventions to address a time limited condition. Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia with psychotic disturbance, muscle weakness, anxiety disorder, and major depressive disorder. Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/24, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicates R4 had moderate cognitive impairment. Review of R4's Care Plan last revised on 12/06/23 revealed, [R4] has an ADL self-care performance deficit related to limited mobility, dementia, impaired balance, non-ambulatory status, depression, anxiety, anemia, and morbid obesity. Interventions include the resident is to be up and dressed, and in her wheelchair after lunch for two hours daily. During an observation on 06/04/24 at 10:47 AM, revealed R4 was asleep in her bed in a night gown with facial hair noted to the resident's upper lip. An attempted interview was declined by R4. During an observation on 06/04/24 at 12:15 PM, revealed R4 in bed asleep, in night gown, with facial hair noted to her upper lip. During an observation on 06/04/24 at 2:24 PM, revealed R4 in bed asleep, in night gown, with facial hair noted to her upper lip. During an interview on 06/04/24 at 3:51 PM, R4's Resident Representative revealed that R4 has been sleeping more during the day but would like the resident to get out of bed and dressed appropriately at least for a few hours during the day when possible. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/05/24 at 8:50 AM, revealed R4 still had facial hair noted to her upper lip. R4 was awake and in bed, in night gown alert but pleasantly confused. An attempted interview with R4 revealed that she has cognitive impairment, during the attempted interview R4 began to pick at her facial hair when questioned about it. During an observation on 06/06/24 at 8:15 AM, revealed R4 with facial hair noted to her upper lip, R4 was finished with breakfast and laying in bed in a nightgown. During an interview on 06/06/24 at 1:20 PM, Certified Nursing Assistant (CNA)4 revealed that R4 often refuses to get out of bed during the day and is awake during the morning most days but likes to go back to sleep after lunch. CNA4 stated that she was unaware that R4's Care Plan states that she is to be dressed after lunch and out of bed in her wheelchair. During an interview on 06/06/24 at 3:14 PM, CNA6 revealed they are the resident's assigned CNA for today and was the resident's CNA on 06/05/24, and provided R4 with a shower on 06/05/24. CNA6 stated that the resident is often resistive to care but was able to redirect the resident on 06/05/24 and make her more agreeable to a shower. CNA6 stated that they have nowhere to document if a resident refuses to be shaved in their system, so they tell nursing staff and it is documented in the nurses notes. During an interview on 06/06/24 at 3:39 PM, the Director of Nursing (DON) revealed staff are required to update changes with resident within 7 days after the comprehensive assessment and as needed with resident changes. The DON further stated that she expects staff to document refusal in the EMR within 48 hours so that the MDS coordinator and IDT team can revise the resident care plan to reflect their behaviors. The IDT team also involve family and make them agreeable with the plan of care before finalizing the care plan, but care plans are updated on a as needed basis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42424 Based on observations, interview, record review, and review of facility policy, the facility failed to offer/provide Resident (R)4, a dependent resident, with Activities of Daily Living (ADL) care related to facial hair, for 1 of 3 residents reviewed for ADL care. Findings include: Review of facility policy titled Activities of Daily Living: last revised 02/12/24 revealed The resident will receive assistance as needed to complete ADLs. Any change in the ability to perform ADLs will be reported to the nurse. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services that ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that a resident who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to: Dementia with psychotic disturbance, muscle weakness, anxiety disorder, and major depressive disorder. Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/24, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicates R4 had moderate cognitive impairment. Review of R4's Care Plan last revised on 12/06/23 revealed, [R4] has an ADL self-care performance deficit related to limited mobility, dementia, impaired balance, non-ambulatory status, depression, anxiety, anemia, and morbid obesity. Interventions include the resident is to be up and dressed, and in her wheelchair after lunch for two hours daily. During an observation on 06/04/24 at 10:47 AM, revealed R4 was asleep in her bed, in a night gown, with facial hair noted to the resident's upper lip. An attempted interview was declined by R4. During an observation on 06/04/24 at 12:15 PM, revealed R4 in bed asleep, in night gown, with facial hair noted to her upper lip. During an observation on 06/04/24 at 2:24 PM, revealed R4 in bed asleep, in night gown, with facial hair noted to her upper lip. During an interview on 06/04/24 at 3:51 PM, R4's Resident Representative revealed that R4 has been sleeping more during the day but would like the resident to get out of bed and dressed appropriately at least for a few hours during the day when possible. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/05/24 at 8:50 AM, revealed R4 with facial hair noted to her upper lip, awake in bed, in night gown, alert but pleasantly confused. An attempted interview with R4 revealed that she has cognitive impairment, during the attempted interview R4 began to pick at her facial hair when questioned about it. During an observation on 06/06/24 at 8:15 AM, revealed R4 with facial hair noted to her upper lip, R4 was finished with breakfast and laying in bed in a nightgown. During an interview and observation on 06/06/24 at 1:20 PM, Certified Nursing Assistant (CNA)4 revealed that CNA's are responsible for trimming residents facial hair, and it is completed on an as needed basis. CNA4 further stated that they trim facial hair when it reaches a certain length, and agreed that R4 had enough facial hair for staff to trim at this time. During an interview on 06/06/24 at 2:42 PM, the Director of Nursing (DON) revealed that CNA's are responsible for providing residents with ADL care such as shaving/grooming residents on an as needed basis and should be offered to residents at least two times a week during their shower days. The DON further stated that if a resident refuses to have ADL care performed, the CNA's are responsible for informing nursing staff so it can be documented in the resident's record. During an interview on 06/06/24 at 3:14 PM, CNA6 revealed they are the resident's assigned CNA for today and was the resident's CNA on 06/05/24, and provided R4 with a shower on 06/05/24. CNA6 stated that the resident was resistive to care yesterday but she eventually was able to redirect the resident and make her agreeable to take a shower, due to the resident's agitation CNA6 did not offer to trim R4's facial hair but told the nurse. CNA6 stated that they have nowhere to document if a resident refuses to be shaved in their system, so they tell nursing staff and it is documented in the nurses notes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43322 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure that medications were properly stored and secured for Resident (R)15, for 1 of 1 residents reviewed. Findings include: Review of facility policy titled, , Storage and Expiration Dating of Medication, Biologicals with an effective date of 12/01/07, revealed, Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Facility should store bedside medications or biologicals in a locked compartment within the resident's room. Facility should ensure that only Facility representatives and the appropriate resident maintains the keys, access cards, electronic codes, or combinations which open the locked compartment. Review of R15's Face Sheet revealed R15 was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes, chronic obstructive pulmonary disease, hypertension, and heart disease. Further review of R15's Face Sheet documented, Special Instructions: Please do not order medications from Omnicare. Resident will receive medications from CHAMPVA Med-By-Mail East- 1(866)229-7389. Medications will be mailed to son and he will deliver them to the facility. Medications will come in 3 month supply. Fax number to CHAMPVA (MBM) 1-(303) [PHONE NUMBER] for medication changes or any new medications. PLEASE CALL CHAMPVA WHEN MEDICATIONS ARRIVE AND LET THEM KNOW WE RECEIVE MEDICATIONS AND THEY WILL START REFILL PROCESS. Review of R15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/24, revealed R15 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R15 was cognitively intact. Review of R15's Medication Self Administration Review with an agreement date of 04/18/22, revealed R15 is capable of self administering the following medications: Tylenol 325 Q6H PRN (every 6 hours as needed), hair skin and nails vitamin 2 tabs daily, stopain extra strength roll for muscle pain, menthol 2.5% muscle rub cream. Further review of the Self Administration Review revealed a comment stating, only the medications listed above . During an observation & interview on 06/04/24 at 11:25 AM, revealed R15's room contained two plastic bins containing medications. The plastic bins were stored above a wardrobe closet in R15's room. Observation of the plastic bins revealed the bins were not locked or secured. The plastic bins contained the following medications: Meclizine HCL 25 MG Chew TAB 90 Lisinopril 20 MG Tab 60 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol Succinate 100 MG SA Tab 90 Gabapentin Capsules USP 300 MG 270 Pantoprazole NA 40 MG EC Tab 90 Losartan 25 MG Tab 90 Dapagliflozin 10 MG Tab 8 bottles 30 Amlodipine Besylate 10 MG Tab 90 Loperamide HCL 2 MG Cap 2 bottles 30 Furosemide 20 MG Tab 5 bottles 90 Albuterol Inhaler 90 mcg-1 box Premarin 0.625mg-1 box Combivent Inhaler 100 20mcg-9 boxes Fluticasone 100/50-1 box Finger stick lancets-3 boxes R15 stated, They didn't have enough room in the drawer to keep all my meds, so they keep it in here. During an interview on 06/06/24 at 8:53 AM, the Director of Nursing (DON) revealed, R15 gets her meds delivered from Veterans Administration (VA), R15's son is a physician and he is scared that she will run out of medication. R15's son put them (medications) up there where R15 couldn ' t reach it. The DON further stated, We do room rounds every day and the staff never mentioned it. Based on our policy, the medication has to be stored in a secured location, and it was up high to where she couldn't reach it. The bins are clipped shut. The resident is a special case and she gets anxiety. We did what we thought was fit, by keeping it up high and clipping them shut. During an interview on 06/06/24 at 8:57 AM, License Practical Nurse (LPN)1 revealed, R15's son always comes in bringing stuff. And he wont tell us what he bringing in. During an interview on 06/06/24 at 9:04 AM, Certified Nursing Assistant (CNA)5 stated, I never paid attention to it. There was medication inside the closet. The medication was in boxes. During a follow up interview on 06/06/24 at 9:06 AM, R15 stated, I keep my meds in here for about 8 months. They [facility staff] said they didn't have anywhere to put it [medications]. It used to be in paper boxes, my son bought the plastic bins. They never had zip ties or locks on it.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 48835 Based on National Pressure Injury Advisory Panel, record review, interview, and observation, the facility failed to failed to provide physician supervision of a pressure ulcer for Resident (R)49's right foot, for 1 of 4 residents reviewed for pressure ulcers. Findings include: Review of the National Pressure Injury Advisory Panel, titled, Prevention and Treatment of Pressure Ulcers/Injuries Quick Reference Guide, dated 2019 revealed under recommendation, Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable Pressure Injury. Review of R49's Face Sheet revealed the facility admitted R49 on 02/07/24, with diagnoses including but not limited to: hip fracture, pressure ulcer of right heel unstageable, weakness, and orthostatic hypotension. Review of R49's skin/wound note dated 02/07/24 at 3:14 PM, revealed, [R49] admitted today with a dehisced surgical wound on his left buttock due to a debridement of a wound as well as a abscess. Resident also has a DTI on right heel measuring 5x6.4cm. and is dry eschar with some granulation tissue noted on the dorsal side. Medical Doctor (MD) is aware of present treatments for these wounds. Review of Nursing Wound Observation dated 02/07/24, recorded R49's right heel as an unstageable pressure ulcer with necrotic tissue to 75% of the wound bed. Review of Nursing Wound Observation dated 03/20/24, recorded R49's right heel as unstageable deep tissue injury improving with 60% necrotic tissue. Review of Nursing Wound Observation dated 04/24/24, recorded R49's right heel as a stage 2 after surgeon debrided the wound. Review of Nursing Wound Observation dated 05/08/24, recorded R49's right heel as a stage 2 improving with granulation tissue present. No slough was recorded. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Wound Observation dated 05/15/24, recorded R49's right heel as a stage 2 improving, with slough 10% and granulation tissue. Serous drainage was noted. Apply aquacell AG (an absorbant dressing with ionic silver, a proven broad spectrum antimicrobial) to right heel, cover with mepore dressing Monday, Wednesday, Friday. Review of Nursing Wound Observation dated 05/29/24, recorded R49's right heel as a stage 2, unchanged with 10% slough noted. Apply gauze moistened with Dakins solution to right heel wound, apply mepore dressing and float heels when in bed. Review of Nursing Wound Observation dated 06/05/24, recorded R49's right heel as a stage 2 unchanged, with 10% slough. Apply gauze moistened with Dakins solution to right heel wound, apply mepore dressing and float heels when in bed. During an observation on 06/05/24 at 11:41 AM, of R49's right heel wound with Licensed Practical Nurse (LPN)2, revealed the heel presents as a large open wound, observed with thick black necrotic tissue covering approximately 60% of the open area. There was also tan slough, throughout the remaining area with some red beefy tissue. No odor was noted. The heel had redness and some inflammation. Review of Physician Progress Notes, since R49's admission revealed the following: 02/12/24 with diagnosis cellulitis left buttock, continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/23/2024 cellulitis left buttock, Seen by wound nurse, discussed case with her. 02/14/2024 cellulitis left buttock, Seen by wound nurse, discussed case with her. 02/15/2024 cellulitis left buttock, Seen by wound nurse, discussed case with her. 02/19/2024 cellulitis left buttock, Seen by wound nurse, discussed case with her. 02/20/2024 sacral decubitus ulcer improving, no infection, I examined [R49] with [LPN2], his wound is improving, look clean. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/21/24 sacral decubitus ulcer improving, no infection. I examined [R49] with [LPN2], his wound is improving, look clean 02/21. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/22/24 sacral decubitus ulcer improving, no infection. I again discussed with [R49] that his sacral wound would not heal unless he spent more time of the bed offloading his weight off of the wound. I examined [R49] with [LPN2], his wound is improving, look clean 2/21. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. (continued on next page)

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Life Care Center of Hilton Head	120 Lamotte Drive Hilton Head Island, SC 29926

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/23/24 sacral decubitus ulcer improving, no infection. I remind [R49] and nursing staff and therapy to offload his weight from the wound, I again discussed with [R49] that his sacral wound would not heal unless he spent more time of the bed offloading his weight off of the wound. I examined [R49] with [LPN2], his wound is improving, look clean 2/21. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/26/24 sacral decubitus ulcer improving, no infection. MRSA in the buttock wound. I remind [R49] and nursing staff and therapy to offload his weight from the wound, I again discussed with [R49] that his sacral wound would not heal unless he spent more time of the bed offloading his weight off of the wound. I examined [R49] with [LPN2], his wound is improving, look clean 2/21. I asked [R49] to spend the day in his chair, bed only to sleep. Explained this will help his wound healing. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/27/24 sacral decubitus ulcer improving, no infection. I remind [R49] and nursing staff and therapy to offload his weight from the wound, I again discussed with [R49] that his sacral wound would not heal unless he spent more time of the bed offloading his weight off of the wound. I examined [R49] with [LPN2], his wound is improving, look clean 2/21. I asked [R49] to spend the day in his chair, bed only to sleep. Explained this will help his wound healing. Continue Augmentin and doxycycline for wound infection. Seen by wound nurse, discussed case with her. 02/28/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offload his wound. 02/29/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offload his wound. 03/01/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. 03/04/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. 03/05/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. 03/06/24 sacral decubitus ulcer improving, no infection. I debrided his sacral wound at bedside 2/28, 20 min. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. 03/22/24 sacral decubitus ulcer improving, no infection. I started Augmentin twice a day for 7 days. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 425147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/01/24 sacral decubitus ulcer improving, no infection. Cellulitis left buttock. I started Augmentin twice a day for 7 days. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with LPN 2 from wound care. 04/24/24 I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with [LPN2] from wound care. 04/25/24 Status post IV fluids for dehydration, no dizziness. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with[LPN2] from wound care. 04/29/24 Status post normal saline 1 Liter 4/25. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with [LPN2] from wound care. 04/30/24 Status post normal saline 1 Liter 4/25. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with [LPN2] from wound care. 05/01/24 Status post normal saline 1 Liter 4/25. I will send him back to surgery for an incision and drainage. Continue to speand more time off the bed to help offloading weight from his wound. I remind [R49], nursing staff and therapy to offlaod his wound. [R49] had a recent sacral abcess. Went to went to outside physician who felt abcess resolved, completed course of ABT. Spoke with [LPN2] from wound care. 06/06/24 a noted was added, written as a late entry from 06/03/24. Saw [R49] wound rounds. Has a left heel wound stage two. 60% necrotic, 20% slough 20% granulation. Wound is improving. During an interview on 06/06/24 at 10:54 AM, the Medical Doctor (MD) stated, When I round, I round with [LPN2], the wound nurse. [R49] has 2 wounds, one on his sacrum and one on his left heel. I saw the heel either earlier this week or last week. The wound on his heel is fairly new to me, I was told about it a week ago. I said it is a stage 2. A stage 2 is a wound that is past the superficial skin into the dermis, typically, it depends. [R49] has some necrosis to the wound. I may not have documented on the heel because I've been observing his sacral wound. All the notes that are written are for the sacrum. It may be that the wound on the heel has got worse recently. [LPN2] mentioned the wound to me yesterday but I did not see it yesterday.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47075 Based on review of the facility policy, observation, and interview, the facility failed to follow infection control standards during wound care of Resident (R)49, for 1 of 4 residents reviewed for pressure ulcers. Findings include: Review of the undated facility policy titled, Wound Care Treatment Clean Dressing Change Skills Evaluation revealed under policy, Wound Care; gently remove the old dressing and place in the trash, discard soiled gloves, clean hands. Hand hygiene; hand washing or hand sanitizer per policy. Review of R49's Face Sheet revealed the facility admitted R49 on 02/07/24, with diagnoses including but not limited to: hip fracture, pressure ulcer of right heel unstageable, weakness and orthostatic hypotension. During an observation of a dressing change for R49 on 06/05/24 at 11:41 AM, Licensed Practical Nurse (LPN)2 gathered all the supplies needed for the dressing change and placed them on a clean tray, lined with a barrier. LPN2 knocked on the door and entered the room and closed the door. R49 gave consent for an observation of the dressing change. R49 was positioned on his right side facing the door. LPN2 explained the procedure to R49 and after placing the tray on his overbed table, she washed her hands at the sink. LPN2 donned gloves and proceeded to remove the soiled dressing from R49's right heel. LPN2 removed the gloves and donned another pair of gloves. LPN2 did not wash her hands or sanitize her hands before donning the second pair of gloves. The wound was observed with thick hard black eschar covering approximately 60% of the wound bed, with additional tan slough marbled with beefy red tissue. The was also inflammation and some redness on the outer portion of the heel. There was no odor present. LPN2 then cleaned the wound with normal saline and applied Calmoseptine with a q-tip on the outer perimeter of the wound, as she stated, To protect the outer skin. LPN2 removed her gloves, sanitized her hands from the hand sanitizer located on the wall in the room. After donning a 3rd pair of gloves, LPN2 used a skin prep pad and applied it outside the perimeter of the Calmoseptine. LPN2 then applied a 2x2 dressing soaked in Dakin's solution (a diluted hypochlorite solution used as an antiseptic) directly on the wound bed. LPN2 then applied the outer dressing, and dated and initialed it. During an interview on 06/05/24 at 11:55 PM, LPN2, after R49's dressing change of his right heel, stated, I thought I sanitized my hands after removing the soiled dressing and changing gloves, but I cannot remember. I know I sanitized after applying the Calmoseptine with the q-tip. During an interview on 06/06/24 at 12:25 PM, the Director of Nurses (DON)stated, For a dressing change, remove the old dressing, remove gloves, hand sanitize, then put gloves on. 48835