STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445306	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Health of Portland Rehab & Wellness Cent	215 Highland Circle Drive Portland, TN 37148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, hospital record review, observation, and interview, the facility failed to provide care and services to prevent the development of a pressure ulcer/injury for 1of 4 (Resident #4) sampled residents reviewed for pressure ulcers. On 8/20/2025, Resident #4, a resident with impaired mobility who was at risk for pressure ulcers, was readmitted to the facility with an immobilizer to her left lower leg. The facility failed to assess, monitor, and document Resident #4's skin integrity underneath the immobilizer daily from 8/21/2025 to 9/8/2025, resulting in a pressure injury and an infection to the left lateral (outside portion of leg) ankle which resulted in actual Harm to Resident #4. The findings include: 1. Review of the facility policy titled, Splints and Braces, dated 1/31/2025, revealed .Staff will ensure proper application, monitoring, maintenance, and documentation of all splints and braces to promote resident safety, comfort, and functional ability. Review of the facility policy titled, Skin Integrity, dated 1/31/2025, revealed .A resident receives care, consistent with professional standards of practice, to prevent avoidable skin integrity issues and does not develop avoidable skin integrity issues unless.A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent avoidable skin integrity issues from developing.The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified.The Nurse Leader/Wound Nurse shall document all impaired skin integrity areas such as: pressure, stasis, surgical incision, or diabetic ulcers in the EMR [Electronic Medical Record] on an ongoing basis or until closed or the resident has been discharged . 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with a readmission to the facility on 8/20/2025, with diagnoses including Fracture of Left Patella (Bone in front of the knee joint), Disorders of Bone Density and Structure, Dementia, and Osteoarthritis. Review of the Event Report dated 8/15/2025, revealed Resident #4 sustained a fall in the hallway, hit her head, had a laceration and swelling above the left eye, and complained of shoulder pain. The physician was notified. Review of the Physician Orders dated 8/15/2025, revealed .Send to ER (Emergency Room) for eval and treat . Review of the discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 was discharged on 8/15/2025 to the hospital. Resident #4 had no pressure injuries. Review of the Consultation Report from [Name of Hospital] dated 8/16/2025, revealed .reports reason for admission is FELL AT NURSING HOME .CT (computerized tomography scan) imaging of the left knee have identified a .patella (knee) fracture (break) .continue to wear the knee immobilizer to refrain from flexion of the knee.patient may be weight bear [bearing] as tolerated only while wearing the knee immobilizer. The facility failed to implement orders related to the left knee immobilizer on Resident #4's left leg upon readmission to the facility on 8/20/2025. Review of the Nurses' Note dated 8/21/2025 at 11:17 PM, revealed Resident #4 wore an immobilizer and the skin underneath was within normal limits. Review of the entry MDS dated [DATE], revealed Resident #4 readmitted to the facility from an acute care hospital on 8/20/2025. Review of the Daily Skilled Notes from 8/21/2025 through 8/31/2025, revealed the staff failed to assess Resident #4's skin under the left lower extremity immobilizer on the following days: a. 8/23/2025 .Skin Integrity .Braces, casts, immobilizers (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 0686 Level of Harm - Actual harm Residents Affected - Few	.Immobilized/Casted Limb.N/A [not applicable] . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. b. 8/24/2025 The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. c. 8/28/2025 .Skin Integrity .Braces, casts, immobilizers .Skin tears, abrasions, bruises .Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. d. 8/29/2025 .Skin Integrity .Braces, casts, immobilizers.N/A.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. Review of the Daily Skilled Notes from 9/1/2025 through 9/8/2025, revealed the following: a. 9/1/2025 .Skin Integrity .Braces, casts, immobilizers.N/A.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. b. 9/2/2025 .Skin Integrity.N/A.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. c. 9/6/2025 .Skin Integrity.Braces, casts, immobilizers, or orthotic devices present.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. d. 9/7/2025 .Skin Integrity.Braces, casts, immobilizers, or orthotic devices present.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. e. 9/8/2025 .Skin Integrity.Braces, casts, immobilizers or orthotic devices present .N/A.Immobilized/Casted Limb.N/A . The facility was unable to provide documentation that the skin on the left lower extremity underneath the immobilizer was assessed. Review of the Event Report.Skin Integrity Events. dated 9/8/2025, revealed .Quarter sized area where immobilizer has rubbed skin.Location of wound - Left lateral lower leg above ankle.Size of Wound.Quarter size.Possible contributing factors to skin integrity impairment.immobilizer to left leg.DON [Director on Nursing]/Wound Nurse notified to enter into Wound Management System.Yes.New Interventions - Immediate actions taken.Provide padding for cast, splint, devices.Treatments Wound Care: Skin observation to beneath knee immobilizer every shift.DON/Wound Nurse notified.Yes.Wound placed in Wound Management.No. The facility failed to stage, assess, and accurately document a newly acquired pressure injury. Review of the Nurses Note dated 9/8/2025, revealed .During skin assessment a quarter size pressure area to left lateral leg above ankle was observed. Resident is wearing an immobilizer to left leg r/t [related to] patella fracture. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was cognitively intact. Resident #4 was coded as at risk for developing pressure ulcers and was coded as having no pressure, venous or arterial wounds. Review of the Physician Order's dated 9/9/2025, revealed: a.Nursing to remove left knee immobilizer to inspect skin BID [twice a day] Every Shift Day, Night. b.Nursing check circulation under the device BID to left knee immobilizer Every Shift Day, Night. c.Nursing reposition LLE (left lower extremity) with left knee immobilizer, ensure in the correct alignment Every Shift Day, Night. d.Wound Care: Skin observation to beneath knee immobilizer every shift Every Shift Day, Night. e.Monitor area above left lateral ankle every shift Every Shift Day, Night. f.Apply skin prep to above left lateral ankle daily Every Shift Day Special Instructions: Apply skin prep to above left lateral ankle daily. Review of the Nurses Note dated 9/16/2025, revealed .new orders were received to discontinue use of left leg immobilizer. Review of the Event Report.Skin Integrity Events. dated 9/17/2025, revealed .Pressure.Location of wound - left lateral ankle.Size of Wound.Length - 2cm [centimeters].Width - 1.5cm.Drainage.pus/minimal blood.Possible contributing factors to skin integrity impairment.pressure.DON/Wound Nurse notified to enter into Wound Management System.Yes.Pain Assessment Post Event.Yes, able to verbalize pain.Resident Pain Description.just hurts.Pain Location as identified per resident.left lateral ankle.Provider Notification Yes, Name of the provider notified. [Named Care Partners] .Treatments (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound Care: Wound observation to left ankle every shift.Evaluation Notes: tx [treatment] in place monitoring to continue DON/Wound Nurse notified.Yes.Wound placed in Wound Management.Yes. Review of the Nurses Note dated 9/17/2025, revealed .New order per wound NP [Nurse Practitioner] culture wound to left lower leg. Review of the Nurses Note dated 9/17/2025, revealed .Pressure wound noted in left lateral ankle. Minimal purulent drainage noted with blood tinged mixed with pus. Surrounding tissue mildly red, no significant odor. Resident complaining of pain 5/10. PRN [as needed] Tramadol [medication used for pain] was given.prescribed Doxycycline [medication used to treat infection] 100mg [milligrams] 2x[times] daily for 7 days and wound culture. Review of the Physician Order's dated 9/17/2025, revealed .doxycycline .100 mg.Twice a day.r/t to wound infection left lateral ankle. Review of the Nurses Note dated 9/18/2025, revealed .Pressure injury to lower left lateral leg occurred d/t [due to] patients leg immobilizer.Doxycycline [antibiotic] was ordered to treat wound infection. Review of the Wound Management Detail Report dated 9/18/2025, revealed .Length .2.8 [cm] Width .2 [cm] .Depth .0.2 [cm].Exudate [the drainage that seeps out of a wound] color and consistency: Serosanguineous [pale red to pink, thin and watery].Stage: Unstageable - Deep Tissue.Tissue Type: Slough [dead, stringy, yellow or tan tissue in a wound]. Review of the Physician's Order dated 9/18/2025, revealed .Cleanse left lower lateral leg with .0.125% [percent] Dakins [wound cleaner], apply medihoney [used to treat wounds] and silver ag+ [alginate] [used to treat wounds], cover with silicone bordered dressing every day and PRN. Review of the Wound Culture results dated 9/21/2025, revealed .Heavy Growth Staphylococcus Aureus [type of bacterium]. Review of the Nurses Note dated 9/30/2025, revealed .Results of wound culture to left leg resulted noting Staph [Staphylococcus]. During an interview on 12/2/2025 at 2:14 PM, the Director of Nursing (DON) was asked if Resident #4 returned to the facility on 8/20/2025 with an immobilizer to her left leg. The DON stated, Yes. The DON was asked when the orders were entered related to monitoring the resident's skin under the immobilizer to the left lower extremity. The DON stated, .On the 9th [9/9/2025] when the reddened area was discovered.and we entered the orders that should have been entered in the first place [on 8/20/2025] to monitor. During an interview on 12/3/2025 at 8:54 AM, Licensed Practical Nurse (LPN) A acknowledged she was the nurse who discovered the wound to Resident #4's left ankle. LPN A stated .I found the wound around September the 8th.looked like the skin had been rubbed above her left ankle.it was a red spot.about dime size. LPN A was asked what she did when she discovered the wound. LPN A stated .Obtained orders for skin prep to apply to skin and keep area covered to keep brace from rubbing. LPN A was asked if she staged the wound. LPN A stated .I am not comfortable staging. I will normally get the DON and have her look at it. During an interview on 12/3/2025 at 9:18 AM, the Assistant Director of Nursing (ADON) was asked when were you made aware of the wound on Resident #4's left ankle. The ADON stated, .I was notified by the nurse who found it.I looked at [Resident #4's] wound to the left ankle on the day it was found. The ADON was asked if she staged and documented her findings. The ADON said she did not document anything pertaining to the wound on Resident #4's left ankle when it was discovered and reported to her. During an interview on 12/3/2025 at 2:12 PM, .The DON was asked when should orders have been entered for skin checks related to Resident #4's immobilizer. The DON stated .The standing orders should have been entered at admission [readmission from the hospital on 8/20/2025], but they got missed and were not entered until when the redness was discovered. During a telephone interview on 12/3/2025 at 2:36 PM, the Medical Director was asked should there have been documentation on Resident #4's wound to the left ankle when it was discovered as a reddened area and when it became unstageable, approximately 10 days later. The Medical Director stated .I would want to see the documentation of how the wound was progressing. During an Interview on 12/4/2025 at 8:53 AM, the DON was asked if Resident #4's wound to the left ankle was found on 9/8/2025, should it have been staged when it was found. The DON stated .yes it should have been staged. The facility's failure to assess the skin integrity of Resident #4's left lower extremity underneath the immobilizer on a daily basis, resulted in actual harm to Resident #4 when a reddened (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	area developed into an unstageable pressure ulcer, which became infected and required antibiotic administration.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of Center for Disease Control (CDC) website guidelines, medical record review, observation, and interview, the facility failed to ensure the prevention and spread of infection when 1 of 1 staff (Assistant Director of Nursing (ADON)) failed to perform hand hygiene and failed to use appropriate Personal Protective Equipment (PPE) while performing wound care for 2 of 2 (Residents # 4 and #16) sampled residents reviewed. The findings include: 1.Review of the facility policy titled, Enhanced Barrier Precautions, dated 1/30/2024, revealed .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.Enhanced Barrier Precautions (EBP) are additional measures to attempt to decrease transmission of Multidrug-Resistant Organisms (MDRO).If a resident is placed on EBP, appropriate signage is placed at the room entrance so that personnel and visitors are aware .of instructions for use of PPE, and/or instructions to see a nurse before entering the room .EBP are indicated for residents who have chronic wounds. Review of the facility policy titled, Hand Hygiene Policy, dated 6/27/2025, revealed .To minimize the transmission of infectious agents and reduce the risk of healthcare-associated infections.in residents, staff, and visitors.Hand hygiene refers to any action of hand cleansing including handwashing with soap and water or using alcohol-based hand rub (ABHR).Perform hand hygiene.Before and after resident contact.Before performing aseptic tasks.After removing gloves. Review of the CDC website article titled About Handwashing, dated 2/16/2024 revealed .Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs.Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.Scrub your hands for at least 20 seconds.Rinse your hands well under clean, running water.Dry your hands using a clean towel or an air dryer. Review of the CDC website article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/2024 revealed .Enhanced Barrier Precautions .Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Fracture of Left Patella, Dementia, Protein-Calorie Malnutrition, and Chronic Pain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was cognitively intact. Review of the Care Plan dated 9/17/2025, revealed Resident #4 had a Pressure Ulcer to her Left Lower Leg. Review of the Physician Order dated 10/9/2025, revealed .Wound Care: Cleanse left lower lateral leg.dressing every day. Observation in Resident #4's room on 12/2/2025 at 11:40 AM, revealed the ADON during wound care and after taking the old dressing off, went to the sink to wash her hands for 4 seconds, applied new gloves and completed the dressing change. After completion of the wound care, the ADON went back to sink and washed her hands for 3 seconds. The ADON failed to wash her hands for an adequate amount of time during the pressure ulcer wound dressing change. 3. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Fracture of Left Femur, Protein-Calorie Malnutrition, Depression, Dementia, and Kidney Failure. Review of the annual MDS assessment dated [DATE], revealed Resident #18 scored an 11 on the BIMS assessment, which indicated she was moderately cognitively impaired. Resident #18 was coded as having a pressure ulcer. Review of the Physician's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order dated 11/20/2025, revealed .Wound Care: Cleanse pressure injury to right heel.Change daily. Review of the Physician's Order dated 11/20/2025, revealed .Wound Care: Cleanse pressure injury to left heel.Change daily. Observation in Resident #18's room on 12/2/2025 at 10:20 AM, revealed the ADON entered the room without donning PPE, applied gloves, cleansed the left heel and took her gloves off, applied another set of gloves, put medication on the bandage and applied the dry dressing. The ADON then took the gloves off and put another pair of gloves on and cleansed the right heel and took her gloves off. The ADON applied another set of gloves, put medication on the bandage and applied the dry dressing. The ADON then went to the sink in the room and washed her hands for 5 seconds. The ADON failed to don PPE per the facility policy prior to wound care, she failed to wash her hands prior to the start of the treatment and failed to perform hand hygiene after glove removal or between wound treatments. The ADON then failed to adequately wash her hands in the sink. During an interview on 12/2/2025 at 2:57 PM, the Director of Nursing (DON) was asked, while doing a dressing change when should hand hygiene be performed. The DON stated, Prior to starting patient care, after taking a dirty dressing off and before applying a new dressing and when they get done, they should wash again. The DON was asked should they perform hand hygiene after glove changes. The DON stated, Yes. The DON was asked when you should follow Enhanced Barrier Precautions. The DON stated, When doing a high contact activity with a resident. The DON was asked if enhanced barrier precautions should be followed during a dressing change. The DON stated, Yes. The DON was asked how long a staff member should wash their hands. The DON stated, .approximately 25-30 seconds.