STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445449	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Westwood	524 West Main Street Decaturville, TN 38329

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility document review, facility investigation review, employee file review, observation, and interview, the facility failed to protect the resident's right to be free from neglect for 1 of 4 (Resident #1) sampled residents reviewed for abuse which resulted in physical harm for Resident #1. The findings include: 1. Review of the undated facility policy titled, Skin and Wound Monitoring and Management, revealed, .A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable . The purpose to this policy is that the facility provides care and services to .Pressure Injury .The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear . Review of the undated facility policy titled, Abuse: Prevention of and Prohibition Against, revealed, .Abuse is willful infliction of injury .with resulting physical harm, pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .Adverse event is an untoward, undesirable, and usually unanticipated event that causes .serious injury, or the risk thereof .Identification .Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor of the Facility administrator immediately .the deprivation by an individual of goods and services . Reporting/Response .Allegations of abuse, neglect .will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Parkinson's Disease with Dyskinesia, Morbid Obesity, Type 2 Diabetes Mellitus, and Urinary Tract Infection. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #1 required partial/moderate assistance with toileting hygiene, supervision or touching assistance with roll left and right, and substantial/maximal assistance with toilet transfer and chair/bed-to-chair transfer. Resident #1 had no skin conditions coded on the quarterly MDS. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes dated 5/17/2025, revealed .SN [skilled nurse] called to resident room by CNA [Certified Nursing Assistant], stated resident was not acting right, will not arouse. SN checked BS [blood sugar], sugar @58 [milligrams/deciliter (mg/dl)]. 1 mg [milligram] of Glucagon administered to left thigh. Resident did not arouse, pupils unresponsive to light. Resident still would not arouse, repeating same incoherent words. BS rechecked, sugar 52 [mg/dl]. Resident displayed severe jerking, unable to get resident to arouse. [Named Facility Nurse Practitioner (FNP)] notified, received order to send resident to the ER [emergency room] .EMS [Emergency Medical Services] arrived. Residents BS 71 at the time. She was more alert at that time, but c/o [complained of] severe back and kidney pain. Resident has been transported to the hospital . Review of the Progress Notes dated 5/17/2025, revealed .This nurse called [named Hospital #1] ED [Emergency Department] for an update on resident. Talked to .ED and then was transferred to med-surg floor and .informed that resident was admitted to hospital on med-surg floor for UTI [Urinary Tract Infection] and Hypoglycemia .patient POA [Power of Attorney], informed at this time . Review of Hospital #1's Wound Location report dated 5/17/2025, revealed .Site A Location [left] upper buttock .abrasion .looks like skin peeled off from removal of bandage .Site B Location [right] upper buttock . abrasion looks like skin peeled off from removal of bandage .Site C Location [left] under gluteal cleft [crease between the buttocks and leg] .abrasion .Site D Location [right] under gluteal cleft .abrasion . Review of the Evening Shift CNA ASSIGNMENT SHEET dated 5/17/2025 revealed CNA F was assigned 7 rooms on the 200 Hall. The census reflected 11 residents to be on CNA F's assignment for this date. The assignment sheet noted, .SN [Skilled Nurse] found resident [Resident #1] on a bedpan that no CNA said they put her on it. Resident's bottom was open in a ring due to sitting on bed pan - the bed was wet, brown ringed & [and] cover over resident was wet. [Named CNA F] denied putting the resident on the bedpan . The assignment sheet was signed by Registered Nurse (RN) A. Review of the Care Plan Report for Resident #1 dated 5/17/2025, revealed a focus for at risk for impaired skin integrity, abrasions, bruises, skin tears due to fragile skin and on 5/17/2025 an intervention was added which revealed, .Skin Injury - Staff educated to not leave resident on bed pan for extended periods of time and remain with resident during use to reduce the risk of injury . Review of the Progress Notes dated 5/18/2025 revealed, . [Named Family Member (FM A)] is resident's POA and 1st emergency contact and was updated on profile sheet. FM A wanted to make sure that staff notified her with all healthcare needs, and she was the one to make decisions when [Named Resident #1] unable to make wishes known .She visits often, but has no right to make healthcare decisions. [Named FM A] and I discussed [Named Resident #1]'s overall physical and mental decline .Daughter realistic in mom's status, stated she had noted the decline, with decrease alertness, periods of confusion, and forgetfulness noted. Discussed with daughter, that this past Saturday, [Named Resident #1] was noted lethargic, blood sugar low, prepared to transfer to ER [Emergency Room] . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes dated 5/20/2025 revealed, .continuation of previous note [referring to the Progress Notes dated 5/18/2025]: When preparing resident to be transferred to ER, resident was on the bedpan, noted excoriated buttock with skin reddened, raw and opened areas noted. [Named Resident #1] had fell asleep while on bedpan, staff performed peri care, charge nurse documented skin change, and performed wound care. CN [Charge Nurse] educated staff on change in resident's cognition, to make sure to monitor closely, limit use of bedpan, due to the risk for skin integrity. Daughter made aware .Will update care plan and educate staff . Review of the facility investigation signed by the Administrator and Staffing Coordinator on 5/19/2025 revealed, On the evening of 5/17/2025, this writer received a call from [Named Staffing Coordinator]/On Call Nurse, that resident [Named Resident #1] had a decline and was needing transportation to the hospital. The staff had discovered that [Resident #1] was on the bed pan when they were preparing her for transfer to the hospital. Staff was concerned about length of time [Resident #1] had been on the bed pan as their [there] was a skin sheared area to [Resident #1]'s buttock. We began to investigate by getting statements from prior night shift and day shift that had care for [Resident #1]. [Resident #1] is normally cognitive enough that she calls for staff when she if [is] finished with bed pan but had a change of condition during the day which did not allow her to call for assistance as normal. Nurses were called to the room at supper time due [to] CNA calling them to the room because of a report of change of condition. Nurses assessed, consulted with [Named Facility Nurse Practitioner] to send to ER. Upon getting resident ready for transport staff discovered the bed pan under resident. Nurses noted sheared area to buttocks. Resident was transported to [Named Hospital #1] for evaluation and treatment of change of condition .An in service was initiated on 5/17/2025 regarding bed pan usage. Staff member [CNA F] that was assigned to [Resident #1] refused to sign in service leaving facility stating that she would not be returning. Staff Coordinator contacted employee to discuss with employee stating that she was not signing the in service nor writing a statement. Employee also stated that she would not be returning to facility. Review of CNA F's employee file revealed a termination form was noted with last day worked 5/17/2025, with explanation for termination as employee quit without notice and employee is not eligible for rehire. The termination form was signed by the Administrator and the Director of Nursing (DON) on 5/20/2025. Review of the Progress Notes dated 5/22/2025, revealed .Resident returned to facility from acute Hospital stay related to UTI, hypoglycemia. Resident noted to have large scattered bruising/discoloration to buttocks measuring 31x25 [Centimeters]. New order received for Hydrocolloid dressings to be placed on buttocks. Resident is alert, slight confusion noted at times today . Review of the LN (Licensed Nurse)-Skin Ulcer Non-Pressure Weekly note dated 5/23/2025, revealed .Site: Buttock .Shear-redness noted with open area noted to central portion .Size .31 [cm long] x 25 [cm wide] . Depth 0.1[cm] .New order for hydrocolloid [a type of bandage that helps wounds heal by creating a moist environment and absorbing fluid] to buttocks . Review of the Order Review History Report revealed, .TX [treatment] Buttock-Cleanse with NS [Normal Saline] or wound cleanser. Apply hydrocolloid dressing every day shift .Order Date .5/23/2025 . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation of wound care in Resident #1's room on 5/28/2025 at 10:35 AM, revealed right hip with a defined sheared area in the shape of a crescent (a curved shape) which measured approximately 32 cm long, 2.5 cm in the widest area, and superficial depth. The wound to the right hip extended from the top of her buttocks to right above her leg. A wound was noted in the center above her buttocks fold measuring approximately 4.5 cm long, widest area of 1 cm, and superficial in depth. The left buttocks revealed a sheared area in the shape of a crescent at the top of buttocks approximately 8 cm long, 2 cm wide, and superficial in depth. Further down on the left buttocks revealed another crescent shaped wound at the base of the buttocks approximately 4 cm long, 2 cm wide, and superficial in depth. On the upper top of her lower leg under the fold of the left buttocks appeared another crescent shaped wound measuring approximately 3 cm long, 2 cm wide, and superficial in depth. During an interview on 5/27/2025 at 9:15 AM, Resident #1 stated, .I went to the hospital because my sugar went low .staff left me on the bed pan, I couldn't find my call light, I waited and waited .I fell asleep on the bedpan .It was over 3 hours . Resident #1 was asked how she knew it was over 3 hours. Resident #1 pointed at her watch on her arm and stated, I wear a watch and watch the time . Resident #1 was observed in a wide bariatric bed with an alternating pressure mattress. Resident #1 stated, .the facility got me this bed when I got back from the hospital . During an interview on 5/27/2025 at 11:07 AM, RN A stated, .I was the nurse that sent [Named Resident #1] to the hospital .she slept most of the day .sugar was low I gave glucagon it was still at 52 [mg/dl] I called the ambulance .I told the CNA let's get her cleaned up before EMS gets her .she was on a bedpan when we took her off the bedpan it took the hide off her skin .the CNA caring for her was a new aide here .I know she knew she had the resident because I made the assignments that day .there was urine in the bedpan .no CNA claimed to have put her on the bedpan .the resident can't put herself on the bedpan .the CNA assigned to her walked out . RN A was asked to explain Resident #1's condition when she found her on the bedpan. RN A stated, .I found dark urine in the bed pan, brown ring on her bed .I could tell she hadn't been changed she told me her bottom was sore .the resident was unable to tell us who put her on the bedpan .I called [Named Family Member FM E] she was the first person to call on the list but I think that has been changed now . During an interview on 5/27/2025 at 11:37 AM, FM B stated, .I spoke with the Director of Nursing [DON] and Administrator .we had mutual talk about the change in her cognition and being left on the bedpan for a long time .I don't have details on the time she was left on the bedpan .usually she could tell the staff when she was ready to be off the bedpan but her cognition had changed . During an interview on 5/27/2025 at 1:45 PM, CNA C was asked to give examples of neglect. CNA C stated, . if a CNA neglects to check on a resident, leave them wet, not answering call lights .if you place a resident on a bedpan you should come back and check to make sure the resident is off the bedpan .the in service was to not leave them on the bedpan because [Named Resident #1] was left on the bedpan to long . During an interview on 5/27/2025 at 1:50 PM, CNA D was asked the different examples of abuse and why CNAs were given education on placing a resident on bedpan in May. CNA D stated, .it should be reported immediately to the Abuse Coordinator the Administrator .we were in serviced on the bedpan because [Named Resident #1] was left on the bedpan too long .we were trained to come back after 5-10 minutes, take the resident off the bedpan clean the resident up because if the resident is left to long it could leave sores and mess up the residents skin . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/2025 at 2:08 PM, the Staffing Coordinator was asked about CNA F's employment, work performance, and why the employee no longer works at the facility. The Staffing Coordinator stated, .I would not expect the resident to be left on the bedpan for a long period of time, I wish things had been different .residents should be checked on at least every 2 hours .I have no idea on what time she was placed on the bedpan because the employee failed to fill out a statement .generally one person could place her on the bedpan .she couldn't put herself on the bedpan . The Staffing Coordinator was asked to review the Evening Shift CNA ASSIGNMENT SHEET dated 5/17/2025. The Staffing Coordinator stated, .it doesn't appear that she [Resident #1] received the care she needed. The Staffing Coordinator was asked if she (Resident #1) didn't receive the care she needed would that be considered neglect. The Staffing Coordinator stated, .I guess so .I will say she is usually someone who could tell you she needs off the bed pan, but a CNA should return and check on the resident or report to the oncoming shift they are on the bed pan. I do feel the wounds occurred due to the bedpan . During a telephone interview on 5/28/2025 at 2:10 PM, the FNP stated, .I haven't seen the wounds yet, I am going by tomorrow to look at it. [RN A] told me what she assumed happened. I was aware the facility performed an investigation .staff assigned to her that day isn't employed anymore . The FNP was asked what she would expect a CNA to do after placing a resident on a bedpan. FNP stated, .place the resident on the bed pan .provide privacy .return to take the resident off the bedpan no longer that 15-30 minutes or stay with the resident until finished .the CNA should know to go back and check on the resident . During an interview on 5/28/2025 at 2:20 PM, the DON was asked about the incident involving Resident #1. The DON stated, .the resident was always very verbal and would call and anyone would take her off the bedpan, not always the same person getting her off as the one who put her on the bedpan . The DON was asked if a resident was unable to express her needs, are their needs just not performed. The DON stated, . they [staff member] should have come back .It [wounds] appeared to show the definition of a bedpan .the CNA no longer works here .we immediately started education with the staff .I don't know what time she was placed on the bedpan but I know it was on day shift .the employee left that night .the assignment sheet just shows the resident needed to be changed . The DON was asked if Resident #1 was given goods and services she needed on 5/17/2025 on the evening shift. The DON stated, .personal care is taking someone off the bedpan . The DON was asked if Resident #1 experienced neglect on 5/17/2025. The DON stated, . neglect is willfully done .the resident was sent to the ER because she was in a different situation that [than] she normally was .blood sugar was low, nurse tried to fix that .the area to the bottom was discovered and the nurse immediately reacted to that .the staff was trained to not always assume the resident can tell you when they are finished but always follow back with the resident . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/28/2025 at 2:41 PM, the Administrator was asked if she was the Abuse Coordinator and did the facility feel Resident #1 experienced abuse related to neglect on 5/17/2025. The Administrator stated, .I am the Abuse Coordinator .if the resident was able to tell me .I wouldn't call that neglect .but in talking with staff she was coherent when she was placed on the bedpan .I don't know what time she was placed on the bedpan .[Named CNA F] would not give a witness statement .she just walked out .abuse is willfully done with the intent to harm someone . The Administrator was asked to review the facility policy on abuse and neglect and stated, .withholding services .it does state that but in this instance, we provided the services in the thoughts she could communicate with us .I would expect a CNA to follow up but generally she is very cognitive .I feel like she had a change in condition . The Administrator was asked if a resident can't communicate their needs can a staff member just leave their needs unmet. The Administrator stated, .No ma'am . The Administrator was asked did the resident receive the services she needed on 5/17/2025. The Administrator stated, .I think the staff did that .the CNA seen the condition change and a nurse was called in to check the resident .after looking at everything and statement of the change in the condition with the resident .we cared for the resident as normally we would, and we got her medical attention .it was no intentional act on my staff's part . The Administrator was asked why CNA F left without filling out a witness statement on 5/17/2025 and never returned to work. The Administrator stated, .I am not sure why she left .I never seen anything that was abusive or neglectful .We did talk to [Named FM A] the POA .she didn't get along with [Named FM E] they butt heads a lot .we didn't want to be caught in a crossfire, so we made sure the POA was the first person to call . During a telephone interview on 5/28/2025 at 4:35 PM, RN G from Hospital #1 stated, .I remember [Named Resident #1]. I try to be diligent about looking at the resident skin when they are admitted to the hospital . when I rolled the resident over she had horizonal abrasions on both sides above her buttocks and also under her gluteal folds .one on each side .the areas were not noted on the paperwork from the facility .it looked like someone had removed a bandage and ripped the top layer of her skin off .it did look like a bedpan could have caused the areas .the resident didn't voice how the areas happened .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, hospital record review, and facility investigation review, the facility failed to ensure allegations of neglect were reported immediately, but not later than 2 hours after the allegation was made for 1 of 4 (Resident #1) sampled residents reviewed for abuse. The findings include: 1. Review of the undated facility policy titled, Skin and Wound Monitoring and Management, revealed, .A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable . The purpose to this policy is that the facility provides care and services to .Pressure Injury .The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear . Review of the undated facility policy titled, Abuse: Prevention of and Prohibition Against, revealed, .Abuse is willful infliction of injury .with resulting physical harm, pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .Adverse event is an untoward, undesirable, and usually unanticipated event that causes .serious injury, or the risk thereof .Identification .Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor of the Facility administrator immediately .the deprivation by an individual of goods and services . Reporting/Response .Allegations of abuse, neglect .will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Parkinson's Disease with Dyskinesia, Morbid Obesity, Type 2 Diabetes Mellitus, and Urinary Tract Infection. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Resident #1 required partial/moderate assistance with toileting hygiene, supervision or touching assistance with roll left and right, and substantial/maximal assistance with toilet transfer and chair/bed-to-chair transfer. Resident #1 had no skin conditions coded on the quarterly MDS. Review of the Progress Notes dated 5/17/2025, Resident #1 was not acting right and was unarousable. Her blood sugar (BS) was 58 milligrams/deciliter (mg/dl) and Glucagon was administered. Resident #1 remained unresponsive and displayed severe jerking. The provider was notified, and Resident #1 was sent to the Emergency Room. Her BS was 71 at the time of transfer, and she was more alert and complained of severe back and kidney pain. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 5/17/2025 revealed, .This nurse called [named Hospital #1] ED [Emergency Department] for an update on resident. Talked to .ED and then was transferred to med-surg floor and .informed that resident was admitted to hospital on med-surg floor for UTI and Hypoglycemia . patient POA [Power of Attorney], informed at this time . Review of Hospital #1's Wound Location report dated 5/17/2025 revealed .Site A Location [left] upper buttock .abrasion .looks like skin peeled off from removal of bandage .Site B Location [right] upper buttock .abrasion looks like skin peeled off from removal of bandage .Site C Location [left] under gluteal cleft [crease between the buttocks and leg] .abrasion .Site D Location [right] under gluteal cleft .abrasion . Review of the Evening Shift CNA ASSIGNMENT SHEET dated 5/17/2025, revealed CNA F was assigned to Resident #1. The assignment sheet noted the nurse found Resident #1 on a bedpan and her bottom was open in a ring. The bed was, .wet, brown ringed & the cover over resident was wet . CNA F denied placing Resident #1 on the bedpan. The assignment sheet was signed by Registered (RN) A. Review of the Progress Notes dated 5/18/2025 revealed, .[Named Family Member FM A] is resident's POA and 1st emergency contact and was updated on profile sheet. Daughter wanted to make sure that staff notified her with all healthcare needs, and she was the one to make decisions when [Named Resident #1] unable to make wishes known .[Named Complainant]. She visits often, but has no right to make healthcare decisions. [Named FM A] and I discussed [Named Resident #1]'s overall physical and mental decline . stated she had noted the decline, with decrease alertness, periods of confusion, and forgetfulness noted. Discussed with daughter, that this past Saturday, [Named Resident #1] was noted lethargic, blood sugar low, prepared to transfer to ER [Emergency Room] . Review of the Care Plan Report dated 5/17/2025, revealed the intervention was added which documented, . Skin Injury-Staff educated to not leave resident on bed pan for extended periods of time and remain with resident during use to reduce the risk of injury . Review of the facility investigation signed by the Administrator and Staffing Coordinator on 5/19/2025 revealed, On the evening of 5/17/2025, this writer received a call from [Named Staffing Coordinator]/On Call Nurse, that resident [Named Resident #1] had a decline and was needing transportation to the hospital. The staff had discovered that [Resident #1] was on the bed pan when they were preparing her for transfer to the hospital. Staff was concerned about length of time [Resident #1] had been on the bed pan as their [there] was a skin sheared area to [Resident #1]'s buttock. We began to investigate by getting statements from prior night shift and day shift that had care for [Resident #1]. [Resident #1] is normally cognitive enough that she calls for staff when she if [is] finished with bed pan but had a change of condition during the day which did not allow her to call for assistance as normal. Nurses were called to the room at supper time due [to] CNA calling them to the room because of a report of change of condition. Nurses assessed, consulted with [Named Facility Nurse Practitioner] to send to ER. Upon getting resident ready for transport staff discovered the bed pan under resident. Nurses noted sheared [[NAME]] area to buttocks. Resident was transported to [Named Hospital #1] for evaluation and treatment of change of condition .An in service was initiated on 5/17/2025 regarding bed pan usage. Staff member [CNA F] that was assigned to [Resident #1] refused to sign in service leaving facility stating that she would not be returning. Staff Coordinator contacted employee to discuss with employee stating that she was not signing the in service nor writing a statement. Employee also stated that she would not be returning to facility. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 5/20/2025 revealed, .continuation of previous note [referring to the Progress Notes dated 5/18/2025]: When preparing resident to be transferred to ER, resident was on the bedpan, noted excoriated buttock with skin reddened, raw and opened areas noted. [Named Resident #1] had fell asleep while on bedpan, staff performed peri care, charge nurse documented skin change, and performed wound care. CN [Charge Nurse] educated staff on change in resident's cognition, to make sure to monitor closely, limit use of bedpan, due to the risk for skin integrity .Will update care plan and educate staff . Review of the Progress Notes dated 5/22/2025 revealed Resident #1 returned to the facility from the hospital and was noted to have a large scattering of bruising and discoloration to the buttocks which measured 31 centimeters (cm) by 25 cm. Resident #1 was noted to exhibit slight confusion at times. Review of the CNA F's employee file revealed a termination form was noted with last day worked 5/17/2025 with explanation for termination as employee quit without notice and employee is not eligible for rehire. The termination form signed by the Administrator and DON on 5/20/2025. During an interview on 5/27/2025 at 9:15 AM, Resident #1 stated, .staff left me on . bed pan, I couldn't find my call light, I waited and waited .I fell asleep on the bedpan .It was over 3 hours . Resident #1 was asked how she knew it was over 3 hours. Resident #1 pointed at her watch on her arm and stated, I wear a watch and watch the time . Resident #1 was observed in a wide bariatric bed with an alternating pressure mattress. Resident #1 stated,the facility got me this bed when I got back from the hospital . During an interview on 5/27/2025 at 11:07 AM, RN A stated, .I was the nurse that sent [Named Resident #1] to the hospital .she slept most of the day .sugar was low I gave glucagon it was still at 52 I called the ambulance .I told the CNA let's get her cleaned up before EMS gets her .she was on a bedpan when we took her off the bedpan it took the hide off her skin .the CNA caring for her was a new aide here .I know she knew she had the resident because I made the assignments that day .there was urine in the bedpan .no CNA claimed to have put her on the bedpan .the resident can't put herself on the bedpan .the CNA assigned to her walked out . RN A was asked to explain Resident #1's condition when she found her on the bedpan. RN A stated, .I found dark urine in the bed pan, brown ring on her bed .I could tell she hadn't been changed she told me her bottom was sore .the resident was unable to tell us who put her on the bedpan .I called [Named Family Member FM E Complainant] she was the first person to call on the list but I think that has been changed now . During an interview on 5/27/2025 at 11:37 AM, FM B stated, .I spoke with the Director of Nursing [DON] and Administrator .we had mutual talk about the change in her cognition and being left on the bedpan for a long time .I don't have details on the time she was left on the bedpan .usually she could tell the staff when she was ready to be off the bedpan but her cognition had changed . Refer to F-600