STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445453	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Forest Cove	45 Forest Cove Jackson, TN 38301

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379 Based on policy review, observation, and interview, the facility failed to provide a clean and sanitary environment for 3 of 4 (100-Hall, 200-Hall and 300-Hall) hallways observed. The findings include: 1. Review of the facility's policy, titled Housekeeping-Cleaning and Disinfecting, revised 4/22/2024, revealed . It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .Report to the Administrator and Maintenance areas with mold, cracked tile/grout, or any damaged items in need of repair . 2. Observations on the 100 Hall on 9/18/2024 at 9:55 AM, and 3:55 PM, by the nurse's station revealed a ceiling tile that appeared to be wet and had brown areas on the ceiling tile. Observations on the 200 Hall on 9/18/2024 at 10:00 AM, and 4:00 PM, at the end of the hallway by room [ROOM NUMBER] revealed 4 ceiling tiles, that appeared to have black areas on the ceiling tiles. Observations on the 300 Hall on 9/18/2024 at 10:05 AM, and 4:05 PM, past the nurse's station by room [ROOM NUMBER] revealed a ceiling tile that appeared to have black areas on the ceiling tile. During observations and interview on 9/18/2024 at 5:45 PM, the Administrator and Maintenance were shown the ceiling tiles on 100 hall, 200 hall and 300 hall and was asked what the black and brownish colors were on the ceiling tiles. The Administrator stated, .it could be mold or mildew .we have condensations .I'm not aware of any mold problems . During an interview on 9/25/2024 at 2:44 PM, the Maintenance Supervisor confirmed the facility should be kept in good repair.

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379 Based on the National Pressure Injury Advisory Panel 2019 Guidelines, policy review, medical record review, observation, and interview, the facility failed to provide care and services to appropriately identify pressure ulcers/pressure injuries (PU/PIs), to provide services to promote healing, and to promptly notify the physician or practitioner for changes in the right foot PU/PI wound status to reduce the risk for infection for 1 of 4 (Resident #9) sampled residents reviewed for PU/PIs. The facility's failure to timely implement wound care and promptly notify the physician or practitioner of Resident #9's deteriorating right foot PU/PI wound that developed drainage and had an odor, resulted in Actual Harm when Resident #9 was sent to the emergency room , admitted to the hospital with the diagnosis of Osteomyelitis [a serious infection of the bone], and underwent a 5th metatarsal [long bone in the foot] amputation [removal of the area, usually by surgical procedure]. The findings include: 1. Review of the National Pressure Injury Advisory Panel 2019 Guidelines, revealed .Skin and soft tissue assessment is the basis of pressure injury prevention and treatment. Skin and tissue assessment is an essential component of any pressure injury risk assessment and should be conducted as soon as possible after admission, as a component of a full risk assessment .Each time the individual's clinical condition changes, a comprehensive skin and tissue assessment should be conducted to identify any alterations to skin characteristics or integrity, and to identify any new pressure injury risk factors .In addition to comprehensive skin assessment, a brief skin assessment of the pressure points should be undertaken during repositioning .Presence of persistent erythema can indicate a need to increase frequency of repositioning. Check pressure points onto which the individual will be repositioned to ensure that the skin and tissue has fully recovered from previous loading .Ongoing skin assessment is necessary to detect early signs of pressure injury . 2. Review of the facility's policy titled, Documentation of Wound Treatment, revised [DATE], revealed .The purpose of this policy is to provide a consistent process for accurate and complete documentation of wound assessments and treatments .The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are .1. Complete 2. Accurately documented .Notifications to physician .regarding wound or treatment if there is a change in wound status . Review of the facility's policy titled, .Wound Care Guideline, revised [DATE], revealed .Accurate and timely wound assessment is important to ensure correct diagnosis and for developing a plan of care to address the resident, the wound, and the skin problems that impact healing. Identifying at risk resident's and implementing preventative care to reduce the risk of pressure injury development and maintain skin integrity . The wound etiology should be determined by the wound care nurse or designee with a complete wound assessment .Evaluate the wound for signs of increasing bioburden and/or infection. Notify physician of the observations .Increased redness and/or warmth to the surrounding tissue .Purulent drainage or increased drainage .Foul or pungent odor .Deteriorating wound .Increasing or new wound pain .Resident .with pressure injuries will receive continued interventions and treatments to promote healing and reduce the risk of infection . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, .Notification of Change, revised [DATE], revealed .The purpose of this policy is to ensure the facility promptly .consults the resident's physician .when there is a change requiring notification . 3. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Paraplegia [loss of movement and feeling in the lower half of the body], Colostomy [surgical opening in the colon for feces to leave the body into a bag], Severe Sepsis without Septic Shock [a serious condition when the body has an improper response to an infection], End Stage Renal Disease [(ESRD) failure of the kidneys to function correctly], Atherosclerosis of Arteries [build up in the artery walls], Peripheral Vascular Disease [circulatory condition with reduced blood flow through the blood vessels], and Coronary Artery Disease [damage or disease of the heart's major blood vessels]. Review of the ULTRASOUND REPORT, dated [DATE], revealed .DUPLEX LOWER EXTREMITY ARTERIAL UNILATERAL, RIGHT Comparison: [DATE] revealed, .Conclusion: NO significant stenosis within visualized RIGHT lower extremity arterial tree .RIGHT ABI [ankle brachial index] [the ABI is an ultrasound of the ankle] is compatible with MINIMAL ischemia . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #9 was cognitively intact, and had impaired range of motion (ROM) to both lower extremities. Resident #9 was dependent on staff for bathing and was at risk for developing pressure ulcers. The assessment further revealed Resident #9 was mobile via (by way of) electric wheelchair. Review of Resident #9's Clinical Notes dated [DATE], revealed .resident [#9] reported new wound [facility acquired] on right foot, pictures are in wound phone . Review of the WOUND ASSESSENT REPORT, dated [DATE], revealed .Etiology Wound Team to Evaluate . Onset date [DATE] .Foot, Right, 5th digit .Current [DATE] .L [length] x[times] W [width] x D [depth] .3.3 [centimeters-cm] x 2.9 [cm] x 0.1 cm . Review of the WOUND ASSESSENT REPORT, dated [DATE], revealed the wound nurse documented, . Etiology Vascular - Arterial Ulcer .Onset date [DATE] .Plantar Foot Right, Metatarsal head 5th .Last assessment date [DATE] .Erythema, Edema, Abnormal .Drainage: Large: Bloody .L x W x D 4.9 [cm] x 5.0 [cm] x 0.0 [cm] . Review of Resident #9's care plan dated [DATE], revealed .Vascular Arterial Ulcer to Metatarsal head 5th plantar foot Right [facility] acquired [DATE] [2024] . Interventions .Refer to weekly wound assessment and MD [Medical Doctor] orders for current treatments and interventions .Assess and monitor wound treatment . for effectiveness and complications .Notify the physician if current wound treatment is not effective . Review of Resident #9's [DATE] TREATMENT, revealed, .Calcium Alginate .Two Times Daily Starting [DATE] Order Date: [DATE] .right foot, 5th metatarsal .Clean area with Normal Saline. Apply Calcium Alginate to promote .debridement and cover with .dressing . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility was unable to provide documentation that the physician was notified of the new wound and failed to provide wound treatment for the right foot 5th metatarsal head from [DATE] until [DATE]. Review of the WOUND ASSESSENT REPORT, dated [DATE], revealed .Etiology Vascular - Arterial Ulcer . Plantar Foot Right, Metatarsal head 5th .Erythema, Edema, Abnormal .Drainage: Large: Bloody .deep reddish purple .L x W x D 5.9 [cm] x 6.6 [cm] x 0.1 [cm] . Review of Resident #9's Clinical Notes dated [DATE], revealed .Resident has left for dialysis .tx [treatment] done as ordered, with increased drainage to wounds, DON [Director of Nursing] notified and aware and appointment scheduled for [DATE] to be rescheduled for a sooner appointment XXX[DATE] .called wound care to see if resident could get an earlier appointment than ,d+[DATE] [2024], clinic did not have any available appointments stated that the only way they could get him in is if someone cancelled. Advised nurse to call every day to check for availability . The facility was unable to provide documentation that anyone had called the wound care clinic every day to see if there had been a cancellation for Resident #9 to get an earlier appointment. Review of the WOUND ASSESSENT REPORT, dated [DATE], revealed .Etiology Vascular - Arterial Ulcer . Plantar Foot Right, Metatarsal head 5th . deep red, maroon tissue .L x W x D 5.8 [cm] x 5.7 [cm] x 0.0 [cm] . The wound assessment report further revealed the wound had a large amount of bloody (sanguineous) drainage, the peri-wound (area around the wound) had erythema and edema, and the wound was Malodorous [having an odor, unpleasant smell]. Review of the WOUND ASSESSENT REPORT, dated [DATE], revealed .Etiology Vascular - Arterial Ulcer . Plantar Foot Right, Metatarsal head 5th .Maceration, Edema, Abnormal .Odor: Malodorous .Drainage: Large: Thick, yellow/green/grey .deep red, maroon tissue .L x W x D 5.4 x 5.2 x 0.0 . The facility failed to notify the physician or the Family Nurse Practitioner (FNP) of the deterioration of Resident #9's right metatarsal foot wound to include the change in drainage and odor, and failed to notify the physician or FNP that Resident #9 was unable to be seen at the wound care clinic until [DATE]. Review of the [Named Wound Clinic] document dated [DATE], revealed .Patient .is paraplegic and has ESRD requiring dialysis 3 days per week .is not a diabetic and is not a smoker. He has previously been a patient of wound care .The right foot is warmer than his left foot .Malodorous odor from the right foot .I'm sending the patient to the ED [Emergency Department] as he requires intense inpatient care .I have .called an ambulance to transport the patient .This wound is currently classified as a .Stage IV [4] wound with etiology of Pressure Ulcer and is located on the Right, Plantar Metatarsal head fifth .wound measures 7 cm length x 4.9 cm width x 1.3 cm depth .There is muscle, tendon, and Fat Layer [Subcutaneous Tissue] exposed .large amount of serosanguineous drainage noted .necrotic tissue [tissue that has died due to lack of blood flow, injury, infection or disease] within the wound bed including Eschar [collection of dry, dead tissue in a wound] .Slough [dead tissue separating from living tissue] and Necrosis [death of cells or tissue through disease or injury] of Muscle . The facility documented the right foot PU/PI measurements had no depth on [DATE] and [DATE], the wound clinic documented on [DATE] the right foot PU/PI had a depth of 1.3 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Clinical Notes for Resident #9 dated [DATE], revealed .Resident transferred to [Named Hospital] on [DATE] from wound care appointment via EMS [Emergency Medical Services] . Review of the PRESSURE INJURY/CLINICAL CONDITION RECORD, for Resident #9 dated [DATE], signed by the wound nurse and the FNP, revealed I have reviewed this patient's clinical condition .Based on this patient's known risk factors, development of a pressure injury may occur or has occurred and deemed unavoidable. Nursing care has been reviewed and includes approaches listed in the patient's care plan. Medical interventions are listed on the physician's order sheet . Review of the hospital .Discharge Summary revealed, .admitted : [DATE] .discharge date : [DATE] . Admission Diagnoses: OSTEOMYELITIS 5th TOE/METATARSAL S/P [status post] AMPUTATION .presents from the wound care clinic due to worsening wound on right foot. Bloody drainage and odor noted from wound .amputation XXX,d+[DATE] [[DATE] date of amputation] .Wound vac in place and functional . Review of the Ultrasound dated [DATE], revealed .US [ultrasound] LE [lower extremity] Arterial Duplex Right . IMPRESSION: No definite flow-limiting disease . Review of the facility .SOAP [Subjective, Objective, Assessment, and Plan] Note dated [DATE], revealed . Hospital follow up .Patient .sent to ER [emergency room] from wound care clinic for worsening right foot wound, diagnosed with osteomyelitis .right fifth toe .underwent amputation of right fifth toe. Currently on IV Vancomycin and Invanz three days per week at dialysis .Patient is seen sitting up in wheelchair this afternoon following dialysis . Observation and interview in the resident's room on [DATE] at 2:55 PM, revealed the Staffing Coordinator provided wound care to Resident #9's right foot surgical wound. The Staffing Coordinator stated, .still has sutures in wound .no odor .looking pretty good .sees the wound care clinic . During an interview on [DATE] at 2:03 PM, FNP A, was shown Resident #9's ultrasound reports and confirmed Resident #9's wounds were not vascular and stated the report shows .complete normal [blood] flow. During an interview on [DATE] at 9:51 AM, Registered Nurse (RN) B confirmed Resident #9 told her (on [DATE]) that he had a wound on his right foot, she took pictures of the wound and notified the previous wound care nurse and that the wound care nurse was coming in. RN B stated, .I cleaned it .dressed it and took pictures .I don't do treatments .I don't stage .just notified .at this point there were no orders .she [referring to the previous wound care nurse] was supposed to come in and assess and put in new orders for the wound . RN B was asked why you tried to get him an earlier appointment for the wound clinic. RN B stated, Because he asked .it didn't look good [referring to the wound on right foot] .I let the nurses behind me know .and then the wound care nurse . RN B confirmed that she did call the wound care clinic again but didn't document it. During a telephone interview on [DATE] at 9:25 AM, Licensed Practical Nurse (LPN) C confirmed she had provided wound care on Resident #9 on the second shift on [DATE]rd, 2024 and stated, .I .pulled off the old dressing .it stunk so bad .it was stuck to his foot .I had to saturate it with normal saline .I asked him was it not changed [twice a day] .and he said no .I go in the next day .and it was the same dressing I had put on the day before when I changed his dressing .they let the treatment nurse go . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:34 PM, the Director of Nursing (DON) was asked when a wound is discovered when should treatment be started. The DON stated, Immediately. The DON confirmed the provider should have been notified of Resident #9's new wound. The DON was asked if she was made aware of the deterioration of Resident #9's right foot wound. The DON stated, I didn't know anything about the wound declining till the day of him going to wound care [appointment] and he got sent to the hospital .we should have definitely made the doctor aware and sent him to the hospital if he couldn't get in [referring to the wound care clinic earlier than [DATE]th]. During an interview on [DATE] at 5:15 PM, the Administrator was asked when a wound is identified, when should wound care treatment be provided. The Administrator stated, .when it's ordered . The Administrator was asked if a wound is identified on the 19th should it have taken 3 days to receive wound care. The Administrator stated, No, Ma'am it should not take 3 days . The Administrator confirmed when a wound is identified the provider should be notified and orders for treatment should be given and stated, It's a change in condition and the provider [Physician or FNP] should be notified . The Administrator confirmed Resident #9 should not have had to tell the staff that he had a new wound on the right foot and that wounds should be classified correctly. The Administrator was asked what the facility should have done for Resident #9's declining wound from [DATE]th to [DATE]th. The Administrator stated, I should have been made aware and the provider .I think the provider could have .provided solutions for issues .I would say .should have been sent to the ER .I was concerned too when I was made aware . During an interview on [DATE] at 5:30 PM, the DON confirmed the facility was unable to provide documentation that Resident #9 had received wound care on the plantar right foot 5th metatarsal head when the wound was identified on [DATE] and that Resident #9's first treatment was on [DATE]. During a telephone interview on [DATE] at 12:00 PM, Physician D was asked should you be notified of a resident's declining wound with increased drainage and odor. Physician D stated, I would expect them [the facility] to call us and let us know, the DON has my cell phone, 3 different ways to contact us .should have been documented . Physician D was asked what should have been done when the facility was unable to get Resident #9 an earlier wound care clinic appointment when the wound was declining. Physician D stated, . should have called me, and if they had called me, I would have sent him to the ER .could have made a difference if it was declining wound . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 10:36 AM, FNP A confirmed she had not been notified of the new wound on [DATE] and was asked when Resident #9 should receive treatment for the new wound. FNP A stated, .on [DATE]th [the day the wound was identified]. FNP A confirmed Resident #9 should not have waited 3 days after the wound was identified to receive wound care treatment and stated, The previous wound care nurse was not good to notify me when wounds were getting worse. The surveyor informed FNP A that on [DATE]th, the facility had called the wound care clinic to get an appointment and was instructed to call back every day to see if there had been a cancellation. FNP A was asked should the staff have called every day to see if there was a cancellation. FNP A stated, Absolutely. FNP A confirmed she was never notified of the wound having an odor or increased drainage and stated, I was never aware of him having odor to that wound until he went to the hospital. FNP A was asked should you have been made aware. FNP A stated, Absolutely. FNP A was asked should wounds be classified correctly. FNP A stated, Yes. FNP A was asked if she was notified on [DATE]th of the wound draining thick yellow, green purulent drainage. FNP A stated, No. FNP A was asked should Resident #9 had to wait until his appointment to wound care with a declining wound with odor and increased drainage. FNP A stated, No. FNP A was asked should you have been made aware. FNP A stated, Yes. FNP A was asked what you would have done if the facility had made you aware of the decline of the wound. FNP A stated, .wound cultures .antibiotics . FNP A confirmed she would have sent him to the emergency room . FNP A was asked if the facility did everything possible to prevent the wound from getting worse. FNP A stated, No. FNP A was asked about her [DATE] documentation deeming the wound to be unavoidable and was asked if was still unavoidable. FNP A stated, The wound itself was unavoidable, the progression should have been avoidable. FNP A was asked if she aware of the concerns the facility had with the previous wound care nurse. FNP A stated, I know they had discussions with the treatment nurse about things not being right .I do know that now they have the right people in wound care and the DON to make sure things are done correctly. During a telephone interview on [DATE] at 11:58 AM, the Medical Director was asked if he was aware of the facility's concerns with the previous wound care nurse. The Medical Director stated, .started off energetic . didn't do the job they wanted her to do . The Medical Director was informed that Resident #9 had developed a new wound, and was asked when the provider should have been notified. The Medical Director stated, Fairly quickly . The Medical Director was asked if the facility should have notified the physician or FNP of a declining wound with an odor. The Medical Director stated, .no doubt building up infection . The Medical Director was asked if the wound clinic was notified on [DATE] and unable to get Resident #9 an appointment and was told to call back every day to see if there was a cancellation, what should the facility have done. The Medical Director stated, Should have called every day .and should have been documented . The Medical Director was asked what should have happened when Resident #9's wound developed an odor and increased drainage. The Medical Director stated, .would have cultures .talked to the NP .or high level care . or sent to the ER .sounds like somebody should have taken action sooner .communicate .got a problem .let's get him in .I would talk to [Named Physician D] .I'm sure he's not happy either .