STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. Building B. Wing	04/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Ft. Worth	8001 Western Hills Blvd Fort Worth, TX 76108

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify consistent with his or her authority, the resident representative when there was a change in the resident's physical, mental, or psychosocial status for 1 resident (Resident #1) of 9 residents reviewed for notification of change of condition. The facility failed to ensure the MD and/or the Wound Care Doctor were consulted for direction on wound care orders for Resident #1 upon readmission to the facility on [DATE] with two small open wounds on the right and left buttock. The facility failed to ensure the MD and/or the Wound Care Doctor were consulted for direction on wound care orders on 04/11/2024 when a new wound developed on Resident #1's coccyx. Resident #1 was not seen by the Wound Care Doctor until 04/22/24 and was sent out to hospital with an unstageable wound on her sacrum, resulting in surgery to debride the wound. An Immediate Jeopardy (IJ) was identified on 04/26/2024. While the IJ was removed on 04/27/2024 at 12:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at risk of increased pain, infections, development of new pressure ulcers, and decline in quality of life and serious harm for residents. Findings included: Record review of Resident #1's face sheet dated 04/23/2024 indicated an [AGE] year-old female initially admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses of Unspecified Dementia (mile cognitive impairment), congestive heart failure (heart does not bump blood enough to meet the body's needs), hypertension (pressure in blood vessels is too high), and Type 2 diabetes (problems in the way the body regulates and uses sugar as fuel). (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 4, indicating severe cognitive impairment. Resident #1 required supervision for eating, substantial/maximal assistance with toileting and personal hygiene, and dependent for transfer. She was always incontinent of bowel and bladder. Resident #1 was at risk of developing pressure ulcers/injuries, she did not have any unhealed pressure ulcers/injuries but had moisture associated skin damage - treatments include applications of ointments/medications. Record review of Resident #1's Comprehensive Care Plan dated 03/14/2024 reflected, [Resident #1] has an ADL self-care performance deficit r/t impaired gait2/balance, poor comprehension r/t Dementia/Alzheimer's, revised on 03/25/2024. Interventions included extensive to total x 2 for bed mobility, transfers, dressing, and toileting. [Resident #1] has actual impairment to skin integrity of the peri area r/t incontinence. Interventions: Triad cream per family request, initiated 04/04/2024. Record review of Resident #1's March 2024 Nursing MAR reflected Preventative Skin Care: Apply Moisture Barrier every shift and PRN. Start Date - 03/29/2024. D/C Date - 03/28/2024. Record review of Resident #1's March 2024 TAR did not reflect treatment orders. Record review of Resident #1's April 2024 Nursing MAR and TAR did not reflect treatment orders. Record review of the Weekly Nursing Skin assessment dated [DATE] completed by LVN A reflected, Resident #1 had observed skin issues. The site(s), type, measurements, or stage were not identified. The Notes section revealed Has wound tx to her buttocks, sacrum daily and prn. Record review of the Weekly Nursing Skin assessment dated [DATE] completed by LVN A reflected, Resident #1 had observed skin issues. An unmeasured pressure wound was identified to the left and right buttocks. An unmeasured open area was identified to the Coccyx. The Notes section revealed Has wound tx to her buttocks, sacrum daily and prn. Record review of the Weekly Wound Progress note 04/21/24 completed by the WCN reflected, Resident #1 had 1 wound; pain management program was in place Routine and PRN; the notified RP and date were blank. The physician was notified 04/21/24. The wound type was other and the location reflected wound has deteriorated rapidly in the past 2 days; Heavy exudate (drainage that seeps out of wounds); an undescribed exudate color or appearance; and the wound bed appearance other. The wound was measured (LxWxD): 9 cm x 10 cm x 0.5 cm. Additional Comments: WOUND HAS DETERIORATED LOOKS LIKE ABSCESS. Doctor notified with orders for wound care ASAP. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/23/2024 at 11:25 AM, ADON B stated she was the Wound Care Nurse. She said when Resident #1 admitted to the facility on [DATE], she did not have any wounds. She said Resident #1 was sent to the hospital for a UTI and returned to the facility on [DATE] with two small open wounds on her right and left buttocks. She said the family wanted them treated with cream they brought in because that seemed to help in the past. She said she did not consult the MD or Wound Care Doctor about the wounds because she attributed them to moisture related and only warranted barrier cream. She stated she completed Resident #1's wound care daily and the wound did not get better or worse. She said on 04/04/2024 she started pursuit of having the family sign a consent form to see the Wound Care Doctor because Resident #1 did not get out of bed and the wounds were not getting better. She said she did not consult with the Wound care Doctor because they would not see Resident #1 without a consent. She said she was able to have the family complete the consent on 04/08/2024 but the Wound care Doctor had already rounded for the day and did not see Resident #1. She said she had not discussed Resident #1 with the Wound Care Doctor on 04/08/2024 because she did not have the consent signed until after the Doctor left the facility. She said she was not aware that LVN A had documented the development of another wound on Resident #1's sacrum, during a skin assessment on 04/11/2024. She said the Wound care Doctor was next in the facility on 04/15/2024 but she was late on that day and was not able to provide the consent to the Doctor, therefore the Doctor, did not see Resident #1's wounds again. She stated she last saw Resident #1's wounds on 04/18/2024 and they looked normal to her. She said she worked on 04/21/2024 and LVN E called her to look at Resident #1's wound. She said it deteriorated a lot and seemed to have an abscess and measured 9 cm x 10 cm x 0.5 cm. She stated the MD was notified by LVN E and the MD told them to clean and dress the wound and referred to the WCD on 04/22/2024. She said she had not consulted with the MD or the WCD about Resident #1's wounds until 04/22/2024 when the Wound Care Doctor sent Resident #1 to the hospital for possible debridement. ADON A stated she did wound care daily, which included applying cream to the wound and dressing it, Monday through Friday and the nurses followed up with wound care on the weekends. She said it was important to follow doctor's orders for wound care, but the family only wanted triad cream applied to the wound. She said she should have consulted the WCD on 04/04/2024 when she initially felt Resident #1 should be seen by the WCD. In an interview on 04/23/2024 at 12:33 PM, the DON stated, Resident #1 returned to the facility on [DATE] from the hospital with an opening (sheer) on the sacrum. She stated the family only wanted the wound to be treated with cream. She said the family was to sign a consent for Resident #1 to see the WCD and did on 04/08/2024 after the WCD had already left the facility. She said the facility needed a consent for residents to see the WCD but not to consult with them. She said the next time the WCD was in the facility on 04/15/24, the WCN was late, and they missed each other. Resident #1 was not seen by the WCD. She said the WCN should have discussed the wound with the WCD or MD to get treatment orders in place. She said she needed to put a system in place for someone else to round with the WCD in the WCN's absence. She said on 04/22/2024, RN G called her to tell her about Resident #1's wound. She said LVN E called the MD and was instructed to clean and dress the wound and refer to the WCD the next day, 04/22/2024. She said Resident #1 was sent to the hospital on by the WCD on 04/22/24. She said she expected nursing staff to follow the facility's policy and ensure they consulted the physician when changes in skin are noted. She said she expected staff to obtain and follow treatment order for all wounds. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 04/23/2024 at 1:38 PM, the WCD stated she did not see residents unless there was a referral and consent completed. She said she knew the WCN was getting a consent from the facility but had not discussed the wounds with her. She said she came to the facility every Monday and on 04/15/2024 Resident #1 was not on her list of residents to see. She said the WCN was not there that day. She said the WCN provided the consents and list of residents to see. She said she would like to be notified and consulted of wound changes for all residents because wounds can deteriorate quickly. She said all wounds should have treatment orders in place if not from the WCD then from the MD. In an interview on 04/23/2024 at 1:46 PM, CNA D stated when Resident #1 returned to the facility from the hospital on 03/28/2024, she had a small opening on her bottom and the family wanted them to use cream to treat it. She said they placed signage on the walls directing this. She said she worked with Resident #1 on 04/10/2024 and again on 04/17/2024 and 04/18/2024 the wound looked the same. She said she worked with Resident #1 on 04/22/2024 and the wound looked like it burst and was huge. In an interview on 04/23/2024 at 1:53 PM, LVN C stated she sent Resident #1 to the hospital on 04/22/2024 by the WCD. She said the wound had grown, was very deep and the skin was all gone. She said it had not been like that last week. She said she had not been notified that it had worsened. An observation on 04/23/2024 at 4:15 PM at the hospital, of Resident #1 revealed her sleeping. She was propped on her side with wedges. In an interview on 04/23/2024 at 4:20 PM, Family Member O stated Resident #1 returned to the facility from the hospital on 03/28/2024. She said Resident #1's wound was about the size of a quarter and not deep or oozing but it was a little red. She said she brought cream to the facility for them to use on the wound because that seemed to help in the past. She said the WCN did not ask her to sign a consent for Resident #1 to see the WCD until 04/08/2024 and it was provided immediately. She said on 04/21/2024 the facility called her and said the wound had gotten larger and started oozing. She said the WCD saw Resident #1 on 04/22/2024 and sent her to the hospital. She said Resident #1 had surgery to remove infection. In an interview on 04/23/2024 at 4:30 PM, Hospital RN P said Resident #1 had debridement surgery this morning. She said there was an ulcer under the wound which burst and revealed deep tissue damage. She said they used wedges to position Resident #1 on her side and they alternate every 2 hours. In an interview on 04/26/2024 at 2:10 PM, LVN A stated she did the readmission assessment for Resident #1 when she returned to the facility on [DATE]. She said Resident #1 did have open areas on her buttocks. She said the top layer of skin was off. She said the family wanted to use cream on the wound and she entered that into the orders. She said she had not consulted with the MD about the cream treatment. She said when she did the skin assessment on 04/11/2024, an additional wound was on the coccyx. She said the MD should be informed of all wound changes and treatment orders requested. In an interview on 04/26/2024 at 2:49 PM, ADON B stated - she did not open the weekly skin assessments but used the report to identify new wounds and follow up, she said she would let the MD know about new wounds and request treatment orders then enter them into the clinical record. She said she did not do that for Resident #1 because the family only wanted the use of cream. She said she followed up with wounds as best she could but often had to work as a floor nurse. She said the risk to residents of not consulting the MD or WCD could result in new or worsening wounds. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 04/26/2024 at 3:28 PM, LVN E stated, she called RN G on 04/20/2024 about Resident #1's deteriorating wound and informed her there were no wound treatment orders in the clinical record. She said RN G contacted the DON and they told her the family was aware of the wound and only wanted cream as treatments. She said the wound on Resident #1's right buttock was open and not as deep as the wound on the left buttocks and there was not drainage. LVN E said on 04/21/2024, Resident #1's wound was worse and developed some odor and drainage. LVN E said she notified the MD who instructed her to clean and dress the wound then refer to the WCD on 04/22/2024. In an interview on 04/26/2024 at 3:28 PM, ADON F stated when the WCN was not available nursing staff typically called her to round with the WCD. She said all treatments needed to be order and nurses needed to follow doctor's order. She said she expected skin assessments to be completed weekly and documented in the clinical record. She said if there were changes they needed to be noted in the 24-hour report for follow up. In an interview on 04/26/2024 at 3:28 PM, RN G stated, LVN E called her on 04/20/2024 to inform her that Resident #1 did not have wound treatment orders in place. She said she asked the WCN who told her the family only wanted the wound treated with cream they brought from home. She said it did not make sense to her and called the DON who told her the same thing. She said the WCD should have seen Resident #1 on their next visit to the facility on [DATE]. She said there was not documentation that the MD or WCD had seen the wound or that treatment orders were requested. She said not consulting the MD or requesting treatment orders placed Residents at risk of worsening wounds and harm. In a telephone interview on 05/01/2024 at 8:45 AM, the MD stated he was not aware of Resident #1's wound until the facility called him on 04/21/2024 informing him of the worsening wound. He said he instructed them to clean and dress the wound and refer to the WCD on 04/22/2024. He said he had seen Resident #1 since her return to the facility on [DATE] but did not know she had a wound. He said he would expect to be informed of any wounds and would put treatment orders in place until the resident could be seen by the WCD. He said everyone who had a wound needed to be seen by the WCD to prevent new or worsening wounds. He said it seemed the delay in obtaining consent and coordination to see the wound care doctor delayed Resident #1's appropriate wound care and caused it to worsen. Record review of LVN A's nurse note dated 03/28/2024 at 4:15 PM, reflected, [Resident #1] readmitted to facility . observed having 2 small openings on each buttock, 3 cm x 2 cm on left and 2 cm x 2 cm on right, cleaned area and applied house cream . Record review of LVN E's nurse note dated 04/20/2024 at 12:00 PM, reflected, [Resident #1] was assessed after night nurse asked to follow up on findings of a open area, When assessed resident was noted to have 2 deep wounds to sacrum area, with moderate drainage. [RN G] made aware of findings. [RN G] called DON to make aware, DON stated that the family is aware of findings, family wanted only Coloplast cream to be put on wound. When relieved by evening nurse [ADON B] was made aware of findings, nurse stated she was aware of wound, and that family denied wanting any other treatment but a thick layer of the Coloplast to be put on her wound. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Weekly Wound Progress note dated 04/22/24 completed by the WCN reflected, Resident #1 had 1 wound; pain management program was in place Routine and PRN; the RP and Physician were notified 04/22/24. The wound was described as an unstageable pressure ulcer to the sacrum; Heavy exudate; an undescribed exudate color or appearance; and the wound bed appearance other. The wound was measured (LxWxD): 10 cm x 12 cm x 0.1 cm. Additional Comments: Wound MD Recommend to send to the hospital for surgical debridement. Record review of the Hospital CT findings on admission reflected, Large collection of gas and debris in the posterior midline and right of midline overlying the coccyx and inferior sacrum. Overall size of this is about 4 cm AP by a maximum of 4.3 cm transverse. Craniocaudal dimensions are about 14 cm but it should be noted that this is not 1 uniform collection. Pockets of mottled collection of gas with some areas containing debris. No definite drainable fluid collection is present. Portions of this inflammatory process about the coccyx, axial image 60 series 3, sagittal image 18 series 6 but no definite periosteal reaction at this time though early osteomyelitis would be difficult to fully exclude. The Administrator, DON and Regional Clinical Services Director were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 04/26/2024 at 5:15 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal was accepted on 04/27/2024 at 12:30 PM and included: In-Service conducted. DON, ADON, Wound Care Nurse and Administrator were re-educated by the Regional Clinical Services Director on policy for completing weekly skin assessments, Notification of Physician for Orders/Change of Condition and Prevention and Treatment of Pressure Ulcers. This was completed on 04/26/24. DON started re-education of nurses on 04/24/24 on completing weekly skin assessments, Notification of Physician for Orders and notifying DON/Wound Care Nurse of any new areas identified. This was completed on 4/26/24. All facility licensed nurses received education on timely notification of Physician, Pressure Ulcer Prevention and Identification and Documentation of Pressure Ulcers/Skin Conditions from Clinical Specialists in Wound Care and DON this was initiated and completed 04/26/24. Nurses who are off, on vacation or leave of absence will be provided education prior returning to work. An in-service template will be developed for all agency nurses to review and sign off on prior to working their shifts and will be verified by off going nurse. DON/Designee will monitor daily for compliance. Implementation: IDT will review all Pressure Ulcers, Arterial/Stasis Ulcers or any other significant wound weekly during clinical WE CARE Meeting. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All newly identified skin issues will be assessed by Wound Nurse and DON upon identification. Physician will be notified by charge nurse upon discovery of any new wound. DON/Admin will monitor corrective measures daily during Morning Meeting and Afternoon Stand Down Meeting. RDCS/RDO will monitor compliance weekly. Implementation Date of Changes In-servicing was initiated on 04/24/24 and was completed on 04/26/24 Agency staff and on leave or PRN nurses that work in the facility will have in-servicing completed prior to working the floor by the DON/Designee. Agency in-serve template was placed in the agency orientation binder on 04/26/24. At this time the facility is not utilizing agency staff. Involvement of Medical Director The Medical Director, was notified about the immediate Jeopardy on 04/26/24. Monitoring of the POR DON/Designee will monitor for compliance daily during clinical round and weekly during weekly skin rounds for 4 weeks. Involvement of QA QAPI reviewed and approved the Plan of Removal on 04/26/24. QAPI will review plan for compliance monthly for 3 months. Who is responsible for implementation of process? Administrator and DON (Director of Nursing). On 04/27/2024 at 2:00 PM the surveyor began monitoring the facility's Plan of Removal. Interviews on 04/27/2024 between 2:15 PM and 4:00 PM with RN G, LVN H, CNA I, CNA J, CNA K, LVN L, LVN M, and LVN N. Interviews with staff represented 1st, 2nd, and 3rd shifts and all days of the week. Staff were able to convey appropriate knowledge of the POR Inservice including the identification of changes in wound condition, prevention strategies for pressure ulcers, reporting changes to the DON and physician, requesting physician orders when a change in wound condition is noted, and documenting wound status. All staff stated the DON would monitor these actions. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/27/2024 at 4:45 PM, the DON stated, she understood that the facility failed to ensure all wounds were seen by the physician promptly and ensure treatment orders were in place. She said she had been in serviced by the Regional Director of Clinical Services on the following: new and worsening skin, consulting with the MD, referring to the Wound Care Physician, documenting changes in condition in the 24-hour report, and entering MD orders She said they have initiated in services with staff on these topics and will continue until all staff have been in serviced. She said she would monitor this though chart reviews. In an interview on 04/27/2024 at 4:57 PM, the Administrator stated the DON, both ADONs (including ADON A - Wound Care Nurse) were in serviced by the Regional Director of Clinical Services. She stated all nursing staff were educated on notification of Physician, pressure ulcer prevention and identification and documentation of pressure ulcers/skin conditions from by an outside company specializing in wound care. She said these will be monitored by the DON through assessment reports and nursing communication records. She said she would monitor this through the IDT and QUPI process. Record review of the facility's in-service record dated 04/26/2024, and titled, Prevention, identification and notification for pressure ulcers, timely treatment, orders, and POR, reflected the in-services as conducted by the Regional Director of Clinical Services and included signatures of the Administrator, DON, and both ADONs. She stated in-servicing will be on-going to ensure all staff understand the facility's expectations. Record review of the facility's in-service record addressed to CNAs, dated 04/26/2024, and titled, You must notify charge nurse of any issue with skin. All incontinent residents must have [NAME] cream applied after every peri-care. Residents who require total care must be repositioned Q 2-hours. All residents will receive showers per schedule and notify nurse if they refuse. Record review of the facility's in-service record addressed to Nurses, dated 04/26/2024, and titled, Weekly skin assessments: All skin assessment must be completed per schedule. In new skin issues are identified, charge nurse will notify the PCP and DON. Wound nurse will initiate treatment per orders. Notification of the Wound Care Doctor as well. An Immediate Jeopardy (IJ) was identified on 04/26/2024. While the IJ was removed on 04/27/2024 at 12:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to ensure that residents receive care, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #1) of 9 residents reviewed for pressure ulcers. The facility failed to ensure the MD and/or the Wound Care Doctor were consulted for direction on wound care orders for Resident #1 upon readmission to the facility on [DATE] with two small open wounds on the right and left buttock. The facility failed to ensure the MD and/or the Wound Care Doctor were consulted for direction on wound care orders on 04/11/2024 when a new wound developed on Resident #1's coccyx. Resident #1 was not seen by the Wound Care Doctor until 04/22/24 and was sent out to hospital with an unstageable wound on her sacrum, resulting in surgery to debride the wound. An Immediate Jeopardy (IJ) was identified on 04/26/2024. While the IJ was removed on 04/27/2024 at 12:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures placed residents at a risk of increased pain, infections, development of new pressure ulcers, and decline in quality of life and serious harm for residents. Findings included: Record review of Resident #1's face sheet dated 04/23/2024 indicated an [AGE] year-old female initially admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses of Unspecified Dementia (mile cognitive impairment), congestive heart failure (heart does not bump blood enough to meet the body's needs), hypertension (pressure in blood vessels is too high), and Type 2 diabetes (problems in the way the body regulates and uses sugar as fuel). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 4, indicating severe cognitive impairment. Resident #1 required supervision for eating, substantial/maximal assistance with toileting and personal hygiene, and dependent for transfer. She was always incontinent of bowel and bladder. Resident #1 was at risk of developing pressure ulcers/injuries, she did not have any unhealed pressure ulcers/injuries but had moisture associated skin damage - treatments include applications of ointments/medications. Record review of Resident #1's Comprehensive Care Plan dated 03/14/2024 reflected, [Resident #1] has an ADL self-care performance deficit r/t impaired gait2/balance, poor comprehension r/t Dementia/Alzheimer's, revised on 03/25/2024. Interventions included extensive to total x 2 for bed mobility, transfers, dressing, and toileting. [Resident #1] has actual impairment to skin integrity of the peri area r/t incontinence. Interventions: Triad cream per family request, initiated 04/04/2024. (continued on next page)

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	455416	A. Building B. Wing	04/27/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's March 2024 Nursing MAR reflected Preventative Skin Care: Apply Moisture Barrier every shift and PRN. Start Date - 03/29/2024. D/C Date - 03/28/2024. Record review of Resident #1's March 2024 TAR did not reflect treatment orders. Record review of Resident #1's April 2024 Nursing MAR and TAR did not reflect treatment orders. Record review of the Weekly Nursing Skin assessment dated [DATE] completed by LVN A reflected, Resident #1 had observed skin issues. The site(s), type, measurements, or stage were not identified. The Notes section revealed Has wound tx to her buttocks, sacrum daily and prn. Record review of the Weekly Nursing Skin assessment dated [DATE] completed by LVN A reflected, Resident #1 had observed skin issues. An unmeasured pressure wound was identified to the left and right buttocks. An unmeasured open area was identified to the Coccyx. The Notes section revealed Has wound tx to her buttocks, sacrum daily and prn. Record review of the Weekly Wound Progress note 04/21/24 completed by the WCN reflected, Resident #1 had 1 wound; pain management program was in place Routine and PRN; the notified RP and date were blank. The physician was notified 04/21/24. The wound type was other and the location reflected wound has deteriorated rapidly in the past 2 days; Heavy exudate (drainage that seeps out of wounds); an undescribed exudate color or appearance; and the wound bed appearance other. The wound was measured (LxWxD): 9 cm x 10 cm x 0.5 cm. Additional Comments: WOUND HAS DETERIORATED LOOKS LIKE ABSCESS. Doctor notified with orders for wound care ASAP. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/23/2024 at 11:25 AM, ADON B stated she was the Wound Care Nurse. She said when Resident #1 admitted to the facility on [DATE], she did not have any wounds. She said Resident #1 was sent to the hospital for a UTI and returned to the facility on [DATE] with two small open wounds on her right and left buttocks. She said the family wanted them treated with cream they brought in because that seemed to help in the past. She said she did not consult the MD or Wound Care Doctor about the wounds because she attributed them to moisture related and only warranted barrier cream. She stated she completed Resident #1's wound care daily and the wound did not get better or worse. She said on 04/04/2024 she started pursuit of having the family sign a consent form to see the Wound Care Doctor because Resident #1 did not get out of bed and the wounds were not getting better. She said she did not consult with the Wound care Doctor because they would not see Resident #1 without a consent. She said she was able to have the family complete the consent on 04/08/2024 but the Wound care Doctor had already rounded for the day and did not see Resident #1. She said she had not discussed Resident #1 with the Wound Care Doctor on 04/08/2024 because she did not have the consent signed until after the Doctor left the facility. She said she was not aware that LVN A had documented the development of another wound on Resident #1's sacrum, during a skin assessment on 04/11/2024. She said the Wound care Doctor was next in the facility on 04/15/2024 but she was late on that day and was not able to provide the consent to the Doctor, therefore the Doctor, did not see Resident #1's wounds again. She stated she last saw Resident #1's wounds on 04/18/2024 and they looked normal to her. She said she worked on 04/21/2024 and LVN E called her to look at Resident #1's wound. She said it deteriorated a lot and seemed to have an abscess and measured 9 cm x 10 cm x 0.5 cm. She stated the MD was notified by LVN E and the MD told them to clean and dress the wound and referred to the WCD on 04/22/2024. She said she had not consulted with the MD or the WCD about Resident #1's wounds until 04/22/2024 when the Wound Care Doctor sent Resident #1 to the hospital for possible debridement. ADON A stated she did wound care daily, which included applying cream to the wound and dressing it, Monday through Friday and the nurses followed up with wound care on the weekends. She said it was important to follow doctor's orders for wound care, but the family only wanted triad cream applied to the wound. She said she should have consulted the WCD on 04/04/2024 when she initially felt Resident #1 should be seen by the WCD. In an interview on 04/23/2024 at 12:33 PM, the DON stated, Resident #1 returned to the facility on [DATE] from the hospital with an opening (sheer) on the sacrum. She stated the family only wanted the wound to be treated with cream. She said the family was to sign a consent for Resident #1 to see the WCD and did on 04/08/2024 after the WCD had already left the facility. She said the facility needed a consent for residents to see the WCD but not to consult with them. She said the next time the WCD was in the facility on 04/15/24, the WCN was late, and they missed each other. Resident #1 was not seen by the WCD. She said the WCN should have discussed the wound with the WCD or MD to get treatment orders in place. She said she needed to put a system in place for someone else to round with the WCD in the WCN's absence. She said on 04/22/2024, RN G called her to tell her about Resident #1's wound. She said LVN E called the MD and was instructed to clean and dress the wound and refer to the WCD the next day, 04/22/2024. She said Resident #1 was sent to the hospital by the WCD on 04/22/24. She said she expected nursing staff to follow the facility's policy and ensure they consulted the physician when changes in skin are noted. She said she expected staff to obtain and follow treatment order for all wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 04/23/2024 at 1:38 PM, the WCD stated she did not see residents unless there was a referral and consent completed. She said she knew the WCN was getting a consent from the facility but had not discussed the wounds with her. She said she came to the facility every Monday and on 04/15/2024 Resident #1 was not on her list of residents to see. She said the WCN was not there that day. She said the WCN provided the consents and list of residents to see. She said she would like to be notified and consulted of wound changes for all residents because wounds can deteriorate quickly. She said all wounds should have treatment orders in place if not from the WCD then from the MD. In an interview on 04/23/2024 at 1:46 PM, CNA D stated when Resident #1 returned to the facility from the hospital on 03/28/2024, she had a small opening on her bottom and the family wanted them to use cream to treat it. She said they placed signage on the walls directing this. She said she worked with Resident #1 on 04/10/2024 and again on 04/17/2024 and 04/18/2024 the wound looked the same. She said she worked with Resident #1 on 04/22/2024 and the wound looked like it burst and was huge. In an interview on 04/23/2024 at 1:53 PM, LVN C stated she sent Resident #1 to the hospital on 04/22/2024 by the WCD. She said the wound had grown, was very deep and the skin was all gone. She said it had not been like that last week. She said she had not been notified that it had worsened. An observation on 04/23/2024 at 4:15 PM at the hospital, of Resident #1 revealed her sleeping. She was propped on her side with wedges. In an interview on 04/23/2024 at 4:20 PM, Family Member O stated Resident #1 returned to the facility from the hospital on 03/28/2024. She said Resident #1's wound was about the size of a quarter and not deep or oozing but it was a little red. She said she brought cream to the facility for them to use on the wound because that seemed to help in the past. She said the WCN did not ask her to sign a consent for Resident #1 to see the WCD until 04/08/2024 and it was provided immediately. She said on 04/21/2024 the facility called her and said the wound had gotten larger and started oozing. She said the WCD saw Resident #1 on 04/22/2024 and sent her to the hospital. She said Resident #1 had surgery to remove infection. In an interview on 04/23/2024 at 4:30 PM, Hospital RN P said Resident #1 had debridement surgery this morning. She said there was an ulcer under the wound which burst and revealed deep tissue damage. She said they used wedges to position Resident #1 on her side and they alternate every 2 hours. In an interview on 04/26/2024 at 2:10 PM, LVN A stated she did the readmission assessment for Resident #1 when she returned to the facility on [DATE]. She said Resident #1 did have open areas on her buttocks. She said the top layer of skin was off. She said the family wanted to use cream on the wound and she entered that into the orders. She said she had not consulted with the MD about the cream treatment. She said when she did the skin assessment on 04/11/2024, an additional wound was on the coccyx. She said the MD should be informed of all wound changes and treatment orders requested. In an interview on 04/26/2024 at 2:49 PM, ADON B stated - she did not open the weekly skin assessments but used the report to identify new wounds and follow up, she said she would let the MD know about new wounds and request treatment orders then enter them into the clinical record. She said she did not do that for Resident #1 because the family only wanted the use of cream. She said she followed up with wounds as best she could but often had to work as a floor nurse. She said the risk to residents of not consulting the MD or WCD could result in new or worsening wounds. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 04/26/2024 at 3:28 PM, LVN E stated, she called RN G on 04/20/2024 about Resident #1's deteriorating wound and informed her there were no wound treatment orders in the clinical record. She said RN G contacted the DON and they told her the family was aware of the wound and only wanted cream as treatments. She said the wound on Resident #1's right buttock was open and not as deep as the wound on the left buttocks and there was not drainage. LVN E said on 04/21/2024, Resident #1's wound was worse and developed some odor and drainage. LVN E said she notified the MD who instructed her to clean and dress the wound then refer to the WCD on 04/22/2024. In an interview on 04/26/2024 at 3:28 PM, ADON F stated when the WCN was not available nursing staff typically called her to round with the WCD. She said all treatments needed to be order and nurses needed to follow doctor's orders. She said she expected skin assessments to be completed weekly and documented in the clinical record. She said if there were changes they needed to be noted in the 24-hour report for follow up. In an interview on 04/26/2024 at 3:28 PM, RN G stated, LVN E called her on 04/20/2024 to inform her that Resident #1 did not have wound treatment orders in place. She said she asked the WCN who told her the family only wanted the wound treated with cream they brought from home. She said it did not make sense to her and called the DON who told her the same thing. She said the WCD should have seen Resident #1 on their next visit to the facility on [DATE]. She said there was not documentation that the MD or WCD had seen the wound or that treatment orders were requested. She said not consulting the MD or requesting treatment orders placed Residents at risk of worsening wounds and harm. In a telephone interview on 05/01/2024 at 8:45 AM, the MD stated he was not aware of Resident #1's wound until the facility called him on 04/21/2024 informing him of the worsening wound. He said he instructed them to clean and dress the wound and refer to the WCD on 04/22/2024. He said he had seen Resident #1 since her return to the facility on [DATE] but did not know she had a wound. He said he would expect to be informed of any wounds and would put treatment orders in place until the resident could be seen by the WCD. He said everyone who had a wound needed to be seen by the WCD to prevent new or worsening wounds. He said it seemed the delay in obtaining consent and coordination to see the wound care doctor delayed Resident #1's appropriate wound care and caused it to worsen. Record review of LVN A's nurse note dated 03/28/2024 at 4:15 PM, reflected, [Resident #1] readmitted to facility . observed having 2 small openings on each buttock, 3 cm x 2 cm on left and 2 cm x 2 cm on right, cleaned area and applied house cream . Record review of LVN E's nurse note dated 04/20/2024 at 12:00 PM, reflected, [Resident #1] was assessed after night nurse asked to follow up on findings of a open area, When assessed resident was noted to have 2 deep wounds to sacrum area, with moderate drainage. [RN G] made aware of findings. [RN G] called DON to make aware, DON stated that the family is aware of findings, family wanted only Coloplast cream to be put on wound. When relieved by evening nurse [ADON B] was made aware of findings, nurse stated she was aware of wound, and that family denied wanting any other treatment but a thick layer of the Coloplast to be put on her wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Weekly Wound Progress note dated 04/22/24 completed by the WCN reflected, Resident #1 had 1 wound; pain management program was in place Routine and PRN; the RP and Physician were notified 04/22/24. The wound was described as an unstageable pressure ulcer to the sacrum; Heavy exudate; an undescribed exudate color or appearance; and the wound bed appearance other. The wound was measured (LxWxD): 10 cm x 12 cm x 0.1 cm. Additional Comments: Wound MD Recommend to send to the hospital for surgical debridement. Record review of the Hospital CT findings on admission reflected, Large collection of gas and debris in the posterior midline and right of midline overlying the coccyx and inferior sacrum. Overall size of this is about 4 cm AP by a maximum of 4.3 cm transverse. Craniocaudal dimensions are about 14 cm but it should be noted that this is not 1 uniform collection. Pockets of mottled collection of gas with some areas containing debris. No definite drainable fluid collection is present. Portions of this inflammatory process about the coccyx, axial image 60 series 3, sagittal image 18 series 6 but no definite periosteal reaction at this time though early osteomyelitis would be difficult to fully exclude. The Administrator, DON and Regional Clinical Services Director were notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 04/26/2024 at 5:15 PM, due to the above failures and the IJ template were provided. The facility's Plan of Removal was accepted on 04/27/2024 at 12:30 PM and included: In-Service conducted. DON, ADON, Wound Care Nurse and Administrator were re-educated by the Regional Clinical Services Director on policy for completing weekly skin assessments, Notification of Physician for Orders/Change of Condition and Prevention and Treatment of Pressure Ulcers. This was completed on 04/26/24. DON started re-education of nurses on 04/24/24 on completing weekly skin assessments, Notification of Physician for Orders and notifying DON/Wound Care Nurse of any new areas identified. This was completed on 4/26/24. All facility licensed nurses received education on timely notification of Physician, Pressure Ulcer Prevention and Identification and Documentation of Pressure Ulcers/Skin Conditions from Clinical Specialists in Wound Care and DON, this was initiated and completed 04/26/24. Nurses who are off, on vacation or leave of absence will be provided education prior returning to work. An in-service template will be developed for all agency nurses to review and sign off on prior to working their shifts and will be verified by off going nurse. DON/Designee will monitor daily for compliance. Implementation: IDT will review all Pressure Ulcers, Arterial/Stasis Ulcers or any other significant wound weekly during clinical WE CARE Meeting. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All newly identified skin issues will be assessed by Wound Nurse and DON upon identification. Physician will be notified by charge nurse upon discovery of any new wound. DON/Admin will monitor corrective measures daily during Morning Meeting and Afternoon Stand Down Meeting. RDCS/RDO will monitor compliance weekly. Implementation Date of Changes In-servicing was initiated on 04/24/24 and was completed on 04/26/24 Agency staff and on leave or PRN nurses that work in the facility will have in-servicing completed prior to working the floor by the DON/Designee. Agency in-serve template was placed in the agency orientation binder on 04/26/24. At this time the facility is not utilizing agency staff. Involvement of Medical Director The Medical Director was notified about the immediate Jeopardy on 04/26/24. Monitoring of the POR DON/Designee will monitor for compliance daily during clinical round and weekly during weekly skin rounds for 4 weeks. Involvement of QA QAPI reviewed and approved the Plan of Removal on 04/26/24. QAPI will review plan for compliance monthly for 3 months. Who is responsible for implementation of process? Administrator and DON (Director of Nursing). On 04/27/2024 at 2:00 PM the surveyor began monitoring the facility's Plan of Removal. Interviews on 04/27/2024 between 2:15 PM and 4:00 PM with RN G, LVN H, CNA I, CNA J, CNA K, LVN L, LVN M, and LVN N. Interviews with staff represented 1st, 2nd, and 3rd shifts and all days of the week. Staff were able to convey appropriate knowledge of the POR Inservice including the identification of changes in wound condition, prevention strategies for pressure ulcers, reporting changes to the DON and physician, requesting physician orders when a change in wound condition is noted, and documenting wound status. All staff stated the DON would monitor these actions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/27/2024 at 4:45 PM, the DON stated, she understood that the facility failed to ensure all wounds were seen by the physician promptly and ensure treatment orders were in place. She said she had been in serviced by the Regional Director of Clinical Services on the following: new and worsening skin, consulting with the MD, referring to the Wound Care Physician, documenting changes in condition in the 24-hour report, and entering MD orders She said they have initiated in services with staff on these topics and will continue until all staff have been in serviced. She said she would monitor this though chart reviews. In an interview on 04/27/2024 at 4:57 PM, the Administrator stated the DON, both ADONs (including ADON A - Wound Care Nurse) were in serviced by the Regional Director of Clinical Services. She stated all nursing staff were educated on notification of Physician, pressure ulcer prevention and identification and documentation of pressure ulcers/skin conditions from by an outside company specializing in wound care. She said these will be monitored by the DON through assessment reports and nursing communication records. She said she would monitor this through the IDT and QUPI process. Record review of the facility's in-service record dated 04/26/2024, and titled, Prevention, identification and notification for pressure ulcers, timely treatment, orders, and POR, reflected the in-services as conducted by the Regional Director of Clinical Services and included signatures of the Administrator, DON, and both ADONs. She stated in-servicing will be on-going to ensure all staff understand the facility's expectations. Record review of the facility's in-service record addressed to CNAs, dated 04/26/2024, and titled, You must notify charge nurse of any issue with skin. All incontinent residents must have [NAME] cream applied after every peri-care. Residents who require total care must be repositioned Q 2-hours. All residents will receive showers per schedule and notify nurse if they refuse. Record review of the facility's in-service record addressed to Nurses, dated 04/26/2024, and titled, Weekly skin assessments: All skin assessment must be completed per schedule. In new skin issues are identified, charge nurse will notify the PCP and DON. Wound nurse will initiate treatment per orders. Notification of the Wound Care Doctor as well. An Immediate Jeopardy (IJ) was identified on 04/26/2024. While the IJ was removed on 04/27/2024 at 12:30 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.