STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Health & Rehab Center	184 Buffalo Road Clarksville, VA 23927

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on staff interviews, resident interviews, clinical record, and facility document review, it was determined the facility staff failed to provide a complete and accurate investigation for an injury of unknown origin that affected one resident, (Resident #2, R2) in a sample of five residents. The findings included: The facility staff failed to provide evidence of a thorough investigation to include staff and resident interviews conducted during their investigation and the correct information concerning the resident's pain that was in the clinical record during their investigation period. Resident #2 (R2) was admitted to the facility on [DATE]. Diagnoses for R2 included but are not limited to cerebral infarction unspecified, muscle weakness and unspecified fracture of the lower end of left radius. R2's a quarterly Minimum Data Set (MDS) (an assessment protocol) with an Assessment Reference Date of 3/13/24 coded R2 with severely impaired cognition. On 6/17124 a review of facility documentation was conducted. During a review of the facility's investigation documents, the facility's final summary had that on 5/17/24, R2 worked with therapy and had no pain. The occupational therapy notes on 5/17/24, stated increase in pain reported with movement and extension and had yes to pain in right hip. According to the facility's investigation summary, they noted that R2 worked with therapy on 5/18/24 and complained of some discomfort. However, the occupational therapy notes, within the investigation folder had yes to pain and R2 rated her pain 10/10 on that day. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 3:30 p.m. an interview was conducted with the director of nursing, (DON), and the acting administrator, which was the administrator at the time of the incident. During the interview, this surveyor, DON, and acting administrator went over the final summary of the facility's investigation. The final summary, which was prepared by the acting administrator, stated the investigation had included: all shifts were interviewed. The documents provided only included three staff interviews in the investigation folder and two interviews was from the same staff person. The final summary from the facility investigation stated that the facility conducted interviews facility wide with residents that reported pain. No resident interviews were in the folder. The administrator at the time of the incident, was asked about the interviews and stated, I assumed we did interviews at the time of the investigation but could not find the interviews, so I printed off the quarterly nursing assessments that were closest to the date of the investigations. and the acting administrator provided eight quarterly nursing assessments that included a question about pain in the assessment and the quarterly nursing assessments were reviewed. The eight quarterly assessments provided included two assessments, dated 5/16/23 and 5/20/23 and were completed prior to the start of the facility's investigation date of 5/24/23. The acting administrator and DON verbalized that they would review the investigation findings and present any other information they were able to find. On 6/20/24 at 9:35 a.m. an interview was conducted with Resident #5 (R5). R5 was R2's spouse and roommate at the facility. During the interview R5 remembered that R2 had pain in her RLE (right lower extremity). R5 verbalized that R2 hurt her leg last year and that R2 is not someone that complains. R5 verbalized that R2 had an X-ray on her right leg but cannot remember the exact date. R5 verbalized he was sure it was R2's right leg and that it caused her problems and pain. On 6/20/24 at 9:45 a.m. an interview was conducted with R2. R2 was observed in the restroom unassisted transferring from the commode to the wheelchair. R2 verbalized that she could not recall any incident with her right lower extremity or pain with her right hip. On 6/20/24 at 1:00 p.m. an interview was conducted with the DON, the regional nurse consultant, and the regional vice president of operations. During the interview the final summary of the facility's investigation of R2's fracture of unknown origin was discussed. The missing interviews from staff and residents were reviewed. The regional nurse consultant verbalized that a review of the investigation and R2's clinical record was conducted by her yesterday and no additional information was provided to the survey team. On 6/20/24 a review of the facility document was conducted. The facility policy titled, Virginia Resident Abuse Policy, was reviewed and on page 4 under the section 4 protect the resident read, .staff should report all incidents immediately to their direct supervisors. The assessment should generally include the following: range of motion (ROM); full body assessment for signs of injury; and vital signs. On 6/20/24 at 3:45 an end of day meeting was held with the DON, the regional of clinical services, (RDCS) and the regional vice president of operations. The concerns of the lack of assessment of pain, the lack of pain management and the lack of evidence in the facility's investigation of R2's fracture of unknown origin was discussed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 6:10 p.m. the RDCS presented the surveyor with copies of, POC [point of care] History Report, for 4/15/2024 thru 5/31/24. RDCS verbalized that it was to show the incident and pain did not interfere with her activities. The incident of R2's fracture of unknown origin happened in 5/24/23, which was the prior year. On 6/20/24 at 6:33 p.m. an exit conference meeting was conducted. RDCS asked if this would be considered as past noncompliance and the surveyor responded that the facility's final investigation was not completed with accurate information or evidence to support the investigation, so it did not meet the requirements for past noncompliance. No additional information was provided.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to complete a comprehensive assessment timely for 1 resident (Resident #3- R3), in a survey sample of 5 residents. The findings included: For R3, the facility staff failed to conduct a comprehensive admission minimum data set (MDS) assessment timely. On 6/17/24 and 6/18/24, a clinical record review was conducted of R3's chart. This review on the census tab and in the progress, notes indicated that R3 was admitted to the facility on [DATE]. Review of the assessments under the MDS tab of the EHR (electronic health record) revealed that R3's admission assessment with an assessment reference date (ARD) of 4/14/24, was not completed and signed in section Z0500 until 5/6/24, by RN #1 (registered nurse). On 6/18/24 at 10:25 a.m., an interview was conducted with RN #1 and RN #2, both of whom were MDS nurses. RN #1 explained that admission MDS assessments are to be completed by day 14 of the resident's stay and the CAA (Care area assessments) are to be completed by day 21. During the above interview, RN #1 accessed R3's clinical record and admission MDS assessment. RN #1 confirmed that the MDS should have been completed by 4/21/24 and was not completed until 5/6/24. When asked, if this was timely, RN #1 said, no. RN #1 explained that the facility had an unexpected and unanticipated change in staffing within the MDS department, which lead to the delay. RN #1 also explained that the change in the EHR software had caused some additional delays. On 6/18/24 at 10:25 a.m., during the interview, RN #1, and RN #2, confirmed that they do follow the RAI (resident assessment instrument) manual for guidelines on timing of assessments. On 6/18/24 at 4:05 p.m., during an end of day meeting, the facility's acting administrator, director of nursing, and corporate staff was made aware of the above findings. On 6/20/24, the facility administration was asked if they had a policy regarding the timeliness of assessments, and the RDCS (regional director of clinical services) stated they follow the RAI manual. No facility policy was provided. According to the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated October 2023, For Use Effective October 1, 2023, guidance is given with regards to the timing of MDS assessments. According to the table on page 2-17, titled, RAI OBRA-required Assessment Summary, for an admission/comprehensive assessment, the MDS Completion date and CAA completion date is to be No later than 14th calendar day of the resident's admission (admitted + 13 calendar days). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 3:17 p.m., a pre-decision-making meeting was held with the facility administration, and they were again made aware of the above findings. No further information was provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a baseline care plan for one Resident (Resident #3- R3) in a survey sample of 5 Residents. The findings included: For R3, the facility staff failed to develop a baseline care plan timely and failed to include instructions needed to direct/provide patient centered care of the resident. On 6/17/24 and 6/18/24, a clinical record review was conducted of R3's chart. This revealed that R3 was admitted to the facility on [DATE]. The baseline care plan was developed on 4/11/24, which was outside of the 48 hours following admission as required. According to this 4/11/24 base line care plan, the problem area read, Baseline Care Plan: Resident admitted to facility for (skilled, LTC [long term]) care. This is the Baseline Care Plan identifying initial care needs, risks, strengths, and goals. The goal was stated as, Initial goal is to (discharge to community, remain in LTC, or other). Resident will have access to necessary services to promote adjustment to their new living environment and/or post discharge from facility. The approaches/interventions within the baseline care plan read as follows, activities of daily living: resident will receive necessary assistance for activities of daily living, ANTICOAGULATION THERAPY: Resident will be monitored for abnormal bleeding due to anticoagulation treatment. Will receive anticoagulant therapy as ordered; will be observed for any s/s of abnormal bleeding (bruising, tarry stools, nose bleeds, bleeding gums) and/or hemorrhage; will receive education on risks and benefits of anticoagulant therapy if needed; and be monitored as ordered for lab tests to monitor coagulation factors and will have any abnormal findings reported to provider (MD/NP/PA), Behavioral needs: Resident behavioral health needs will be evaluated and provider contacted as needed, Cultural preferences: Resident will have consideration for cultural needs (select from the following): language barrier, cultural/religious practices, food restrictions/preferences, traditions, beliefs in alternative medicines, unfamiliarity with health care services, other if needed, specify _____, DIET: Resident will receive diet as ordered., FALLS: Minimize potential risk factors related to falls/injury, MEDICATIONS: Resident will be monitored for adverse reactions to high risk medications, PAIN: Resident pain needs will be evaluated/anticipated, SAFETY: Resident will be monitored to minimize risk of wandering and/or elopement, SKIN: Resident will be provided skin care to prevent skin breakdown, SOCIAL SERVICES: Resident will receive initial Social Services evaluation to ensure psychosocial needs will be met. * PASRR II level needs will be addressed if applicable, and THERAPY: Resident will receive therapy service(s) as indicated. The above noted base line care plan did not inform the facility staff of the resident's level of support needed and/or interventions being provided to R3 for daily care needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 10:25 a.m., an interview was conducted with RN #1 (registered nurse), who was the MDS (minimum data set - an assessment) nurse. RN #1 explained that the purpose of the care plan is to develop a plan of care for taking care of the resident and their needs. RN #1 said, It helps us to care for the individual. RN #1 and RN #2, who was also an MDS nurse, both explained that the admitting nurse and/or unit managers are responsible for completing the baseline care plan. The surveyor reviewed R3's baseline care plan with RN #1. RN's #1 and #2 both explained that the new electronic health system just skims the surface and doesn't give details on the needs of the resident. Review of the facility policy titled, Interim/Baseline Care Planning Policy. The policy read in part, Within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan On 6/18/24 at 4:05 p.m., during an end of day meeting, the facility's acting administrator, director of nursing, and corporate staff was made aware of the above findings. On 6/20/24 at 3:17 p.m., a pre-decision-making meeting was held with the facility administration, and they were again made aware of the above findings. No further information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to provide care to residents within the professional standards of practice and within the scope of practice of staff providing care for residents on 3 of 6 nursing units. The findings included: For residents on 3 of the 6 nursing units, the facility staff permitted nursing assistants to apply a zinc topical cream to residents, which was outside of their scope of practice and without a physician order. On 6/17/24-6/18/24, during the clinical record review of the residents sampled (Resident #1-Resident #5), it was not noted that any of the residents had physician orders for the application of barrier cream. On 6/20/24 at 9:44 a.m., an interview was conducted with LPN #4 (licensed practical nurse), who was a unit manager. When asked about the admission process of a resident, LPN #4 explained that when a resident is admitted assessments are conducted to identify resident's risks for skin breakdown by doing a Braden assessment, along with other assessments. When asked to describe the purpose of the Braden, LPN #4 said that it identifies the resident's risk for developing skin breakdown and said, at that time we can put stuff in place to prevent it, we would have them on an air mattress, on a turn and repositioning plan and use barrier cream. On 6/20/24 at 10:50 a.m., an interview was conducted with the facility's treatment nurse. The treatment nurse explained that when a resident is incontinent, they have a barrier cream that the CNA's (certified nursing assistant) applied to help protect the resident's skin from moisture. The treatment nurse explained that anything beyond the barrier cream required an order from the physician and that the nurse would apply it. On 6/20/24 at 2 p.m., an interview was conducted with LPN #5. When asked about the application of zinc, LPN #5 explained this is something that would have to be ordered by the physician, the nurses would have to apply it as a treatment, and sign it off on the TAR [treatment administration record]. LPN #5 further confirmed that the facility does not have any such standing orders, that have already been approved by the provider, that the nurse would automatically implement. On 6/20/24 at 2:15 p.m., an interview was conducted with LPN #7. LPN #7 stated that to apply zinc requires a physician's order and is applied by the nurses. On 6/20/24 at 2:30 p.m., an interview was conducted with LPN #8. LPN #8 explained that barrier cream is applied by the CNA's but anything stronger than that would have to be ordered by the physician and applied by the nurses. LPN #8 showed the surveyor a tube of the facility's barrier cream, which was a white tube with green writing containing 100 grams of Vera Septine, Multi-Purpose Moisture Barrier. When looking at the ingredient listing, the active ingredient was listed as Zinc Oxide 21%. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 2:40 p.m., an interview was conducted with CNA #2. CNA #2 said that the barrier cream is a white tube with green writing called Vera Septine. CNA #2 went on to explain that it is kept in the resident's bedside drawer, is applied with incontinence care, and described it as a thick paste that is whitish pink. During the above interview with CNA #2, LPN #6 approached the surveyor and showed a tube of the Vera Septine, and it was noted that it contained a very thick paste with a pink hue. On 6/20/24, at approximately 5:15 p.m., the facility's director of nursing (DON) explained that they have had issues with supplies being out of stock and have had to change to alternate items, which included the facility barrier cream. When asked if she was aware that the facility barrier cream currently being used contains the active ingredient of 21% zinc oxide and is being applied by the CNA's, the DON said that she was not aware and had not thought about that. On 6/20/24, the facility policy titled, 6.8 Medication Administered through Certain Routes of Administration, was reviewed. This policy read in part, . Topical Medications: Medications are applied to the skin for many reasons including hydration and protection of skin surfaces, treatment of topical irritation or infection, to crease local anesthesia, skin barrier in the peri area, and to administer certain systemic medications .1. Verify medication order on MAR [medication administration record]. Check against physician order. 2. Identify the resident. Explain procedure. Wash hands. Wear gloves, to prevent medication from being absorbed by nurse if accidentally touches patch or ointment . 4.2 apply topical agent to affected area . 9. Document medication administration and/or dressings according to facility policy . The facility's policy titled General dose Preparation and Medication Administration, was reviewed and did not address who is permitted to administer medications and/or topical creams. On 6/20/24 at approximately 6:30 p.m., the facility's director of nursing was made aware of the above findings. No additional information was provided.

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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** 41449 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to provide care and services to ensure residents received care to prevent development of pressure ulcer(s) for one resident (Resident # 3- R3) in a survey sample of 5 residents, resulting in harm for R3. Findings included: For R3, the facility staff failed to implement interventions to prevent the development of and failed to identify and treat a pressure injury until at an advanced stage of wound deterioration, requiring sharps debridement (cutting the dead tissue out), which constituted harm. Review of the clinical record was conducted on 6/17/2024 -6/18/2024 and 6/20/2024. R3 was admitted on [DATE] with diagnoses including but not limited to: Cerebral infarction, difficulty in walking, muscle wasting and atrophy, type 2 diabetes mellitus without complications, hyperlipidemia, and essential (primary) hypertension. R3 was discharged from the facility on 4/29/24. R3's Admission MDS (Minimum Data Set - assessment tool) with an ARD (Assessment Reference Date) of 4/14/2024, coded R3 as having had range of motion impairments bilaterally in upper and lower extremities. R3 was coded as having been dependent in all ADLs (Activities of Daily Living), except eating and oral hygiene. This assessment had no coding for a pressure wound noted but R3 was coded to be at risk for development of pressure ulcer/injuries, based on formal assessments and clinical assessments. R3's baseline care plan did not address any skin breakdown and/or wound. The only notation regarding skin was an approach that read as follows: . SKIN: Resident will be provided skin care to prevent skin breakdown. Review of R3's progress notes and assessments revealed no documentation of any skin issues being present upon admission. On 4/10/24, R3 had labs drawn. A CBC (complete blood count) and CMP (complete metabolic panel). R3's prealbumin, albumin and protein were within normal limits and R3's physician gave no new orders in response to the lab values. According to R3's Braden scale for predicting pressure sore risk assessment, conducted on 4/16/24, R3 was assessed having a score of 12, which indicated high risk for pressure ulcer development. In the section for interventions, nothing was checked/selected. Under the section for plan of care, nothing was checked. On the same day, a weekly skin observation was conducted and documented no skin issues noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/23/24, R3 had another Braden scale for predicting pressure sore risk assessment conducted. R3 was assessed as having a score of 13, which indicated a moderate risk. Under the interventions section, it noted, skin and ulcer/injury treatments, which included but were not limited to: pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care ., none of which were selected. This assessment's alternative option, none of the above were provided, was selected. On the same day, 4/23/24, a weekly skin observation was conducted at 3:07 p.m. and noted no skin issues noted. On 4/30/24, a Braden scale for predicting pressure sore risk was completed, which was the day following R3's discharge home. This assessment identified R3 as being high risk and the interventions of pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, and application of dressings to feet, were all selected. R3's physical therapy notes dated 4/22/24, read in part, .Directed pt [patient] in rolling bilaterally w/ [with] total A [assistance] w/ pt observed to moan in pain throughout. Pt's wife was present this date and reported that pt has significant skin breakdown on his sacral/buttocks region which causes him pain w/ movement. Repositioned pt in R [right] side lying to offload his sacral/buttocks region. Then immediately reported the wife's concerns to the nurse who reports that the wound care nurse will assess and provide tx [treatment] as needed . On 4/22/24, R3 was seen by the nurse practitioner. The NP's note read in part, Chief complaint/Reason for this visit: . Has an abrasion on coccyx . Has a small abrasion on sacral area about 3 cm circular with superficial depth. Pink with granulation tissue in base. No drainage or erythema. Will change daily and refer to wound team . On 4/25/24, R3 was seen by a wound specialist. The wound specialist's note read in part, . pt [patient] was noted a few days ago to have some peeling of the skin and discoloration at his sacral region. Aid was present today and reported that when she was cleansing the pt the skin peeled at there was an ulceration underneath . Sacrum (+) full thickness ulceration that measures 5.4 x 5.5 x 0.2 cm. wound base 40% intact, 20% slough, 5% deep purple, 35% granular before debridement . Performed excisional debridement [cutting dead tissue out] of sacrum wound(s) consisted of: Ulceration site(s) was/were prepped and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic [dead] tissue with a 5mm curette [sharp cutting tool]. There was scant bleeding that quickly subsided with light pressure and cleansing. Patient appeared to tolerate procedure without pain or signs of discomfort . The wound specialist also documented that the wound to be a stage 3 pressure injury. Orders from the wound specialist for treatment of the wound were to -Cleanse site with normal saline or sterile water (Do not use wound cleanser, this may decrease effectiveness of Santyl (collagenase), Apply Santyl (collagenase) ointment (nickel thickness) to wound base- (tx for enzymatic debridement), Cover with foam dressing, provide this care daily and as needed for saturation or soilage . (continued on next page)

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Clarksville Health & Rehab Center	184 Buffalo Road Clarksville, VA 23927

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/27/2024 at 7:24 a.m., a late entry was made for 04/23/2024 of a nursing note about R3 that that read, CNA [certified nursing assistant] reported open area to sacrum. Nurse approximated edges 2cm x 1 cm no depth. Wound base red in color. Small amount of serous drainage noted. Area cleansed with wound cleanser; zinc-based cream applied. Speaking with CNA and looking through chart resident is eating less than 25% at meals. NP aware of findings. Air mattress and wedge for turning and repositioning in place. On 4/27/24, a wound management detail report was entered into R3's chart, by the wound treatment nurse. This document noted the following: Pressure Ulcer: wound type: pressure ulcer, wound location: sacrum, Date/time identified: 4/23/24 13:00, Present on admission/re-entry? No . Observation: Date/time observed pressure ulcer: 4/25/24 at 7:08 a.m. length: 5.4 cm, width: 5.5 cm, can depth be measured? Yes, depth: 0.2, exudate: moderate, . stage: Stage III, tissue type: slough, percent of wound covered by granulation tissue: 35, percent of wound covered by eschar tissue: 5, percent of wound covered by clean, non-granulation tissue: 40, wound edges/margins: edge attached to base, skin surrounding wound: pink/normal, wound healing status: declining, created date/time: 4/27/24 7:14 a.m The above noted form went on to note a second observation that was listed as the following: date/time observed pressure ulcer: 4/23/24 13:00, length: 2 cm, width 1 cm, can depth be measured: no, exudate: light, exudate color and consistency: serous (clear, amber, thin and watery), tissue type: closed/resurfaced, percent of wound covered by clean, non-granulation tissue: 100, wound edges/margins: edge attached to base, skin surrounding wound: assess within 4 cm of wound edge: pink/normal, wound healing status: stable, created date/time: 4/27/24 at 7:08 a.m According to R3's physician orders, on 4/27/24, orders were entered that read, Air mattress to bed, and wedge in place for turning and repositioning, with an effective date of 4/23/24. According to the MAR (medication administration record), neither were signed off as being in place until the night shift on 4/26/24. On 4/23/24, R3 was ordered and started on pro-stat, vitamin C, and zinc for wound healing. The were no record of these interventions prior to R3's wound development, including being in place as preventative measures. According to the medication administration record, R3 had heel protectors bunny boots ordered 4/27/24. Based on the Braden assessments, R3 was identified to be at high risk for development of pressure ulcer development, but there was no evidence of any interventions other than routine care and services provided to all residents. Additionally, R3 had no orders for any wound care implemented until 4/26/24. On 6/17/24 at 3:17 p.m., an interview was conducted with LPN #1. LPN #1 recalled R3 and said, He was very debilitated and was completely dependent on staff for bathing and even eating . he didn't get out of bed daily . he did have a problem on his bottom. When asked if it was present on admission, LPN #1 said, I don't believe it was present on admission. When asked if R3 was on an air mattress, LPN #1 said, We were trying to do turning and repositioning as he would allow, and we put an air mattress on after the wound. LPN #1 confirmed the air mattress was in response to the wound and not placed prior to wound development as a preventative measure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/18/24 at 9 a.m., the facility administrator and Director of Nursing (DON) were asked to provide any evidence they had for consideration of past non-compliance, in light of these findings. They provided a binder that they said was their risk documents. The surveyor asked them to provide a summary of what they found to be the deficient practice, what they did, and when they felt they were in compliance. The facility administrator returned and said, There wasn't any deficient practice, and provided a statement that read as follows, [R3's name redacted]- open area identified. On 4/23/24 CNA reported to nurse that while she was bathing resident his skin peeled off on his sacrum. Nurse cleansed area with wound cleanser and treatments put in place. MD notified. Treatment initiated. Seen by wound provider on 4/25. Treatment changed. 4/26 nurse notified wound provider. Sacral wound worsening. Requesting telehealth visit for 4/29 to determine if sacral may be a KTU [Kennedy terminal ulcer] vs. PI [pressure injury]. Patient discharged prior to telehealth visit. Date of compliance 5/23/24. Ongoing monitoring of any impaired skin integrity. Within this facility provided risk binder with regards to R3, it included staff education and sign-in sheet that had written, pressure ulcer prevention/basic skin care education. Included were documents that read, basic skin care for the CNA/STNA [certified nursing assistant/state tested nurse aide]. It was noted that 28 of the nursing staff had not signed as having received the education. Also within this facility provided risk binder with regards to R3, there was a document titled, Facility Acquired Injuries Investigation Tool, which read in part, Date ulcer identified: 4/23/24, Ulcer us [sic] properly diagnosed as a pressure ulcer? yes . Is the new ulcer in a site of a previously healed ulcer of any type? no. Location of ulcer: Sacrum. Stage of PU [pressure ulcer] at discovery: 3, Is the resident diabetic? no. Prevention strategies that were in place prior to ulcer development: air mattress, turning and repositioning program, heels floated, chair cushion, heel protector/prevalon boots. Nutritional Interventional: multivitamins, Vitamin C, zinc, pro stat 30 ml BID [twice daily] and boost . Is nutritional intake what registered dietician recommends? yes . Another exerpt from this facility acquired injuries investigation tool document went on to read, 1. Is the injury to the patient's skin a pressure ulcer? yes . 3. Discovery date and stage of facility acquired pressure ulcer; 4/23/24, stage 3. 4. document details of event: CNA reported doing incontinence care . Root cause identified for pressure ulcer development? no responses were recorded; this section was blank. What the pressure injury: avoidable or unavoidable (Circle) was blank, with neither option circled. Action Plan for Improvement/Treatment of Pressure Injury, was blank with nothing listed. This document was signed by the facility's wound treatment nurse and dated 4/23/24. On 6/18/24 at 1:56 p.m., the wound treatment nurse was interviewed. The wound treatment nurse reported that the residents' have their skin assessed on admission and then weekly thereafter. The wound treatment nurse said that if a wound is noted, staff would let her know, she woud have the wound specialist see the resident to stage the wound, and get an order from the resident's doctor for treatment, until the wound specialist sees the resident. The wound treatment nurse went on to say that she rounds with the wound specialist, who would tell me what she wants for orders, and we discuss it during our at-risk meeting. The wound treatment nurse also said, If at risk, we put things in place like air mattress, turn and repositioning, and talk to the dietician about vitamins, prostat, etc. During this interview, the treatment nurse was asked about the turning and repositioning and barrier cream, which she confirmed is routine care for all residents. When asked to describe what additional measures were put in place, since R3 was total care, unable to reposition to alleviate pressure, and had a Braden score that identified him to be high risk for wound development, the treatment nurse asked if she could get back to the surveyor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	When asked about the treatment to R3's wound, the wound treatment nurse stated that on 4/26/24, she identified the wound had worsened, and had an onion odor. The treatment nurse stated she called the wound practitioner who gave the order to cleanse with Dakin's. The clinical record revealed that, on 4/27/24, the wound care order was entered as a late entry for 4/26/24, and read, Cleanse stage 3 PI [pressure injury] to sacrum with Dakins, apply Santyl and foam dressing change QD [every day] and PRN [as needed]. According to the medication administration record (MAR), treatment to the wound was not performed until 4/27/24. When asked about these findings, the wound treatment nurse stated that the Santyl had to be ordered and they had to wait for it to arrive. When asked about the late entry, the wound treatment nurse said that at times she gets busy and will remember later and go back in and chart. On 6/18/24 at 3:30 p.m., a follow-up interview was conducted with the treatment nurse. When asked about R3's air mattress, the wound treatment nurse said, We put the air mattress on right after found [referring to the wound]. The wound treatment nurse was shown R3's MAR and asked why the air mattress was showing as having been ordered on 4/23/24 but was not signed off as being in place until 4/26/24. The wound treatment nurse said, I recall putting the air mattress on, on the 23rd, when we found it [the wound], but didn't address that the order had not been entered until 4/27/24. On 6/18/24 at 4:05 p.m., during an end of day meeting, the facility's administration and corporate staff were made aware of the above findings. They were asked to provide any additional information to the survey team upon their return on 6/20/24. On 6/20/24 at 9:04 a.m., the facility's director of nursing (DON) provided the survey team with documentation of the specifications of the mattress that they had on R3's bed. The DON said, it is a pressure relieving mattress and he [R3] was being turned and repositioned, was getting up into recliner chair with a cushion and therapy was working with him. When asked if they had documentation/evidence of the turning and repositioning, the DON said they did not. On 6/20/24 at 9:44 a.m., an interview was conducted with LPN #3, who was the unit manager where R3 resided. LPN #3 explained that Braden scales are conducted on admission to identify if a resident is at risk for development of pressure ulcers. LPN #3 went on to say, At that time we can put stuff in place to prevent that, we would have them on an air mattress, on a turn and repositioning, and use barrier cream. LPN #3 confirmed that turning and repositioning and barrier cream are standard and routine care practices used for all residents who are incontinent. On 6/20/24, interviews were conducted with the treatment nurse and LPN #6. Both confirmed that all the mattresses in use at the facility are pressure reducing and are standard for all residents, as well as the use of barrier cream for incontinent residents. Each of them also confirmed that turning and repositioning is part of routine care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/20/24 at 2:45 p.m., an interview was conducted with CNA #2. CNA #2 reported that R3 had peeling skin on his buttocks, and she was going to put cream [she clarified to be barrier cream] on the bleeding spot that had been there a couple of days. CNA #2 said, The peeling wasn't where the bleeding spot was. CNA #2 explained when she moved her hand, R3's skin stuck to her glove and came off. CNA #2 said that the area started to bleed and she notified the nurse immediately. CNA #2 reported that R3 would get up around 10:30 a.m. to 11 a.m., into a recliner chair daily, would be returned to bed for incontinence care around 3-3:30 p.m., would be gotten back up following the incontinence care until after supper, and would be put back to bed for the day around 6 p.m. CNA #3 said towards the end of his stay at the facility, R2 would want to stay in bed more and once in a while would say his bottom was hurting. When asked about R3's bed and if an air mattress was on the bed, CNA #3 reported that the air mattress was put on the bed sometime after the incident on 4/23/24, indicating maybe the following day but wasn't sure. On 6/20/24 at approximately 5:30 p.m., a phone interview was conducted with the wound specialist. The wound specialist stated that when she saw the wound .it was irregular shaped, the tissue loss was not the whole wound, but it was 20% and it was deep purple. The wound specialist was unable to say how long it would take for such a wound to develop but said that upon her assessment of R3, she would not have anticipated the wound to deteriorate rapidly and did not feel the resident was in organ failure or significantly compromised. On 6/20/24, a review was conducted of the facility's 24-hour nursing reports. R3 was not noted on any of the reports during his stay at the facility. When a resident with the same first initial and last name was noted with a right leg wound, a clinical record review confirmed it was not R3, which the Regional [NAME] President of Operations also confirmed that it was not R3. On 6/20/24, a review was conducted of the facility's at-risk meeting minutes for the time frame R3 was a resident of the facility. R3 was not noted on any of the documents. On 6/20/24 at approximately 4:30 p.m., a meeting was held with the Regional [NAME] President of Operations (RVPO). When asking if the survey team was going to accept past non-compliance, the RVPO asked if he had seen the evidence provided to the survey team, he said he had not. The RVPO then joined the surveyor in the conference room and was given the facility's Risk binder with regards to R3. Upon being handed the binder, the RVPO said, well, I'm used these binders being about this thick [and noted about an inch- inch and 1/2 thick, with a hand gesture] and said, I see what you mean. The RVPO began looking through the binder and identified that many of the facility staff had not signed the education. The RVPO was also notified that when asked what the deficient practice was that had been identified and put a plan in place to correct, the facility administrator told the survey team, no deficient practice was noted. The RVPO was then notified that past non-compliance had not been achieved. Review of the facility policy titled, Skin and Wound Care Best Practices, was conducted. This policy read in part, 1. Skin care and pressure injury prevention: provide pressure reduction/redistribution for those at risk: offload/suspend heels for at risk residents, reposition at a frequency determined by risk assessment to avoid pressure to bony prominences, provide pressure redistribution/relief devices according to interdisciplinary assessment and recommendation . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled, Pressure Injury Prevention and Treatment Policy, was reviewed. This policy read in part, Residents admitted with existing pressure injuries will receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable . Residents will be assessed for pressure injury risk on admission . using the Braden Scale for Predicting Pressure Ulcer Risk . The policy titled, Resident Review Meeting Best Practice, was reviewed. The policy read in part, The interdisciplinary team will meet on a weekly basis to conduct a review of all residents who have experienced a change in condition, weight loss, acute infections, skin conditions, falls during the week and/or ongoing behaviors. The team will conduct a comprehensive review of the resident's clinical record to ensure develop and implementation of the necessary interventions to address each resident's specific risk has taken place and is appropriate for the resident F. The residents risk assessments will be reviewed, and re-assessment will be completed as deemed necessary . On 6/20/24, during an end of day meeting, the facility's director of nursing and corporate staff was made aware of the above findings. No further information was provided.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on staff interviews, resident interviews, clinical record and facility documentation, the facility staff failed to provide pain management, resulting in numerous instances of untreated pain, which constituted harm for one resident (Resident #2 - R2), in a survey sample of five residents. The findings included: For R2, who had a right hip fracture of unknown origin, the facility staff failed to respond to and treat the resident's documented complaints of unrelieved pain on 12 occasions, which adversely affected her level of physical functioning in therapy and constituted harm. Resident #2 (R2) was admitted to the facility on [DATE]. Diagnoses for R2 included, but were not limited: to cerebral infarction unspecified, muscle weakness and unspecified fracture of the lower end of left radius. R2's quarterly Minimum Data Set (MDS), (an assessment protocol) with an Assessment Reference Date of 4/14/23 coded R2 with a BIMS (brief interview for mental status score) of 7, which indicated severely impaired cognition. R2's most recent MDS, with an ARD of 3/13/24, noted R2 had a BIMs of 0. According to the MDS completed in April 2023, R2 required extensive assistance of staff for activities of daily living (ADLs), to include walking, and R2 was noted to have no limitation in her range of motion in her lower extremities. On 6/17/24, during the surveyor's investigation of an injury of unknown origin, a clinical record review was being conducted. According to the physician orders, on 5/24/23, an order was made for an x-ray of the right hip that read, x-ray of right hip. Unable to walk with therapy . There was a nursing note entry dated 5/25/23, that read, Spoke with nurse [name redacted] at [hospital name redacted]. Resident admitted to 5 east with right hip fx [fracture]. Nurse stated ortho recommended surgical intervention. According to R2's nursing progress notes, there was no indication of pain or events leading to the fracture prior to the order for the x-ray. There was a progress note from the nurse practitioner dated 4/27/23, R2 was seen for CC: [chief complaint] Trouble with right foot bending back under wheelchair when husband was pushing her along in the hall. Assisted them back to room. According to the progress note from the NP, both R2 and her roommate, who is her spouse have cognitive impairments. According to the note, it read in part, ROS: [review of systems] UTO [unable to observe] due to confusion. The note indicated a physical exam was conducted which included: vital signs, general, eyes, ENT [ears, nose, and throat], Neck, Respiratory system, CV [cardiovascular], Abdomen, skin, neurological, psychological, and musculoskeletal systems. The musculoskeletal section read, no contractures, nml [normal] muscle tone, symmetrically reduced strength. There was no indication that the R2's range of motion was assessed for her right foot, nothing about pain, nor any orders or communication to nursing to monitor for changes or pain. On 6/17/24, the director of nursing (DON) was asked to provide any facility documentation with regards to incidents involving R2, prior to the hip fracture. The DON reported there were no incidents/events. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/18/24 at 1:50 p.m., an interview was conducted with the NP, who had witnessed R2's incident of having her right foot dragged under the wheelchair on 4/27/23. The NP said that she had a vague recollection of the incident. The NP stated, They [R2 & R5] were between the chapel and the front offices in the facility. The NP stated that she had been walking behind them and noticed that R2's right foot was bent backwards under the wheelchair. The NP stated that she stopped the couple in the hallway and fixed R2's foot and assisted the couple back to their room. When asked if she assessed R2, the NP said that she did not assess at that time because she did not think it was a serious incident, she just helped them back to the room. When asked if she reported the event to nursing, she stated the day the incident happened was her first day at the facility and that she hadn't known anyone and did not report it to anyone. On 5/20/23, the medical doctor (MD) saw R2 for chronic care management discussion. The physician's note documented that urinary retention was addressed, a urinary catheter was reinserted, and noted that a urology consult was pending. On 5/24/23, the NP's note documented that she saw R2 due to physical therapy's report that R2 had not been able to do therapy due to complaints of right hip pain, that an x-ray of the right hip was ordered, and that results showed right hip fracture, for which the NP ordered R2 be sent to the emergency department for evaluation. On 5/26/23 the NP saw R2 for re admission back to the facility after R2's hospital stay. The NP's note had that the family opted for conservative nonsurgical treatment and that R2's pain was being controlled with the current medications. On 6/17/24, an interview was conducted with R2. R2 was noted with cognitive impairments and when asked about the incident from April 2023, and the hip fracture from May 2023, R2 had no recall of either events. On 6/18/24, an interview was conducted with certified nursing assistant, (CNA3). CNA3 was asked about R2 and if she had noticed any changes in the resident prior to the discovery of the hip fracture. CNA3 reported that R2 was moving slow in the mornings and was having some discomfort. CNA3 went on to say that R2 was not putting her right foot down when pivoting/turning, and said, I could tell she was in pain. When asked, what she does when she notices this, CNA3 said that she tells the nurse. The facility had no documentation/evidence of what CNA's report to the nurses to provide to the survey team. On 6/18/24 at 10:00 a.m., an interview was conducted with license practical nurse #9 (LPN9). LPN9 said, If the patient had a decline or change in status, we notify the nurse practitioner, (NP) or the medical doctor, (MD). If the NP or MD is on the unit that we would tell them of the concerns. If the NP or the MD is not in the facility, a communication sheet was filled out or a phone call was made to the provider. LPN9 verbalized that no daily report is received from therapy and that .the therapy staff does not communicate much with nursing department . If therapy staff had a concern that the NP or MD needed to be made aware, then therapy would communicate that with nursing. On 6/18/24, the communication book for R2's providers (doctor and nurse practitioner) was reviewed. The communication book did not have any information dating back to April and May 2023. The Director of Nursing was asked to provide the communication sheets from April and May 2023, but stated that she was not able to find them. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/18/24 at 10:15 a.m., an interview was conducted with OS4, one of the therapy staff, who had worked with R2. OS4 verbalized that a combination of things happened to contribute to R2's decline in therapy, including that R2 verbally refusing and that R2 was having pain that proceeded over a period of days to weeks. When questioned further, OS4 stated that she would talk with aides and nursing about pain medication. OS4 verbalized that if a resident was having pain that after a period of days, would have them put on the short list, which is the MD sheet, to be seen. OS4 verbalized that if it was something she could physically see, I would report it to the nurse on the floor and to the unit manager so the resident can be seen. No documentation was found to evidence this was done. On 6/18/24, an interview was conducted with the DON and the acting administrator. The acting administrator verbalized that the expectation is for anyone to report incidents, assess the resident for injury, assess the resident for pain, and to report any instances of pain so follow up can be done by nursing. The DON said that the purpose of the incident forms was to be completed, so follow up and ongoing monitoring could be completed by nursing. On 6/20/24, a clinical record review of R2's occupational therapy (OT) notes was conducted, which revealed the following: 1. On 5/4/23, the OT note documented that R2 had pain at 5/10 static sitting and 10/10 [severe pain] with standing and weight bearing. The note had no intervention for the pain or that nursing or the provider was made aware of the pain. 2. On 5/8/23, the OT note read in part, .pt [patient] not tolerating tx [treatment] session well this date 2nd to pain and fatigue . patient experienced pain? yes to right hip. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 3. On 5/11/23, the OT note documented that R2 was experiencing pain to right lower leg, had right lateral leaning present, and was needing maximum assistance. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 4. On 5/16/23, the OT note documented that R2 refused to stand, was non-weight bearing to right lower extremity (leg), and that R2 had pain in the right hip. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 5. On 5/17/23, the OT note documented R2 had increased pain with movement and extension and that R2 had pain to right hip. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 6. On 5/18/23, the OT note documented that R2 had pain that was at 10/10 (severe) to right lower leg and indicated OT spoke with physical therapy about right lower extremity contracture. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. On 6/20/24, a clinical record review of R2's physical therapy (PT) notes was conducted, which revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	1. On 5/1/23 at 4:03pm, the PT note documented .patient refused to transfer to chair or to ambulate and that patient had experienced pain to right lower extremity [leg]. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 2. On 5/2/23, the PT note documented patient refused to perform exercises due to all over pain. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 3. On 5/4/23, the PT note documented that R2 required cues to place right foot on the floor to accept weight. The note also documented that R2 displayed limited standing, weight shift, and had pain to right lower extremity. 4. On 5/5/23 at 4:41 p.m., PT note documented that R2 displayed leaning to the left, refused to put weight on right lower extremity, and with each sit to stand, pain worsened in weight bearing to right lower extremity. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. (Tylenol was administered at 10:01 p.m., according to the MAR.) 5. On 5/9/23, PT note documented .patient requested to lay down due to pain and fatigue . The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 6. On 5/11/23, the PT note documented that R2 had pain to right lower extremity but had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 7. On 5/12/23, the PT note documented that R2 was leaning to the left, avoiding full weight on right lower extremity, required cues to weight bear, and was experiencing pain. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 8. On 5/16/23, the PT note documented that R2 had patient experienced pain to right lower extremity and communicated with nursing symptoms that supported the need to check R2 for urinary tract infection. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 9. On 5/17/23, the PT note documented that R2 was unable to stand, patient needing max assistance and was able to balance on left lower extremity only, as R2 was . not wanting to put weight through RLE [right lower extremity] due to pain. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 10. On 5/18/23, the PT note documented that R2 had pain and tightness to right lower extremity. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. 11. On 5/19/23, the PT note documented that R2 was having right hip pain and was avoiding weight to right lower extremity. The note had no intervention for the pain or any indication that nursing or the provider was made aware of the pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495379	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Health & Rehab Center	184 Buffalo Road Clarksville, VA 23927

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F 0697 Level of Harm - Actual harm Residents Affected - Few	12. On 5/22/23, the PT note documented that R2 required constant cues to place right lower extremity flat on floor, to accept weight to the right leg, and that R2 experienced pain to right lower extremity. The PT note documented that nursing was asked to look at patient's right hip due to pain and discharged R2 from physical therapy. On 6/20/23, a clinical record review was conducted on the medication administration record (MAR), which includes a routine pain assessment every shift. The MAR revealed that R2 was assessed as having pain for 16 days from 5/1/23 - 5/24/23 and was given pain medications on six of those days from the nursing pain assessments. Pain medication, which was Tylenol, was administered on 5/1/23, 5/5/23, 5/15/23, 5/19/23, 5/21/23, and 5/24/23, but did not align with the times that therapy documented R2 was having pain. Occupational therapy documented pain on 5/3/23, 5/4/23, 5/5/23, 5/8/23, 5/11/23, 5/15/23, 5/16/23, 5/17/23, and 5/18/23, while Physical therapy documented pain on 5/1/23, 5/2/23, 5/4/23, 5/5/23, 5/9/23, 5/11/23, 5/12/23, 5/16/23, 5/17/23, 5/18/23, 5/19/23 and 5/22/23. On 5/14/23 and 5/18/23, R2's pain was documented as 10/10 or severe in the therapy notes, but according to the MAR, R2 did not receive any pain medications on those days. On 5/5/23, when therapy documented that R2 refused to put weight on right leg and pain worsened with weight bearing, R2 did not receive any medication to relieve that pain, according to the MAR. On 5/12/23, when therapy documented that the resident was unable to bear weight on right lower leg and was experiencing pain, R2 received no pain medication that day, according to MAR. On 5/17/23, when therapy documented that R2 was unable to stand and was experiencing pain, R2 received no pain medications that day, according to the MAR. On 6/20/24 at 3:45, an end of day meeting was held with the DON, the regional director of clinical services (RDCS), and the regional vice president of operations. The concerns for potential harm were discussed regarding staff's failure to assess/monitor for pain/injury after observing R2's right foot being dragged on 4/27/24, as well as the numerous instances therapy documented pain but failed to ensure relief or interventions were provided. No new information was provided. On 6/20/24 at 6:33 p.m. an exit conference meeting was conducted. The DON, RDCS, and the regional vice president of operations was in the meeting and no other information was provided at this time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41449 Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record review for 2 residents (Resident #2 - R2 and Resident #3 - R3), in a survey sample of 5 residents. The findings included: 1. For R2, the facility staff failed to maintain a complete clinical record by not having an x-ray result in the chart. On 6/17/24-6/18/24, and 6/20/24 a clinical record review was conducted of R2's chart. According to the physician progress notes, on 4/27/23 the nurse practitioner (NP) saw the R2 for trouble with right foot back under wheelchair when husband was pushing her along the hall and the NP assisted them back to room. No new orders were put in place. According to another progress note from the NP on 5/24/23, the NP saw R2 due to physical therapy had not been able to do therapy due to complained of right hip pain. The NP ordered an x-ray of the right hip. The results of the x-ray were not in R2's chart. Review of the facility's investigation file, a copy of the x-ray was noted, and the results showed a right femoral neck fracture. The NP ordered to send R2 to the emergency department for evaluation. On 5/26/24 the NP saw R2 for re admission back to the facility after R2's hospital stay. The note had that the family opted for conservative nonsurgical treatment and pain is being controlled with the current medications. 2. For R3, the facility staff failed to maintain an accurate clinical record with regards to skin assessments. A review of the closed clinical record was conducted 6/17/2024 -6/18/2024 and 6/20/2024. On 4/22/24, R3 was seen by the nurse practitioner. This note read in part, Chief complaint/Reason for this visit: . Has an abrasion on coccyx . Has a small abrasion on sacral area about 3 cm circular with superficial depth. Pink with granulation tissue in base. No drainage or erythema. Will change daily and refer to wound team . On 4/23/24, R3 had a weekly skin observation was conducted at 3:07 p.m., and it noted, no skin issues noted. On 04/27/2024 at 7:24 a.m., a late entry was made for 04/23/2024, a nursing note was entered into R3's chart that that read, CNA [certified nursing assistant] reported open area to sacrum. Nurse approximated edges 2cm x 1 cm no depth. Wound base red in color. Small amount of serous drainage noted. Area cleansed with wound cleanser; zinc-based cream applied. Speaking with CNA and looking through chart resident is eating less than 25% at meals. NP aware of findings. Air mattress and wedge for turning and repositioning in place. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24, in the afternoon, interviews were conducted with the wound treatment nurse. The wound treatment nurse stated that on 4/23/24, R3 had skin impairment that was identified by the nursing assistant. On 6/20/24, during an end of day meeting, the facility's director of nursing and corporate staff was made aware of the above findings. No additional information was provided.