STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525266	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehab Ctr	718 Jupiter Drive Madison, WI 53718

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not ensure each resident had a safe, clean, comfortable, and homelike environment or ensure housekeeping provided necessary services to maintain a sanitary, orderly, and comfortable area for 1 of 16 residents reviewed for homelike environment out of a total sample of 17 residents (R31). R31 voiced concerns related to the cleanliness of her room. Evidenced by: Resident Handbook, revised 6/8/08, includes: the facilities housekeeping staff will clean and mop resident rooms daily or more often as needed to ensure a clean, safe, and home-like environment. The facility reserves the right to clean any area or room and to remove items that prevent us safe and sanitary environment. Periodically the housekeeping department will do seasonal cleaning and floor care in resident rooms . Facility policy, entitled, Facility Resident Room Cleaning Procedure, undated, includes Wipe down with Fuzion: telephone, bedside tables, doorknobs, light switches, call light cord, windowsills, all other horizontal surfaces . Dust on Wednesdays . Sweep the entire floor . Mop the entire floor . R31 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) of ARD (Assessment Reference Date) of 6/19/24, indicates R31's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. On 7/10/24 at 10:21 AM R31 indicated housekeeping does not clean her room as often as they should. R31 pointed out her window blinds that were coated in a layer of dust, her window sills that had debris and circular stains from having had soda cans or drink cups set on it, her shelving above her tv was coated with dust, her bedside table had dried liquid stains on it, and her floor had debris settled in the corners and along the perimeter of the room. Surveyor also observed a dark brown spill and spatter under R31's bed and up on the wall behind the bed. Surveyor observed the same dark brown colored spatter to be on the wall near the door and near the dirty linen collection bin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 1:35 PM Surveyor observed R31's room and saw the dark brown spill under the bed and on the wall behind bed, the dark brown spatter on the wall and floor near the room door, the blinds to be covered in a layer of dust, both window sills to still have debris and dried liquid circular stains, her bedside table to have dried liquids stains on it, her shelving above the tv to be coated in dust, and in the corners and around the perimeter of the room there was visible debris and dust collecting. R31 stated, I think the housekeeping should come in once a day at least. On 7/15/24 at 11:26 AM Surveyor observed R31's room to still have debris and dust collecting in the corners or the room and along the perimeter/baseboards. Surveyor observed shelving behind tv to have a layer of dust on it, the bedside table to still have the same dried liquid staining, the windowsills to still have dust, debris, and dried liquids rings, the window blinds to have a layer of dust on them, and the dark brown spill and splatter near the door and under/behind the bed was still there. On 7/15/24 at 11:48 AM Surveyor and Ancillary Director G observed R31's room together noting the window blinds having a layer of dust on them, the windowsill having dried liquid rings and dust and debris settled on them, dust and debris collecting in the corners and along the baseboards, a layer of dust on the top of the wardrobe closets, and the dark brown spill and spatters near the door and under/behind the bed. Ancillary Director G indicated staff should be cleaning these areas more often. Ancillary Director G indicated when the dark brown spill/spatter happened in both areas, it should have been cleaned up immediately. Ancillary Director G indicated it is not just the housekeeping staff's responsibility to address the cleanliness of the facility. Ancillary Director G indicated R31 says at times she does not want chemical cleaners used in her room, so staff do not attempt to clean it. Ancillary Director G indicated staff could use a dust cloth for the blinds, the top of the wardrobe, and the shelving. Ancillary Director G indicated staff could use soap and water to remove the dark brown spill/spatter from the two areas. On 7/15/24 at 4:24 PM NHA A (Nursing Home Administrator) and DON B (Director of Nursing) indicated R31's room should not have a dark brown spatter under her bed and on the wall near the door for 6 days and the facility staff should be cleaning up when they see these things. NHA A indicated housekeeping are to be cleaning surfaces in R31's room regularly and there should not be debris and dust collecting on the blinds, in the windowsills, and along the baseboards.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review the facility did not develop a comprehensive person-centered care plan for 2 of 5 residents (R9 and R42) reviewed for unnecessary medications. The facility did not develop a care plan for R9 and R42's use of Melatonin (a medication used to help with sleep) for insomnia. This is evidenced by: The facility policy, titled Care Plans, Comprehensive Person-Centered, dated December 2016, states in part: .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident .Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and tehri causes, and relevant clinical decision making, When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers . Example 1 R9 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction (stroke), unspecified dementia, anxiety disorder and major depressive disorder. It is important to note, R9 does not have a diagnosis of insomnia or any other sleep disturbance disorders. R9's physician orders include Melatonin 3mg one time a day for insomnia. R9's medication administration record for June and July 2024 shows R9 has received Melatonin daily at 8:00PM. Surveyor reviewed R9's electronic health record and there is no documentation of a sleep assessment or sleep tracking. There is no evaluation of R9's sleep hygiene. Surveyor reviewed R9's comprehensive care plan. There is no care plan indicating insomnia or the use of Melatonin for insomnia. There is no evidence the facility is monitoring R9's sleep hygiene or the effectiveness of Melatonin in promoting sleep. Example 2 R42 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease and dementia. It is important to note, R42 does not have a diagnosis of insomnia or any other sleep disturbance disorders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's physician orders include Melatonin 3mg one time a day for insomnia. R42's medication administration record for June and July 2024 shows R42 has received Melatonin daily at 8:00PM. Surveyor reviewed R42's electronic health record and there is a documented sleep assessment from October 2021. There is not an up-to-date sleep assessment or sleep tracking. There is no evaluation of R42's sleep hygiene. Surveyor reviewed R42's comprehensive care plan. There is no care plan indicating insomnia or the use of Melatonin for insomnia. There is no evidence the facility is monitoring R9's sleep hygiene or the effectiveness of Melatonin in promoting sleep. On 7/16/24 at 9:25AM, Surveyor interviewed RNUM D (Registered Nurse Unit Manager). RNUM D indicated R9 and R42 should have a care plan related to sleep since they are taking medication to help them sleep and monitoring of their sleep hygiene and effectiveness of Melatonin to promote sleep. RNUM D indicated R9 and R42 should have had a sleep assessment completed. RNUM D indicated she is unaware of how frequently a sleep assessment should be conducted. On 7/16/24 at 9:59AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated R9 and R42 should have a sleep care plan in place, monitoring of their sleep hygiene and effectiveness of Melatonin to promote sleep. DON B indicated sleep assessments should be completed quarterly or at least annually. DON B indicated R9 and R42 should have had a sleep assessment completed but did not.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not ensure residents received the necessary treatment and services consistent with professional standards of practice for 2 (R7 and R12) of 5 residents reviewed with non-pressure injuries. *R7 had non-pressure injuries to the left distal shin, the left dorsal foot, and the left calf. The wounds were not comprehensively assessed weekly and the facility documentation for the location and etiology of the non-pressure injuries were not consistent with the Wound Physician. * R12 developed a non-pressure injury to the right buttock on 7/8/2024 that was not comprehensively assessed until 7/12/2024 when R12 was seen by the Wound Physician. Findings include: The facility policy and procedure entitled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 3/2014 documents: Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores, for example immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; . 4. The physician will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin alteration. Example 1 R7 was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, pulmonary fibrosis, chronic obstructive pulmonary disease, congestive heart failure, paranoid schizophrenia, depression, anxiety, and above the right knee amputation, and a history of Methicillin Resistant Staphylococcus Aureus (MRSA). R7 was diagnosed on [DATE] with chronic osteomyelitis of the left ankle and foot. R7's Annual Minimum Data Set (MDS) assessment dated [DATE] indicated R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and had two venous/arterial ulcers. R7 did not have an activated Power of Attorney. R7's Impairment to Skin Integrity Care Plan was initiated on 1/14/2021 with periodic revisions. On 2/9/2024, R7 was seen by the Wound Physician. The Wound Physician documented the following non-pressure injury assessments: -Left distal shin wound of unknown etiology measured 0.69 cm x 0.88 cm x 0.1 cm with 100% granulation. -Left dorsal foot wound of unknown etiology measured 1.4 cm x 1.4 cm x 0.2 cm with 50% slough and 50% granulation. -Left calf trauma wound measured 0.69 cm x 0.88 cm x 0.1 cm with 100% granulation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/9/2024 on the Skin & Wound Evaluation form, nursing documented the following non-pressure injury assessments: -Left front lateral lower leg proximal Stage 1 measured 0.7 cm x 0.9 cm x not applicable. The Wound Physician determined this wound was caused by trauma and not pressure. -Left front lateral lower leg arterial ulcer measured 1.2 cm x 0.9 cm x not applicable with no description of the wound bed. No documentation was found for the left dorsal foot wound on 2/9/2024 as documented by the Wound Physician. No depth measurements were documented for the wounds. LEFT FRONT LATERAL LOWER LEG PROXIMAL: -2/16/2024: Stage 1 measured 0.8 cm x 2.4 cm x not applicable with 100% eschar. -2/23/2024: Stage 1 measured 0.7 cm x 1.2 cm x not applicable with no description of the wound bed. LEFT FRONT LATERAL LOWER LEG: -2/16/2024: arterial wound measured 1.3 cm x 1 cm x not applicable with 100% eschar. -2/23/2024: arterial wound measured 1 cm x 0.6 cm x not applicable with 70% epithelial and 30% granulation. LEFT MEDIAL MIDFOOT: -2/16/2024: arterial wound measured 1.2 cm x 1.5 cm x not applicable with 70% granulation. No other tissue type was documented. -2/23/2024: arterial wound measured 1.6 cm x 1.8 cm x not applicable with 100% granulation. Surveyor noted no depths were measured for any of the non-pressure wounds and the left front lateral lower leg proximal was determined to be non-pressure by the Wound Physician. On 3/1/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessments of the non-pressure wounds. On 3/4/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury with no description of the wound base. On 3/8/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessments of the non-pressure injuries. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury. On 3/15/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the non-pressure injuries. The Wound Clinic documented wounds to the following areas left lateral shin wound (pressure per the wound clinic but non-pressure per the Wound Physician) measured 2 cm x 2 cm x 0.2 cm, and the left dorsal foot wound measured 1.5 cm x 2 cm x 0.2 cm. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left foot Stage 3, pressure injury of the left foot Stage 4, pressure injury of the left calf Stage 3, pressure injury of the left leg Stage 2, lower leg edema, sloughing of wound, open wound of the left great toe initial encounter, and deep tissue injury (no location specified.) Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match and the etiology of wounds was conflicting between the wound clinic and the Wound Physician. On 3/19/2024 at 4:57 PM in the progress notes, Registered Nurse (RN)-H documented wound care clinic pictures were uploaded from 3/15/2024 and all notes from that visit were downloaded to R7's medical record. RN-H documented R7 refused wound pictures from that morning and RN-H will attempt to obtain wound pictures at another time. The facility did not document any weekly assessments from 3/11/2024 until 3/25/2024. On 3/25/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury with no description of the wound base. On 3/29/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessments of the non-pressure wounds. On 4/1/2024 at 4:49 PM in the progress notes, RN-H documented RN-H was unable to obtain updated wound pictures due to R7's refusal (watching a movie and does not want to be disturbed). RN-H documented pictures were uploaded from R7's wound care appointment at the wound clinic on 3/29/2024. R7 was seen at the Wound Clinic on 4/5/2024 and 4/16/2024; comprehensive assessments were documented. On 4/8/2024 at 4:50 PM in the progress notes, RN-H documented RN-H was unable to obtain new pictures of R7's wound that day due to R7 being gone at an appointment that afternoon. RN-H documented R7's wound pictures were uploaded from R7's appointment on 4/5/2024 at the wound clinic and orders were updated in the computer charting system to ensure proper treatment was being done for wounds as of this past appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/2024 at 4:48 PM in the progress notes, RN-H documented R7 did not go out to the wound clinic on Friday (4/12/2024). R7 is to have an appointment on 4/16/2024 with the wound clinic. RN-H documented RN-H asked R7 if wound care and pictures could be done at two different times that day and R7 refused, not wanting to be disturbed. RN-H documented wound pictures would be downloaded to the system tomorrow after R7's appointment. On 4/26/2024 at 4:48 PM in the progress notes, RN-H documented RN-H attempted to assess and get pictures of R7's wound that day due to R7 not being seen in the wound clinic that week. R7 was asked multiple times to allow wound care to be performed by RN-H and the Wound Physician, but R7 refused every time with a different reason why each time. RN-H documented R7 had an upcoming appointment on 4/30/2024; RN-H will attempt to obtain pictures on Monday (4/29/2024), otherwise will download pictures form R7's appointment on 4/30/2024. The facility did not document any weekly assessments completed by facility staff from 3/25/2024 until 4/29/2024. On 4/29/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal continued to be documented as a Stage 1 pressure injury. On 4/30/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the non-pressure injuries. The Wound Clinic documented wounds to the following areas left lateral shin wound (pressure per the wound clinic but non-pressure per the Wound Physician) measured 3 cm x 3.7 cm x 0.2 cm, the left dorsal foot wound measured 1.8 cm x 1.4 cm x 0.1 cm, and the left lateral shin wound measured 0.5 cm x 1.2 cm x 0.1 cm. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left calf Stage 3, pressure injury of the left foot Stage 4, pressure injury of the left foot Unstageable, chronic osteomyelitis of the left foot, lower leg edema, and sloughing of wound. Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match and the etiology of wounds was conflicting between the wound clinic and the Wound Physician. On 5/2/2024, R7 was seen by a vascular surgeon where the suggested course of action was amputation of the left leg due to the fact the wounds would never heal and R7 could potentially become quite sick. R7 was not open to the option of amputation and wound care would continue. From 5/6/2024 through 5/13/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the front left lateral lower leg, proximal continued to be documented as a Stage 1 pressure injury. On 5/13/2024 on the Skin & Wound Evaluation form, nursing charted R7 had an abrasion to the left front lateral lower leg measuring 1.4 cm x 1.5 cm x not applicable with 100% granulation. Surveyor noted R7 had an arterial wound at the same location with no differentiation in proximity to the arterial wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 5/13/2024 through 5/29/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg for an arterial wound and an abrasion, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury. On 6/11/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the non-pressure injuries. The Wound Clinic documented wounds to the following areas: the left shin lateral inferior pressure injury measured 7 cm x 4 cm x 0.6 cm (the wound was documented as pressure by the wound clinic and non-pressure by the Wound Physician), the left dorsal foot wound measured 1.9 cm x 1.5 cm x 0.2 cm, and the left shin lateral superior wound measured 1.2 cm x 1 cm x 0.1 cm. The Wound Clinic documented in the assessment/plan section R7 had numerous Stage 3 and Stage 4 pressure injuries to the left lower extremity. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left foot Stage 3, pressure injury of the left foot Stage 4, open wound of the left great toe initial encounter, pressure injury of the left calf Stage 3, and chronic osteomyelitis of the left foot, lower leg edema, and sloughing of wound. Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match and the etiology of wounds was conflicting between the wound clinic and the Wound Physician. The facility did not document any weekly assessments from 5/29/2024 until 6/25/2024. From 6/25/2024 through 7/10/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left front lateral lower leg proximal, the left front lateral lower leg for an arterial wound and an abrasion, and the left medial midfoot non-pressure injuries. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury. On 7/3/2024 on the Skin & Wound Evaluation form, the left front lateral lower leg abrasion resolved. On 7/10/2024, the assessments on the Skin & Wound Evaluation forms were documented as follows: -Left medial midfoot arterial wound measured 1.8 cm x 2.5 cm x not applicable with 90% granulation and 10% slough. -Left front lateral lower leg arterial wound measured 5.9 cm x 3.6 cm x not applicable with 70% granulation and 30% eschar. -Left front lateral lower leg proximal Stage 1 measured 1.5 cm x 0.9 cm x not applicable with 90% granulation and no other tissue type documented. Surveyor noted no depths were measured and the left front lateral lower leg proximal wound continued to be documented as a Stage 1 pressure injury. On 7/12/2024, R7 was seen by the Wound Physician, the same Wound Physician that had seen R7 on 2/9/2024. The Wound Physician documented the following pressure injury assessments: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left distal shin trauma wound measured 5.87 cm x 3.61 cm x not measurable with 30% slough and 70% granulation. -Left dorsal foot trauma wound measured 1.78 cm x 2.52 cm x not measurable with dried fibrinous exudate (scab). -Left calf trauma wound measured 5.87 cm x 3.61 cm x 0.3 cm with 30% thick adherent devitalized necrotic tissue and 70% granulation. The Wound Physician documented the depth was unmeasurable due to presence of nonviable tissue and necrosis for the left distal shin and the left dorsal foot. Surveyor noted the Wound Physician documentation of the non-pressure injuries was consistent with the documentation on 2/9/2024 regarding the location of the wounds and the etiology of non-pressure. On 7/15/2024 at 12:07 PM, Surveyor observed RN-H provide wound care to R7. R7 was in bed with Kerlix wrapped around the lower left leg. R7 stated R7 has no pain or feeling from the ankle down, but the wounds to the side of the leg has pain. RN-H stated R7 has a lot of wounds to the left lower leg, some are pressure, and some are arterial. RN-H removed the dressings to the left lower leg revealing a wound to the top of the left foot that measured approximately 2 cm x 2 cm x 0.2 cm, a wound to the distal lateral side of the left lower leg that measured approximately 4 cm x 4 cm x 0.2 cm with 50% granulation and 50% eschar, and a wound to the proximal lateral side of the left lower leg that measured approximately 0.5 cm x 0.5 cm x 0.1 cm that was almost healed. RN-H applied the treatments to the wounds and applied bandages as ordered followed by Kerlix around the leg. RN-H stated R7 had been seen weekly by the wound care team at the clinic, but when an amputation of the leg was recommended, R7 did not want that done so the wound clinic team started treating R7 palliatively every other week and then down to once a month. RN-H stated R7 cancelled the appointment with the wound clinic today and since the Wound Physician that comes to the facility saw R7 in the past, the Wound Physician will now be following R7's wounds weekly unless R7 goes to the wound clinic that week. Surveyor asked RN-H who does the weekly wound assessments for the facility. RN-H stated RN-H puts all the measurements into the medical record but if R7 refuses to let RN-H do an assessment, RN-H gets the measurements from the wound clinic. RN-H stated R7 was in a dark place after the wound clinic told R7 of the amputation suggestion and would not let the nurses do treatments or anything. Surveyor asked RN-H if RN-H was wound care certified (WCC). RN-H stated RN-H had been trained in wounds but had not taken the WCC test yet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/15/2024 at 2:29 PM, Surveyor asked RN-H what the process was for assessing wounds. RN-H stated RN-H uses a camera that is connected to the electronic charting system; when RN-H takes a picture of the wound, the measurements are automatically entered into the chart. RN-H stated the Wound Physician will take the measurements from the picture and put that information into the Wound Physician's documentation program. Surveyor asked RN-H why no depth measurements were entered into the assessments. RN-H stated the camera does not measure the depth and the charting program does not allow any further entries into the measurement section, so it automatically fills in Not Applicable. Surveyor asked RN-H if there was a section for narrative writing that could be used to document a depth. RN-H stated yes but had not done that. Surveyor asked RN-H if RN-H reviewed the Wound Physician's documentation of the wound assessments. RN-H stated no. Surveyor shared with RN-H and Director of Nursing (DON)-B the Wound Physician documented the left front lateral lower leg proximal to be from trauma while RN-H documented the wound as a Stage 1 pressure injury. RN-H stated the wound clinic documented the wound as being pressure while the Wound Physician documented the wound as non-pressure, so RN-H was not sure how to chart the wound. Surveyor asked RN-H why there were missing weekly assessments from 3/25/2024-4/29/2024. RN-H stated R7 went to the wound clinic on 3/29/2024, 4/1/2024, 4/5/2024, 4/8/2024 and 4/16/2024 with pictures and notes uploaded from the 4/1/2024, 4/8/2024, and 4/16/2024 appointments and R7 refused in-house assessments on 4/12/2024 and 4/15/2024. RN-H stated R7 refused to see the Wound Physician on 4/26/2024 and they were unable to do an in-house assessment. Surveyor asked RN-H why there were missing weekly assessments from 5/29/2024-6/25/2024. RN-H stated the camera that was used for assessments was not working from 6/2/2024-6/15/2024 so no assessments were obtained at that time. Surveyor requested RN-H clarify the location of wounds RN-H documented and the Wound Physician documented because the names of the locations were not the same making it difficult to follow the progress of the wounds. RN-H provided written clarification of the wound locations: -Left distal shin trauma wound documented by the Wound Physician was the left lateral lower leg arterial wound documented by RN-H. -Left dorsal foot trauma wound documented by the Wound Physician was the left medial midfoot arterial wound documented by RN-H. -Left calf trauma wound documented by the Wound Physician was the front left lateral lower leg proximal Stage 1 wound documented by RN-H. RN-H stated this wound was classified as pressure due to it originally being caused by the top of R7's tubi grips (at one-point R7 had a double layer of tubi grips on top of a nylon stocking provided by the wound care clinic) and the wound clinic also documented it as pressure. On 7/16/2024 at 9:14 AM, Surveyor shared with DON-B (Director of Nursing) the concerns R7's wounds had conflicting etiology and RN-H did not clarify with either the wound clinic or the Wound Physician as to the cause of the wounds, no depth measurements were taken, and the wounds were not comprehensively assessed weekly. Surveyor asked DON-B what the expectation was for assessing wounds when the camera was not working. DON-B stated it was DON-B's expectation that wound assessments were done weekly and if the camera was not working, the measurements should be done manually. No further information was provided at that time. Example 2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12 was admitted to the facility on [DATE] with diagnoses of diabetes, malignant neoplasm of the colon, depression, glaucoma, spinal stenosis, and rectal prolapse. R12's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R12 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs. The MDS documented R12 had a catheter, an ostomy, used supplemental oxygen, and did not have any skin impairments. R12 did not have an activated Power of Attorney. R12's Activity of Daily Living (ADL) Care Plan initiated on 5/18/2022 has interventions bed mobility is with the assist of two and R12 transfers with assist of two and a [NAME] steady lift as well as a Hoyer lift. On 7/8/2024 at 3:29 AM in the progress notes, nursing documented R12 had a new blister on the right inner thigh, about the size of a pea, and an open area with redness right by the rectum. R12 complained of burning and pain. Scheduled Tylenol had been administered one hour prior. A message was left for the Nurse Practitioner and DON. The family would be called in the morning. On 7/9/2024 on the Skin & Wound Evaluation form, RN-H documented the sacrum MASD measured 4.4 cm x 4.0 cm x not applicable with 40% epithelial and 60% granulation. On 7/12/2024, R12 was seen by the Wound Physician. The Wound Physician documented the right buttock MASD measured 2.75 cm x 3.44 cm x 0.1 cm with open areas with exposed dermis. The Wound Physician documented R12 has significant rectal prolapse with ongoing moisture exposure. On 7/15/2024 at 8:38 AM, Surveyor observed RN-H provide wound care to R12. R12 was assisted to a standing position using a [NAME] steady lift. RN-H was able to access the sacral wound with R12 standing. Surveyor observed R12 had MASD to the sacrum and not specifically the right buttock, but the Wound Physician was not present, so Surveyor was unable to clarify the location of the MASD. R12 had a prolapsed rectum. RN-H stated with the prolapsed rectum, the sacral area is exposed to excessive moisture. In an interview on 7/15/2024 at 1:57 PM, Surveyor asked RN-H and DON-B what the process was for assessing wounds and how the documentation worked. RN-H stated RN-H will take a picture of the wound prior to the Wound Physician coming to the facility. RN-H stated the camera is connected to the facility electronic charting system and the measurements pre-fill into the assessment. RN-H stated the camera does not measure depth and the assessment form automatically documents Not Applicable and will not allow the depth measurement to be entered. RN-H stated the Wound Physician gets the measurements from the camera and enters that information into the Wound Physician software. Surveyor asked RN-H if RN-H looks at the Wound Physician documentation. RN-H stated no. RN-H stated the Wound Physician fills out a separate order for any treatment changes and RN-H enters that into the computer. Surveyor shared the concern R12 had a new open area to the sacrum on 7/8/2024 and the wound was not comprehensively assessed with complete measurements including depth until 7/12/2024 when R12 was seen by the Wound Physician. No further information was provided at that time.

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F 0686 Level of Harm - Minimal harm or potential for 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** 38253 Based on observation, interview, and record review, the facility did not ensure residents received the necessary treatment and services consistent with professional standards of practice for 2 (R7 and R12) of 3 residents reviewed with pressure injuries. *R7 had a Stage 4 pressure injury to the left heel, a Stage 4 pressure injury to the left lateral foot, and a Stage 3 pressure injury to the left first toe. The wounds were not comprehensively assessed weekly and the facility documentation for the staging of the pressure injuries were not consistent with the staging by the Wound Physician. *R12 developed a Stage 2 pressure injury to the sacrum on 5/24/2024 that was not comprehensively assessed until 5/31/2024 when R12 was seen by the Wound Physician. The facility documentation for the wound indicated the wound was moisture associated skin damage (MASD) and did not correlate with the Wound Physician documenting the etiology of the wound being pressure. The pressure injury was not comprehensively assessed weekly. R12 developed a Stage 2 pressure injury to the right thigh on 7/8/2024 that was not comprehensively assessed until 7/12/2024 when R12 was seen by the Wound Physician. Findings include: The facility policy and procedure entitled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 3/2014 documents: Assessment and Recognition: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores, for example immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; . 4. The physician will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin alteration. Example 1 R7 was admitted to the facility on [DATE] with diagnoses of peripheral vascular disease, pulmonary fibrosis, chronic obstructive pulmonary disease, congestive heart failure, paranoid schizophrenia, depression, anxiety, and above the right knee amputation, and a history of Methicillin Resistant Staphylococcus Aureus (MRSA). R7 was diagnosed on [DATE] with chronic osteomyelitis of the left ankle and foot. R7's Annual Minimum Data Set (MDS) assessment dated [DATE] indicated R7 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and had two Stage 1 pressure injuries, one Stage 3 pressure injury, and one Stage 4 pressure injury. R7 did not have an activated Power of Attorney. R7's Impairment to Skin Integrity Care Plan was initiated on 1/14/2021 with periodic revisions. On 2/9/2024, R7 was seen by the Wound Physician. The Wound Physician documented the following pressure injury assessments: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left heel Stage 4 measured 5.79 cm x 3.93 cm x 0.3 cm with 20% slough, 60% granulation, and 20% muscle. -Left lateral foot Stage 4 measured 6.32 cm x 3.67 cm x not measurable with 30% thick adherent devitalized necrotic tissue and 70% granulation. The Wound Physician documented the depth was unmeasurable due to the presence of nonviable tissue and necrosis. -Left toe Deep Tissue Injury (DTI) measured 0.57 cm x 4.65 cm with intact purple/maroon discoloration to the skin. On 2/9/2024 on the Skin & Wound Evaluation form, nursing documented the following pressure injuries: -Front left lateral lower leg, proximal Stage 1 measured 0.7 cm x 0.9 cm x not applicable. The Wound Physician determined this wound was caused by trauma and not pressure. -Left lateral foot Stage 4 with the same assessment as the Wound Physician. -Left dorsum 1st digit Stage 1 with the same measurements and description as the Wound Physician. The Wound physician documented the pressure injury was a DTI and not a Stage 1 pressure injury. -Left heel Stage 3 with the same length and width measurements. Nursing did not document a depth of the wound and documented 100% granulation while the Wound Physician documented Stage 4, 0.3 cm depth, and 20% slough, 60% granulation, and 20% muscle. The facility documented weekly on the pressure injuries. LEFT LATERAL FOOT: -2/16/2024: Stage 4 measured 8.6 cm x 3.2 cm x not applicable with 60% granulation and 40% eschar. -2/23/2024: Stage 4 measured 9.1 cm x 3.7 cm x not applicable with 40% granulation, 10% slough, and 50% eschar. LEFT DORSUM 1ST DIGIT: -2/16/2024: Stage 1 measured 0.6 cm x 0.8 cm with 30% granulation. No other tissue type was documented, and Stage 1 does not have granulation tissue. -2/23/2024: Stage 1 measured 0.6 cm x 3.6 cm x not applicable with 30% epithelial and 70% granulation. LEFT HEEL: -2/16/2024: Stage 3 measured 4.6 cm x 3.6 cm x not applicable with 100% granulation. -2/23/2024: Stage 3 measured 5.8 cm x 4.3 cm x not applicable with 50% granulation and 50% slough. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 3/1/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessment of the pressure injuries. On 3/4/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 3/8/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessment of the pressure injuries. On 3/11/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 3/15/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the pressure injuries. The Wound Clinic documented pressure injuries to the following areas: left heel measured 6 cm x 4.5 cm x 0.3 cm, left lateral foot measured 4 cm x 10 cm x 0.4 cm, and the left lateral inferior shin measured 2 cm x 2 cm x 0.2 cm. The left great toe was documented as an active wound with no etiology. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left foot Stage 3, pressure injury of the left foot Stage 4, pressure injury of the left calf Stage 3, pressure injury of the left leg Stage 2, lower leg edema, sloughing of wound, open wound of the left great toe initial encounter, and deep tissue injury (no location specified). Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match. On 3/19/2024 at 4:57 PM in the progress notes, Registered Nurse (RN)-H documented wound care clinic pictures were uploaded from 3/15/2024 and all notes from that visit were downloaded to R7's medical record. RN-H documented R7 refused wound pictures that morning and RN-H will attempt to obtain wound pictures at another time. The facility did not document any weekly assessments from 3/11/2024 until 3/25/2024. On 3/25/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 3/29/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic did not contain any assessment of the pressure injuries. On 4/1/2024 at 4:49 PM in the progress notes, RN-H documented RN-H was unable to obtain updated wound pictures due to R7's refusal. RN-H documented pictures were uploaded from R7's wound care appointment at the wound clinic on 3/29/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7 was seen at the Wound Clinic on 4/5/2024 and 4/16/2024 where comprehensive assessments were documented. On 4/8/2024 at 4:50 PM in the progress notes, RN-H documented RN-H was unable to obtain new pictures of R7's wound that day due to R7 being gone at an appointment that afternoon. RN-H documented R7's wound pictures were uploaded from R7's appointment on 4/5/2024 at the wound clinic and orders were updated in the computer charting system to ensure proper treatment was being done for wounds as of this past appointment. On 4/15/2024 at 4:48 PM in the progress notes, RN-H documented R7 did not go out to the wound clinic on Friday (4/12/2024). R7 was to have appointment on 4/16/2024 with the wound clinic. RN-H documented RN-H asked R7 if wound care and pictures could be done at two different times that day and R7 refused, not wanting to be disturbed. RN-H documented wound pictures would be downloaded to the system tomorrow after R7's appointment. On 4/26/2024 at 4:48 PM in the progress notes, RN-H documented RN-H attempted to assess and get pictures of R7's wound that day due to R7 not being seen in the wound clinic that week. R7 was asked multiple times to allow wound care to be performed by RN-H and the Wound Physician, but R7 refused every time with a different reason why each time. RN-H documented R7 had an upcoming appointment on 4/30/2024; RN-H will attempt to obtain pictures on Monday (4/29/2024), otherwise will download pictures form R7's appointment on 4/30/2024. The facility did not document any weekly assessments completed by facility staff from 3/25/2024 until 4/29/2024. On 4/29/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 4/30/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the pressure injuries. The Wound Clinic documented pressure injuries to the following areas: left heel measured 6 cm x 5.5 cm x 0.2 cm, left lateral foot measured 10.4 cm x 4 cm x 0.5 cm, and the left lateral inferior shin measured 3 cm x 3.7 cm x 0.2 cm. The left great toe was documented as an active wound with no etiology. The Wound Clinic documented in the assessment/plan section R7 had an evolving Stage 4 left heel pressure ulcer secondary to pressure and neuropathy that started around December 2021. R7 also had a Stage 4 pressure injury to the lateral aspect of the left foot as well as a Stage 3 pressure injury to the dorsal aspect of the left foot and the left calf. R7 had a new Stage 1 and 2 pressure injuries to the left lateral and medial shin that have since resolved. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left calf Stage 3, pressure injury of the left foot Stage 4, pressure injury of the left foot Unstageable, chronic osteomyelitis of the left foot, lower leg edema, and sloughing of wound. Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match. On 5/2/2024, R7 was seen by a vascular surgeon where the suggested course of action was amputation of the left leg due to the fact the wounds would never heal and R7 could potentially become quite sick. R7 was not open to the option of amputation and wound care would continue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 5/6/2024 through 5/29/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 6/11/2024, R7 was seen at the Wound Clinic. The documentation from the Wound Clinic included measurements for the pressure injuries. The Wound Clinic documented pressure injuries to the following areas: left heel measured 5.9 cm x 5 cm x 0.2 cm, left lateral foot measured 3.6 cm x 9.2 cm x 0.3 cm, and the left lateral inferior shin measured 7 cm x 4 cm x 0.6 cm. The left great toe was documented as an active wound with no etiology. The Wound Clinic documented in the assessment/plan section R7 had numerous Stage 3 and Stage 4 pressure injuries to the left lower extremity. The Wound Clinic documented the diagnoses for the visit included pressure injury of the left heel Stage 4, pressure injury of the left foot Stage 3, pressure injury of the left foot Stage 4, open wound of the left great toe initial encounter, pressure injury of the left calf Stage 3, and chronic osteomyelitis of the left foot, lower leg edema, and sloughing of wound. Surveyor noted the number of wounds assessed and the number of diagnoses listed did not match. The facility did not document any weekly assessments from 5/29/2024 until 6/25/2024. From 6/25/2024 through 7/10/2024, the facility completed assessments on the Skin & Wound Evaluation form for the left dorsum 1st digit Stage 1, the left lateral foot Stage 4, and the left heel Stage 3 pressure injuries. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 7/10/2024, the assessments on the Skin & Wound Evaluation forms were documented as follows: -Left dorsum 1st digit Stage 1 measured 1.3 cm x 1.7 cm x not applicable with 100% granulation. -Left heel Stage 3 measured 7 cm x 6 cm x not applicable with 70% granulation and 30% eschar. -Left lateral foot Stage 4 measured 5.3 cm x 2.3 cm x not applicable with 30% epithelial, 60% granulation, and 10% slough. Surveyor noted no depths were measured and the staging of the left dorsum 1st digit and the left heel were not accurate. On 7/12/2024, R7 was seen by the Wound Physician, the same Wound Physician that had seen R7 on 2/9/2024. The Wound Physician documented the following pressure injury assessments: -Left heel Stage 4 measured 6.96 cm x 6.03 cm x 0.3 cm with 80% granulation and 20% muscle. -Left lateral foot Stage 4 measured 5.27 cm x 2.34 cm x 0.2 cm with 100% granulation. -Left toe Stage 3 measured 1.34 cm x 1.69 cm x 0.2 cm with 100% granulation. Surveyor noted the Wound Physician documentation of the pressure injuries was consistent with the documentation on 2/9/2024 regarding staging of the wounds; the left toe pressure injury changed from a DTI to a Stage 3 pressure injury due to the characteristic of an open wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/2024 at 12:07 PM, Surveyor observed RN-H provide wound care to R7. R7 was in bed with Kerlix wrapped around the lower left leg. R7 stated R7 has no pain or feeling from the ankle down, but the wounds to the side of the leg has pain. RN-H stated R7 has a lot of wounds to the left lower leg, some are pressure, and some are arterial. RN-H removed the dressings to the left lower leg revealing a wound to the upper knuckle joint of the great toe measuring approximately 2 cm x 2 cm x 0.2 with bloody drainage, a wound to the lateral foot measuring approximately 2 cm x 6 cm x 0.2 cm with dry pink tissue in the wound bed, and a wound to the heel measuring approximately 9 cm x 6 cm x 0.3 cm with granulation and slough to the wound bed. RN-H applied the treatments to the wounds and applied bandages as ordered followed by Kerlix around the leg. RN-H stated R7 had been seen weekly by the wound care team at the clinic, but when an amputation of the leg was recommended, R7 did not want that done so the wound clinic team started treating R7 palliatively every other week and then down to once a month. RN-H stated R7 cancelled the appointment with the wound clinic today and since the Wound Physician that comes to the facility saw R7 in the past, the Wound Physician will now be following R7's wounds weekly unless R7 goes to the wound clinic that week. Surveyor asked RN-H who does the weekly wound assessments for the facility. RN-H stated RN-H puts all the measurements into the medical record but if R7 refuses to let RN-H do an assessment, RN-H gets the measurements from the wound clinic. RN-H stated R7 was in a really dark place after the wound clinic told R7 of the amputation suggestion and would not let the nurses do treatments or anything. Surveyor asked RN-H if RN-H was wound care certified (WCC). RN-H stated RN-H had been trained in wounds but had not taken the WCC test yet. In an interview on 7/15/2024 at 2:29 PM, Surveyor asked RN-H what the process was for assessing wounds. RN-H stated RN-H uses a camera that is connected to the electronic charting system; when RN-H takes a picture of the wound, the measurements are automatically entered into the chart. RN-H stated the Wound Physician will take the measurements from the picture and put that information into the Wound Physician's documentation program. Surveyor asked RN-H why no depth measurements were entered into the assessments. RN-H stated the camera does not measure the depth and the charting program does not allow any further entries into the measurement section, so it automatically fills in Not Applicable. Surveyor asked RN-H if there was a section for narrative writing that could be used to document a depth. RN-H stated yes but had not done that. Surveyor asked RN-H if RN-H reviewed the Wound Physician's documentation of the pressure injury assessments. RN-H stated no. Surveyor shared with RN-H and Director of Nursing (DON)-B the Wound Physician documented the left heel to be a Stage 4 pressure injury while RN-H documented the left heel was a Stage 3 pressure injury and the Wound Physician documented the left great toe was a DTI and then a Stage 3 pressure injury while RN-H documented the left great toe was a Stage 1 pressure injury, even after the wound opened. RN-H stated RN-H thought the staging of a wound could not be changed. DON-B educated RN-H on how the staging of a pressure injury can go from a Stage 1 to a 2, 3, or 4, but the staging number could not get smaller. RN-H stated that was RN-H's misunderstanding of how pressure injuries were staged. Surveyor asked RN-H why there were missing weekly assessments from 3/25/2024-4/29/2024. RN-H stated R7 went to the wound clinic on 3/29/2024, 4/1/2024, 4/5/2024, 4/8/2024 and 4/16/2024 with pictures and notes uploaded from the 4/1/2024, 4/8/2024, and 4/16/2024 appointments and R7 refused in-house assessments on 4/12/2024 and 4/15/2024. RN-H stated R7 refused to see the Wound Physician on 4/26/2024 and they were unable to do an in-house assessment. Surveyor asked RN-H why there were missing weekly assessments from 5/29/2024-6/25/2024. RN-H stated the camera that was used for assessments was not working from 6/2/2024-6/15/2024 so no assessments were obtained at that time. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/16/2024 at 9:14 AM, Surveyor shared with DON-B the concerns R7's pressure injuries were not staged accurately according to the Wound Physician documentation, no depth measurements were taken, and the pressure injuries were not comprehensively assessed weekly. Surveyor asked DON-B what the expectation was for assessing wounds when the camera was not working. DON-B stated it was DON-B's expectation that wound assessments were done weekly and if the camera was not working, the measurements should be done manually. No further information was provided at that time. Example 2 R12 was admitted to the facility on [DATE] with diagnoses of diabetes, malignant neoplasm of the colon, depression, glaucoma, spinal stenosis, and rectal prolapse. R12's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R12 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and had impairment to both arms and legs. The MDS documented R12 had a catheter, an ostomy, used supplemental oxygen, and did not have any skin impairments. R12 did not have an activated Power of Attorney. R12's Activity of Daily Living (ADL) Care Plan initiated on 5/18/2022 has interventions bed mobility is with the assist of two and R12 transfers with assist of two and a [NAME] steady lift as well as a Hoyer lift. R12's Potential for Pressure Related Skin Injury Care Plan initiated 9/4/2018 had the following interventions in place on 5/24/2024: -Administer treatments as ordered and monitor for effectiveness. -Air mattress with setting of 5. (revised 5/11/2021) -Assistance to turn/reposition at least every 2 hours, more often as needed or requested. -Encouragement to use bilateral grab bars to assist with turning. -Pressure relieving/reducing device on bed/chair. -R12 will take a nap every afternoon to relieve pressure to the bottom. -Educate R12/family/caregivers as to causes of skin breakdown. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. -If R12 refuses treatment, confer with R12, interdisciplinary team, and family to determine why and try alternative methods to gain compliance, document alternative methods. -Monitor nutritional status; serve diet as ordered, monitor intake and record. -Roho cushion to wheelchair. -Teach R12/family the importance of changing positions for prevention of pressure ulcers; encourage small frequent position changes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Treat pain as orders prior to treatment/turning, etc. to ensure R12's comfort. -Tubi grips as ordered. R12's At Risk for Impaired Skin Integrity Care Plan initiated 4/17/2018 had the following interventions in place on 5/24/2024: -Skin prep to thighs-blisters 1/23/2023 -Apply barrier cream as needed. -Mepilex to coccyx for protection. -Turn/reposition every 2-3 hours and as needed. -Keep skin clean and dry; use lotion on dry skin. -Encourage good nutrition and hydration in order to promote healthier skin. -Float heels with pillows in bed. -Personal Roho cushion when in chair. -Specialty air mattress in bed: Setting 3 (initiated 9/27/2022). -Treatment per physician orders. -Avoid scratching and keep hands and body parts from excessive moisture; keep fingernails short. -Follow facility protocols for treatment of injury. -Monitor side effects of the antibiotics and over-the-counter pain medications. -Obtain blood work such as CBC with Diff, Blood Cultures and C&S of any open wounds as ordered by the physician. -Use a draw sheet or lifting device to move R12. The unit staff worksheet provided to Surveyor on 7/10/2024 for how to care for residents documents the air mattress for R12 is to be set at 5. Surveyor noted the ADL Care Plan had the air mattress setting at 5 dated 5/11/2021, the At Risk for Impaired Skin Integrity Care Plan had the air mattress setting at 3 dated 9/27/2022, and the current staff worksheet had the air mattress setting at 5. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/24/2024 at 6:37 AM in the progress notes, a Registered Nurse (RN) documented the night nurse gave report that R12 had a new open area to the coccyx area. The RN documented the RN assessed R12; the skin to the coccyx was red with breakdown and three open areas, likely due to pressure and moisture. The area was painful to touch. The area was cleansed with saline and covered with Mepilex. The Nurse Practitioner, Director of Nursing (DON), and the wound care nurse were notified. At 1:27 PM in the progress notes, the RN documented the wound care doctor was not able to see R12 due to R12 refusing. At 3:59 PM in the progress notes, RN-H documented RN-H was notified R12 had a new open area to the sacrum and the Wound Physician had already left for the day when this was reported to RN-H. RN-H attempted to obtain pictures of the wound but R12 refused stating R12 had other obligations. RN-H documented RN-H would attempt to get a picture of the wound the next week. On 5/28/2024 at 5:11 PM in the progress notes, RN-H documented RN-H was attempting to obtain a wound picture but the skin and wound app through the electronic charting system was offline and having issues. The electronic charting system company was called, they confirmed there was an outage with the system, and they are working to try to restore service. There was no estimate of when it would be fixed. On 5/29/2024 at 2:25 PM in the progress notes, an RN documented the open area to the coccyx dressings were changed with no signs/symptoms of infection. The RN documented they were able to get a picture of the wound that day. On 5/29/2024 on the Skin & Wound Evaluation form, RN-H documented the sacrum Moisture Associated Skin Damage (MASD) measured 5.5 cm x 2.5 cm x not applicable with 90% epithelial and 10% granulation. Surveyor noted no depth was measured. On 5/31/2024, R12 was seen by the Wound Physician. The Wound Physician documented the right sacrum Stage 2 pressure injury measured 2.19 cm x 0.9 cm x 0.1 cm with open areas with exposed dermis. An additional note was documented this was a reopening of a prior wound. On 5/31/2024 on the Skin % Wound Evaluation form, RN-H documented the sacrum MASD measured 2.2 cm x 0.9 cm x not applicable with 80% epithelial and 20% granulation. Surveyor noted RN-H did not change the etiology of the wound and continued documenting the wound as MASD rather than a Stage 2 pressure injury as identified by the Wound Physician. The Wound Physician documented the location of the wound to be the right sacrum while RN-H documented the sacrum without specifying the right sacrum. R12 was seen by the Wound Physician on 6/7/2024 and 6/14/2024. The Wound Physician documented the assessment of the Stage 2 pressure injury to the sacrum. RN-H documented on 6/7/2024 and 6/14/2024 on the Skin & Wound Evaluation form the MASD to the sacrum with the same length and width measurements as the Wound Physician but did not document any depth measurement and did not change the etiology of the wound. On 6/21/2024 on the Skin & Wound Evaluation form, RN-H documented the sacrum MASD measured 5.4 cm x 1.2 cm x not applicable with 80% epithelial and 20% granulation. No depth was documented, and the wound continued to be documented as MASD rather than a Stage 2 pressure injury. On 6/28/2024 on the Skin & Wound Evaluation form, RN-H documented the sacrum MASD measured 1.2 cm x 0.7 cm x not applicable with 10% granulation. No other tissue type was documented. No depth was documented, and the wound continued to be documented as MASD rather than a Stage 2 pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/5/2024, R12 was seen by the Wound Physician. The Wound Physician documented the sacrum Stage 2 pressure injury measured 0.62 cm x 0.34 cm x 0.1 cm with open areas of exposed dermis. RN-H documented on 7/5/2024 on the Skin & Wound Evaluation form the MASD to the sacrum with the same length and width measurements as the Wound Physician but did not document any depth measurement and did not change the etiology of the wound. On 7/8/2024 at 3:29 AM in the progress notes, nursing documented R12 had a new blister on the right inner thigh, about the size of a pea, and an open area with redness right by the rectum. R12 complained of burning and pain. Scheduled Tylenol had been administered one hour prior. A message was left for the Nurse Practitioner and DON. The family would be called in the morning. On 7/9/2024 on the Skin & Wound Evaluation form, RN-H documented the sacrum MASD measured 4.4 cm x 4.0 cm x not applicable with 40% epithelial and 60% granulation and the right medial thigh blister measured 0.8 cm x 1.2 cm. No etiology of the blister was documented. On 7/12/2024, R12 was seen by the Wound Physician. The Wound Physician documented the right sacrum Stage 2 pressure injury measured 0.77 cm x 0.53 cm x 0.1 cm with open areas with exposed dermis and the right thigh Stage 2 pressure injury measured 0.82 cm x 1.09 cm x not measurable with open area with exposed dermis and fluid filled blister. The Wound Physician documented additional wound detail: friction associated wound from foley catheter with resultant blister formation from abrasion/shear. On 7/15/2024 at 8:38 AM, Surveyor observed RN-H provide wound care to R12. R12 was assisted to a standing position using a [NAME] steady lift. RN-H was able to access the sacral wound with R12 standing. R12 had MASD to the sacrum as well as an open area to the right side of the sacrum that measured approximately 0.5 cm x 0.5 cm x 0.1 cm with a pink wound base. R12 had a prolapsed rectum. RN-H stated with the prolapsed rectum, the sacral area is exposed to excessive moisture. Surveyor observed a Roho cushion in R12's wheelchair and Surveyor asked RN-H what the air mattress setting was set to. RN-H replied 5. RN-H completed the dressing change to the sacrum. Surveyor did not observe the blister to the right thigh. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/15/2024 at 1:57 PM, Surveyor asked RN-H and DON-B what the process was for assessing wounds and how the documentation worked. RN-H stated RN-H will take a picture of the wound prior to the Wound Physician coming to the facility. RN-H stated the camera is connected to the facility electronic charting system and the measurements pre-fill into the assessment. RN-H stated the camera does not measure depth and the assessment form automatically documents Not Applicable and will not allow the depth measurement to be entered. RN-H stated the Wound Physician gets the measurements from the camera and enters that information into the Wound Physician software. Surveyor asked RN-H if RN-H looks at the Wound Physician documentation. RN-H stated no. RN-H stated the Wound Physician fills out a separate order for any treatment changes and RN-H enters that into the computer. Surveyor shared with RN-H and DON-B the Wound Physician documented the sacral wound as a Stage 2 pressure injury. RN-H was not aware of that. Surveyor shared the concern R12 had a new open area to the sacrum on 5/24/2024 and the wound was not comprehensively assessed until 5/30/2024 when R12 was seen by the Wound Physician. RN-H stated R12 refused to have RN-H or the Wound Physician look at it at that time and then the camera was not working. Surveyor shared the concern R12 had a new open area to the sacrum and a blister to the right thigh on 7/8/2024 and the wounds were not comprehensively assessed with etiology and complete measurements including depth until 7/12/2024 when R12 was seen by the Wound Physician. Surveyor shared the observation of R12's Potential for Pressure Related Skin Injury Care Plan, At Risk for Impaired Skin Integrity Care Plan, and the staff worksheet on the unit have different settings for the air mattress, either a 3 or a 5 with the most recent revision documenting the setting should be at 3. DON-B stated they would look into that. On 7/16/2024 at 9:14 AM, Surveyor shared with DON-B the concerns R12's pressure injury was not documented as a pressure injury by RN-H when it was a Stage 2 pressure injury according to the Wound Physician documentation, no depth measurements were taken, and the pressure injuries were not comprehensively assessed when found. Surveyor asked DON-B what the expectation was for assessing wounds when the camera was not working. DON-B stated it was DON-B's expectation that wound assessments were done weekly and if the camera was not working, the measurements should be done manually. No further information was provided at that time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, interview, and record review the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 3 residents (R5) reviewed out of a sample of 17 residents. R5 was assessed to be at risk for falls with care plan interventions of a low bed and fall mat while in bed. The facility did not ensure interventions were in place when R5 was in bed. Evidenced by: The facility policy, titled Assessing Falls and Their Causes, dated March 2018, states in part: .4. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly .the following information should be recorded in the resident's medical record: . 6. Appropriate interventions take to prevent future falls. The facility policy, titled Care Plans, Comprehensive Person-Centered, dated December 2016, states in part: A comprehensive, person-centered care plan that includes, measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .receive the services and/or items included in the plan of care .include an assessment of the resident's strengths and needs .Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan .Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident .Care plan interventions are chosen only after careful data gathering, proper sequencing of events, care consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . Example 1 R5 was admitted to the facility on [DATE] and has diagnoses that include transient cerebral ischemic attack (a brief stroke-like attack), essential tremor (a nervous system disorder that causes shaking) and dementia with other behavioral disturbance (loss of cognitive functioning). R5's Minimum Data Set (MDS) assessment, dated 6/2/24, indicated that R5's Brief Interview of Mental Status (BIMS) score was a 3. This indicates severe cognition impairment. R5's Morse Fall Risk assessment, dated 5/28/24, has a score of 80. This score indicates R5 is at high risk for falls. R5's care plan, with a revision date of 7/11/24, states in part: .R5 is at risk for falls r/t (related to) impaired mobility, weakness. Goal: will not sustain serious injury .Interventions: .Low bed w/ (with) fall mat next to bed when in bed . Intervention implementation date is 1/22/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) care plan, printed on 7/11/24, states in part: .Low bed and fall mat. On 7/11/24 at 1:30 PM, Surveyor observed R5 sleeping in bed. R5's bed was not in lowest position and a fall mat was not next to the bed. On 7/11/24 at 1:46 PM, Surveyor stopped CNA E (Certified Nursing Assistant) as she walked by R5's room. Surveyor interviewed CNA E. Surveyor asked CNA E if R5 was a fall risk. CNA E indicated she was not sure if R5 was a fall risk and would need to get her CNA care plan to check. CNA E indicated she thought she might have seen a fall mat in R5's bathroom and offered to go into the bathroom to see if there was a fall mat in there. CNA E went into R5's bathroom and found R5's fall mat. CNA E placed the fall mat next to R5's bed. Surveyor asked if R5's bed was in the lowest position. CNA E stated No. Let me grab my sheet to see if it should be. CNA E left R5's room, walked down the hall and into the dining room. CNA E brought back her CNA care plan. CNA E informed Surveyor R5 was not listed as a fall risk on her CNA care plan. Surveyor informed CNA E that R5's nurse care plan indicates he is a fall risk and has interventions for a low bed and fall mat. CNA E went into R5's room and lowered R5's bed to the lowest position. On 7/11/24 at 1:53 PM, Surveyor interviewed RN F (Registered Nurse). RN F indicated R5 was a fall risk and should have a low bed and fall mat. Surveyor informed RN F of the observation of R5 being in bed with no fall mat next to the bed and the bed not in the lowest position. RN F indicated the fall mat should have been in place and the bed should have been in the lowest position. On 7/11/24 at 2:06 PM, Surveyor interviewed RNUM D (Registered Nurse Unit Manager). RNUM D indicated CNA E was not aware of R5's fall interventions because of a printing error the day before. RNUM D explained the CNA care plans are printed every night by the receptionist and the section that explains the fall interventions were missing from the printed sheets for 7/11/24. RNUM D indicated the receptionist printed new sheets and RNUM D was handing out the newly printed sheets to the staff. On 7/11/24 at 2:46PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated the fall interventions of low bed and fall mat should have been in place for R5.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review the facility did not ensure that residents that use psychotropic drugs have appropriate assessments, diagnoses, and consent. This affected 2 of 5 residents (R9 and R42) reviewed for unnecessary medications. R9 receives an antipsychotic for dementia. R42 receives an antipsychotic for anxiety. R42 is receiving an antidepressant and does not have active consent. This is evidenced by: The facility policy, titled Psychotropic Medication Use dated July 2022, states in part: Residents will not receive medications that are not clinically indicated to treat a specific condition .Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. anti-psychotics; b. anti-depressants; c. anti-anxiety medications; and d. hypnotics .are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record .Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Example 1 R9 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction (stroke), unspecified dementia, anxiety disorder and major depressive disorder. R9's physician orders include: Quetiapine Fumarate (antipsychotic) 25mg three times a day for dementia. It is important to note that dementia is not an appropriate indication of use for an antipsychotic. Example 2 R42 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dementia, and anxiety disorder. It is important to note, R42 does not have a diagnosis of insomnia or any other sleep disturbance disorders. R42's physician orders include: Risperidone (antipsychotic) 0.5mg daily at bedtime for anxiety. It is important to note that anxiety is not an appropriate indication of use for an antipsychotic. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Citalopram (antidepressant) 20mg one time a day for anxiety. Surveyor reviewed R42's consent for citalopram. The consent was signed on 1/17/23. R42's consent was not signed within the last 15 months. On 7/16/24 at 9:49AM, Surveyor interviewed RNUM D (Registered Nurse Unit Manager). RNUM D looked for a current consent for R42's citalopram and was unable to locate one. RNUM D indicated consent forms for psychotropic medications should be updated every 15 months. On 7/16/24 at 9:59AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated R9 and R42 did not have an appropriate diagnosis or indication of use for their antipsychotic medications. DON B indicated consents should be updated annually.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 Resident (R1) of 6 observed for Enhanced Barrier Precautions (EBP) and 1 (R1) of 8 opportunities for hand hygiene. Staff did not apply PPE (Personal Protective Equipment) appropriately while completing a treatment to R1 who was on EBP. Staff did not perform hand hygiene for appropriate amount of time during treatment. The facility policy entitled Handwashing/Hand Hygiene, dated October 2023, states, in part: . Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors . Procedure: . Washing Hands: 1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel . The facility policy entitled Personal Protective Equipment-Using Gowns, dated 9/10, states, in part: . Purpose: To guide the use of gowns. Objectives: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525266	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1 To prevent the spread of infections. 2. To prevent soiling of clothing with infectious material. 3. To prevent splashing or spilling blood or body fluids onto clothing or exposed skin; and . Miscellaneous: . 7. Gowns shall be large enough to cover all the wearer's clothing, and they must be tightly cuffed at the sleeves . Procedure Guidelines: Putting on the Gown: . 5. Put your arms onto the sleeves of the gown. 6. Fit the gown at the neck. 7. Secure at the neck (tie or Velcro). 8. Overlap the gown at the back. Be sure clothing is completely covered. 9. Secure at the waist (tie or Velcro) . R1 was admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus with Diabetic Neuropathy and Peripheral Vascular Disease. R1's July's TAR (Treatment Administration Record) includes: - Enhanced Barrier Precautions in place- utilize gown and gloves when coming into contact with wound, IV, catheter, ports, etc. every shift for precautions -Start Date- 4/29/24 . - Monitor skin alterations to left lower leg for s/s (signs/symptoms) infection and healing until resolved every shift- Start Date- 11/8/23 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/11/24, at 3:29PM, Surveyor observed RN C (Registered Nurse) donn (put on) PPE prior to starting R1's treatment to left lower leg. RN C donned gown without tying the neck strings and waist strings leaving the gown open in the back. RN C arranged supplies onto a towel and paper towel on top of R1's bedside table. As RN C was cleaning scissors with an alcohol wipe and arranging supplies, RN C's gown fell off her shoulders. RN C pushed gown back up over shoulders, washed hands, and applied gloves. RN C sat in a chair in front of R1 who was in recliner with legs elevated up on footrest. RN C removed R1's nonskid sock to left foot and removed the Coban dressing. RN C's gown fell off left shoulder and RN C took right hand and pulled gown back up over left shoulder. RN C continued with removing the gauze wrap from R1's leg. As RN C continued removing gauze wrap her gown fell off right shoulder down to elbow. RN C continued with removing ABD pads and polymem dressing. RN C removed gloves and washed hands and applied new gloves. RN C moistened 2 x 2s with warm water and soap and cleansed wound. RN C removed gloves and washed hands. Gown and strings to gown fell off both shoulders; RN C pulled them up then applied gloves. RN C took 2 x 2s and dried wound, removed gloves and performed hand hygiene for 10 seconds and applied new gloves. RN C opened polymem and cut a piece to fit wound, placed it on wound, polymem fell off wound onto footrest and RN C threw piece away. RN C removed gloves and washed hands x 10 seconds and applied new gloves. RN C bent down and opened Vaseline and strings to gown were laying on old dressing to left foot. RN C applied Vaseline to reddened areas to left lower leg. RN C removed gloves, washed hands for 8 seconds, applied new gloves, then cut another piece of polymem, then opened ABD dressing. RN C then applied the polymem to wound and ABD dressing to lower leg. RN C removed gloves and performed hand hygiene x 10 seconds. Gown fell off left shoulder and RN C pushed it back up then applied gloves. RN C opened gauze roll and applied to left foot and up over ABDs. RN C then opened the Coban and started unrolling it onto left foot, RN C 's gown fell off shoulders and RN C attempted to push gown up by pulling arm up without touching as gown was falling onto the foot being wrapped. Both RN C 's shoulders and arms were uncovered by gown while bent over doing wrap. R1's foot with old dressing still on toe touched RN C's N95 mask and cheek, then touched RN C 's stethoscope that was around RN C 's neck and her shirt. RN C removed gloves and performed hand hygiene x 5 seconds, then pulled gown up onto both shoulders. RN C washed hands, applied gloves, then removed old dressing from second digit to left foot. RN C removed gloves and performed hand hygiene x 9 seconds applied gloves and then took 2 x 2s rinsed and applied soap. RN C cleansed toe wound and dried with clean 2 x 2s. RN C removed gloves washed hands x 10 seconds and then applied new gloves. RN C applied isodorb to wound with a qtip and mepilex. RN C removed gloves and washed hands x 10 seconds. Of note: CDC recommends 20 seconds with vigorous hand hygiene. On 7/11/24, at 4:20PM, Surveyor interviewed RN C and asked if it was proper donning a gown without tying the strings around neck and waist. RN C indicated the gown is not big enough for her. Surveyor asked if RN C had talked to DON B (Director of Nursing) about the gown not fitting properly and RN C indicated no and she will say something to DON B. Surveyor asked when R1's foot with the old dressing to toe touched RN C's N95, stethoscope and shirt if she would consider that contamination to her clothing, PPE, and stethoscope. RN C indicated yes. Surveyor asked RN C how long should hand hygiene be performed for and RN C indicated 1 to 2 minutes. Surveyor asked RN C if 5- 10 seconds is long enough for proper hand hygiene and RN C indicated probably not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/11/24, at 4:39PM, Surveyor interviewed DON B and asked how long you would expect proper hand hygiene to be performed for. DON B indicated 30 seconds. Surveyor asked if 5 to 10 seconds for hand hygiene appropriate and DON B indicated no. Surveyor asked if a gown should be tied in the back and DON B indicated yes. Surveyor informed DON B of observation of wound care with RN C and DON B indicated the gown should be tied and not in the field while doing a treatment. The field needs to remain clean. DON B indicated with R1's foot touching RN C 's N95, shirt and stethoscope that would be contaminating her, PPE, and stethoscope.