STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525549	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Square Health Care Center	5404 W Loomis Rd Greendale, WI 53129

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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 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** 47094 Based in interview and record review the Facility did not ensure 1 (R2) of 3 residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the resident's choice. R2 was admitted on [DATE] with a history of diverticulosis and constipation. R2 did not have a care plan initiated for bowel monitoring or interventions. R2 did not have documentation of bowel elimination until 3/10/2025 and R2 did not have a bowel movement documented until 3/12/2025 which was diarrhea and R2 had complaints of nausea. R2 was not assessed and there was no documentation regarding R2 was having nausea and diarrhea. On 3/13/2025 R2 went to the Hospital for further evaluation for complaints of nausea and abdominal cramping and a CT scan showed R2 had moderate colonic stool burden with mildly distended rectal vault. R2 was readmitted to the facility on [DATE] with recommendations to increase R2's laxative to two times a day and add MiraLAX daily, these recommendations were not implemented and a care plan was not initiated for R2's risk for constipation and bowel monitoring. Findings include: R2 was admitted to the facility on [DATE] and has diagnoses that include acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), pressure ulcer (stage 3 sacral region), protein-calorie malnutrition, dependence of supplemental oxygen, anxiety disorder, diverticulosis, and weakness. R2's admission minimum data set (MDS) dated [DATE] indicated R2 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 and the Facility assessed R2 needing moderate assistance with 1 staff member for toileting hygiene and lower body dressing and independent with supervision of 1 staff member for personal hygiene, upper body dressing, and oral hygiene. R2 was always continent of urine and bowel continence was not assessed. R2 was admitted with a stage 4 pressure injury to the sacral area and received an opioid medication (oxycodone) as needed for pain. R2 does not have an activated power of attorney and is own person and makes own medical decisions. R2's hospital discharge paperwork on 3/7/2025 included an informational sheet on prevention of constipation with general instructions and tips that include: - Eating foods high in fiber . - Exercise/ move regularly . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Drinking plenty of fluids . - Monitor for: pain, fever, nausea/vomiting, contact provider if have not had bowel movement in 4 days. On 3/7/2025, at 2010 (8:10 PM), in the progress notes, nursing documented (R2) arrived at facility at 1850 (6:50 PM) . abdomen soft, non-tender, bowel sounds noted in all four quadrants, and continent of both bowel and bladder. Surveyor notes there is no documentation when R2 last had a bowel movement, and a care plan was not initiated for risk of constipation, history of diverticulosis and opioid usage with no monitoring or interventions implemented. On 3/12/2025, at 12:25 PM, in the progress notes registered dietitian (RD)-M documented . (R2) complaint (sic) nausea today. Provided chicken soup, crackers, and white soda for lunch. Later in the afternoon R2 was in bed and stated was feeling better. Surveyor reviewed an assessment note dated 3/13/2025 (no time indicated) from the nurse practitioner that documents: - Social history: Diet: encouraged to stick to a bland diet and ensure adequate fluid intake due to gastrointestinal (GI) upset symptoms. - Medications: Tylenol (used for headache), Zofran (used for nausea), Levsin (used for nausea and abdominal cramping) - . (R2) reports new onset of headache and nausea symptoms this morning. (R2's) chief complaints are headache and nausea, both of which started this morning. R2's overall health status appears stable with no signs of acute distress noted. Vital signs are stable. - Physical Examination: . general: no acute distress noted, Abdomen: bowel sounds are present and active, abdomen is not tender to palpitation . - Assessment and Plan: 1. Headache and nausea: (R2) reports experiencing headache and nausea this morning. These acute symptoms are likely causing discomfort and affecting (R2's) well-being. Administer Tylenol for headache relief, new orders for Zofran and Levsin for nausea and cramping, encourage adherence to bland diet, ensure adequate fluid intake. Surveyor reviewed the documentation on the 24 hour boards for 3/11/2025, 3/12/2025, 3/13/2025 and noted there was no documentation to monitor R2 for nausea. The following was documented for R2: - 3/11/2025 night shift documented: sleep study. Day shift and evening shift did not have documentation. - 3/12/2025 night shift documented: sleep study. Day shift and evening shift did not have documentation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/13/2025 night shift documented: sleep study, (R2) slept through the night. Day shift and evening shift did not have documentation. Surveyor notes that there is no documentation on the 24 hour board indicating R2 experienced nausea on 3/12/2025 and R2 experienced headache, nausea, and abdominal cramping on 3/13/2025, or that R2 went out to the emergency roiagnom on [DATE]. Surveyor notes that there was not a comprehensive assessment done for R2 when R2 had complaints of nausea on 3/12/2025. There is no documentation regarding monitoring or R2 after complaints of nausea on 3/12/2025 and complaints of headache, nausea, and abdominal cramping on 3/13/2025. On 3/13/2025, at 1515 (3:15 PM), in the progress notes licensed practical nurse (LPN)-E documented LPN-E received phone call from R2's family member with concerns that were reported from R2. LPN-E went in to assess R2, upon entering room R2 was in a pleasant mood. Vital signs were stable, . R2 did not have complaints of abdominal pain, no pain noted with palpitations, bowel sounds present in all four quadrants, abdomen was soft and non-tender. R2 did not complain of nausea or vomiting. R2 stated last bowel movement was today. On 3/13/2025, at 1535 (3:35 PM), in the progress notes LPN-E documented R2's family member (different family member than previously charted) arrived at facility demanding R2 be sent to the emergency room . LPN-E informed R2's family member that R2 did not have concerns when assessed and is stable. R2's family member still demanded R2 be sent to the emergency room . LPN-E updated the nurse practitioner (NP) and an order was obtained to transfer to the emergency room for further evaluation. On 3/14/2025, at 1656 (4:56 PM), in the progress notes nursing documented (R2) returned to the facility from [Hospital name] . pleasant mood, no concerns noted at this time. R2's discharge summary from the hospital dated 3/14/2025 documents the following: Start taking these medications: -Polyethylene glycol 3350 (MiraLAX): Take 17 grams by mouth daily for 10 days. Stir in 4 to 8 ounces of liquid until dissolved and drink. Continue these medications which have changed: -Senna 8.6mg: Take 2 tablets (17.2mg total) by mouth 2 times daily for 15 days What changed: when to take this (previously ordered 1 time daily) Discharge summary/ Hospital Course dated 3/14/2025 documents: R2 .presented to the emergency room with a chief complaint of lower left abdominal pain. (R2) had complete workup including CT of abdomen which showed no acute abnormalities. (R2's) labs were unremarkable with normal liver function tests (LFT's), lipase. (R2) reports pain has completely resolved and tolerating oral intake without any issues. (R2) was recommended to take MiraLAX for stool burden, but declined, and increase senna to 2 tablets twice a day. (R2) is medically stable without acute inpatient care needs at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CT Abdomen/ pelvis with contrast (result date 3/14/2025) Impression: 1. No acute CT finding to account for abdominal pain. 2. Moderate colonic stool burden with mildly distended rectal vault, correlate for constipation. 3. Severe sigmoid diverticulitis with no acute inflammatory changes identified. R2 has the following physician orders in place: . - Senna Oral Tablet 8.6mg: Give 2 tablets by mouth one time a day for constipation, hold for loose stools. (order date: 3/7/2025) - Bisacodyl Rectal Suppository 10mg: Insert 1 suppository rectally every 24 hours as needed for constipation. (order date: 3/7/2025) - Acetaminophen (Tylenol) 325mg: Give 2 tablets by mouth every 4 hours as needed for pain. Surveyor noted that R2 requested and received 2 tablets of Tylenol 325mg on: - 3/11/2025 at 9:16 AM, verbal pain rating of 2/10 - 3/14/2025 at 1520 (3:20 PM), verbal pain rating of 3/10 - 3/14/2025 at 2152 (9:52 PM), verbal pain rating of 5/10 Surveyor notes R2 did not receive Tylenol as directed by the NP for headache in the morning on 3/13/2025. - Oxycodone HCl oral tablet 5mg: Give 1 tablet by mouth every 6 hours as needed for pain. (order date: 3/7/2025, discontinue date: 3/10/2025) Surveyor noted that R2 requested and received 1 tab Oxycodone 5mg on: - 3/8/2025 at 1500 (3:00 PM), verbal pain rating of 5/10 - 3/9/2025 at 2227 (10:37 PM), verbal pain rating 2/10 - 3/10/2025 at 1410 (2:10 PM), verbal pain rating 5/10 - 3/10/2025 at 2107 (9:07 PM), verbal pain rating 4/10. Surveyor notes that the hospital discharge orders for R3 the following orders did not get implemented upon R2's admission back to the facility on [DATE]: 1. Polyethylene glycol 3350 (MiraLAX): Take 17 grams by mouth daily for 10 days. Stir in 4 to 8 ounces of liquid until dissolved and drink. 2. Senna 8.6mg: Take 2 tablets (17.2mg total) by mouth 2 times daily for 15 days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	What changed: when to take this (previously ordered 1 time daily) On 3/17/2025, at 9:57 AM Surveyor observed R2 sitting in a wheelchair watching TV. R2 stated that R2 has bowel issues and tends to get constipated. Surveyor asked R2 when last bowel movement was. R2 was not sure when last bowel movement was. Surveyor asked if staff assess R2's abdomen or ask when last bowel movement was. R2 stated that staff ask when she had bowel movements sometimes and push on stomach sometimes. R2 denied having any concerns at this time and felt fine. On 3/17/2025 at 2:10 PM, Surveyor interviewed LPN-E who stated LPN-E worked evening shift on 3/13/2025 and did not get report of R2 having concerns with nausea or pain during shift report or from other staff. LPN-E stated after phone call with R2's family member and went to go check on R2. LPN-E stated R2 did not have complaints of nausea, vomiting, or cramping and stomach was soft and not tender. LPN-E stated R2 had complaints of pain to the area her pressure injury was, and Tylenol was given for that pain and was effective. LPN-E stated R2's other family member then came to the facility was irate and confrontational with staff demanding R2 go to the emergency room (ER). LPN-E stated LPN-E spoke with R2 regarding going to the ER since R2 is own person. LPN-E stated R2 agreed to be sent to the ER. LPN-E called the NP and gave report, and an order was given to send R2 to the ER for abdominal pain. On 3/18/2025, at 11:00 AM, Surveyor interviewed LPN-G who stated was the charge nurse on the morning shift of 3/13/2025. LPN-G did not recall having any concerns with R2 regarding nausea or abdominal cramping. LPN-G stated does not recall getting in shift report for day/ night prior of any concerns that R2 had episodes of nausea. Surveyor asked how bowels are monitored for residents. LPN-G stated certified nursing assistants (CNAs) documents in the tasks section in Point Click Care (PCC, electronic medical record) whenever a resident has a bowel movement. If a resident goes 3 days without a bowel movement the resident will get flagged in the system and the nurses are notified to assess and implement an intervention. LPN-G does not recall if R2 ever flagged for no bowel movements or had concerns regarding R2 having any constipation concerns. Surveyor reviewed R2's bowel elimination in PCC and noted the following documentation does not begin until 3/10/2025, 3 days after R2 was admitted to the facility. Surveyor did not see documentation that R2 was assessed prior to 3/10/2025 regarding if R2 had a bowel movement or was being monitored. 3/10/2025: - 1323 (1:23 PM) no bowel movement (BM) - 2018 (8:18 PM) not applicable (N/A) 3/11/2025: no documentation 3/12/2025: -0820 (8:20 AM) incontinent, large/loose/watery/diarrhea (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes R2 did not have a documented BM until 3/12/2025 which is 5 days after R2 was admitted to the facility. There is no documentation regarding R2 having an episode of diarrhea on 3/12/2025 in the morning that indicates if nursing was notified, or that R2 was assessed after having an episode of diarrhea. R2 continued to receive Senna Oral Tablet 8.6mg (2 tablets) which was to be held with loose stools. 3/13/2025: - 1349 (1:49 PM) no BM - 1910 (6:10 PM) N/A (R2 at hospital) 3/14/2025: -1948 (6:48 PM) incontinent, large/loose/watery/diarrhea 3/15/2025 - 11:11 AM no BM - 2159 (9:59 PM) continent (no description of BM documented) 3/16/2025: - 0014 (12:14 AM) no BM - 11: AM continent, medium/formed/normal - 2127 (9:27 PM) N/A 3/17/2025: -12:05 PM no BM 3/18/2025: -12:40 PM no BM Surveyor notes that R2's bowel elimination monitoring was not done consistently every shift. On 3/18/2025, at 2:47 PM, Surveyor interviewed registered nurse (RN)-H who stated if a resident goes 3 days without a bowel movement, then the resident is assessed and review of orders to see if they should be given anything. RN-H stated the CNAs keep nursing updated as to whether a resident did not have a bowel movement or if the resident had diarrhea so then the resident can be assessed. RN-H did not recall R2 having concerns with complaints of nausea or constipation. RN-H stated that the CNAs document bowel elimination in the resident medical record in PCC, but RN-H also asks when doing assessments when their last BM was but does not necessarily always document a progress note, it is just something RN-H asks the residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/2025, at 3:15 PM, Surveyor interviewed CNA-J who stated CNA-J cared for R2 on the night of 3/12/2025 into the morning of 3/13/2025. CNA-J did not recall getting in shift report that R2 was experiencing nausea, pain, or diarrhea/constipation. CNA-J stated documenting in bowel elimination is only if a resident has a BM. If the resident does not have a BM, then it is not documented anywhere. CNA-J stated that BMs get reported to nursing if they are loose or a lot. CNA-J did not recall if CNA-J ever reported to nursing that R2 did not have a BM. On 3/18/2025, at 3:37 PM, Surveyor interviewed medication tech (MT)-K who worked with R2 day shift on 3/12/2025. MT-K stated R2 did have complaints of nausea later in the morning around 10:00 AM. MT-K stated the CNA told MT-K that R2 was dry heaving and complaining of nausea. MT-K reported R2's concerns to LPN-L. Surveyor asked if MT-K checked or saw R2. MT-K stated that when MT-K gave R2's medication earlier R2 did not have any complaints and took the medications without difficulty. MT-K did not go check on R2 because med techs are not able to do any assessment of any kind on residents which is why MT-K reported it to LPN-L. MT-K stated MT-K is not sure what LPN-L did. MT-K stated that later in the afternoon R2 was fine and did not report any nausea or vomiting to MT-K. MT-K stated that any shift report or documentation in progress notes or the 24 hour board are done by the nurse. MT-K reported it to LPN-L so LPN-L would have done any reporting of R2's concerns. Surveyor asked if MT-K is present during shift report and if R2's concerns were passed along to the upcoming shift. MT-K stated will sometimes stay for report, but did not stay on 3/12/2025 because LPN-L was staying later. On 3/18/2025, at 4:00 PM, Surveyor shared concerns nursing home administrator (NHA)-A and chief nursing officer (CNO)-C. Surveyor asked how often staff is required to document resident's bowel elimination. CNO-C stated that CNAs document bowel elimination at least once a shift and each time a resident has a bowel movement. Surveyor shared that facility staff are not documenting R2's bowel elimination consistently, on 3/10/2025 (3 days after R2's admission) was the first documentation for R2's bowel elimination and 3/12/2025 (5 days after R2's admission) was the first documentation that R2 had a bowel movement which was loose/diarrhea. Surveyor shared that R2 experienced loose stools on 3/12/2025 with nausea, abdominal cramping, and dry heaves and there was not a comprehensive assessment documented indicating R2 was assessed or monitored. Surveyor shared that there is no documentation in the progress notes or 24 hour boards indicating R2's complaints of nausea on 3/12/2025 and nausea, headache and abdominal cramping on 3/13/2025. Surveyor also shared that R2 was not given Tylenol as directed by the NP for a headache and later in the evening R2 went to the hospital with abdominal pain and was noted to have moderate colonic stool burden with mildly distended rectal vault, correlate for constipation. Surveyor shared concerns that the hospital discharge paperwork on 3/14/2025 had orders that were not implemented for: 1. Polyethylene glycol 3350 (MiraLAX): Take 17 grams by mouth daily for 10 days. Stir in 4 to 8 ounces of liquid until dissolved and drink. 2. Senna 8.6mg: Take 2 tablets (17.2mg total) by mouth 2 times daily for 15 days What changed: when to take this (previously ordered 1 time daily) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor also shared that R2 currently does not have a care plan initiated for risk of constipation and history of severe diverticulosis with monitoring or interventions in place. CNO-C replied they will look into the medication orders. Surveyor also shared that R2 did not have a care plan initiated on R2's 3/7/2025 admission for risk of constipation and history of diverticulosis and after R2's readmission on 3/14/2025. CNO-C stated that since the facility stopped using agency staff, they realized some opportunities for education of staff and thorough documentation and charting. On 3/19/2025, at 8:51 AM, Surveyor interviewed LPN-L who stated LPN-L does not recall getting informed by MT-K that R2 was having nausea or vomiting. LPN-L does not recall R2 having complaints of nausea or concerns with constipation or diarrhea when caring for R2. On 3/19/2025 at 9:39 AM, Surveyor interviewed RD-M who stated they do recall R2 having complaints of nausea on 3/12/2025. RD-M stated that RD-M brought R2 some soup, crackers, and white soda for lunch. RD-M went back after lunch and R2 felt much better. RD-M stated R2 did not say R2 had any vomiting and that R2 was just nauseous feeling. Surveyor asked RD-M if R2's nausea was reported to nursing. RD-M stated that R2's nausea was not reported because R2 felt much better after lunch and did not have any further concerns, so RD-M thought maybe R2 just needed to eat something. On 3/19/2025, at 10:14 AM, Surveyor interviewed MT-N who stated R2 did have complaints of nausea on 3/13/2025 on day shift and MT-N notified the NP who went into assess R2. MT-N stated that the NP ordered something for nausea and abdominal cramping. MT-N could not recall if R2 had complaints of a headache or not, but just remembers the nausea. MT-N stated that R2 did not complain of any more nausea the rest of the day. MT-N was not aware of any concerns with R2 having diarrhea or constipation. MT-N stated nothing got passed on in shift report that MT-N can recall. On 3/19/2025, at 11:30 AM, CNO-C stated that the orders were looked at for R2's readmission from 3/14/2025 and fixed. CNO-C stated that no bowel assessments could be located for R2 prior to 3/10/2025. On 3/19/2025, at 12:30 PM, Surveyor shared concerns with NHA-A and CNO-C that R2 did not have a care plan initiated for risks of constipation and history of diverticulosis with monitoring and interventions, R2 did not have consistent documentation or monitoring of R2's bowel elimination or that R2's nausea/ diarrhea was not addressed on 3/12/2025 and R2 went to the hospital with abdominal cramping on 3/13/2025 with diagnoses of moderate colonic stool burden with mildly distended rectal vault, correlate for constipation. Surveyor also had concern that R2's orders from readmission from the hospital on 3/14/2025 were not addressed to prevent further constipation issues. CNO-C stated that a bowel monitoring policy and procedure could not be located, but it does exist and will email Surveyor the bowel monitoring policy. At the time of this write up, Surveyor has not received an email with the bowel monitoring policy and procedure.

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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** 38146 Based on observation, interviews, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services to promote healing and prevent new injuries from developing for 1 of 2 (R3) residents reviewed for pressure injuries. R3's pressure injuries were not comprehensively assessed and treatment was not implemented timely. This deficient practice resulted in R3's development of a stage 3 pressure injury. Findings include: The facility policy titled Skin Assessment implemented 3/1/19 documents (in part) . . It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. 1. A full body, or head to toe skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 7. Documentation of skin assessment: Document type of wound. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). The facility policy titled Wound Management which was not dated, documents (in part) . .To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. 5. Treatment decisions will be based on: Etiology of the wound, characteristics of the wound (pressure injury stage, size and volume/characteristic of exudate) and location of the wound. 7. Treatments will be documented on the Treatment Administration Record. R3 admitted to the facility on [DATE] and has diagnoses that include severe hypoxic ischemic encephalopathy, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with hypoxia, anoxic brain damage, Cerebral Infarction, Heart Failure, Major Depressive Disorder, spondylosis lumbosacral region, Hidradenitis Suppurativa, and Epilepsy. R3's Admission MDS (Minimum Data Set) dated 1/27/25 documents: Always incontinent of B&B (bowel and bladder) and dependent for toileting hygiene and bed mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Care Area Assessment (CAA) documented: Is this resident at risk of developing pressure ulcers? Yes. Resident has one or more unhealed pressure ulcer(s) at stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by: Number of stage 3 pressure ulcers = 1. Existing pressure ulcer/injury - assess location, size, state, presence and type of drainage, presence of odors, condition of surrounding skin. Extrinsic risk factors: Pressure, needs special mattress or seat cushion to reduce or relieve pressure. Maceration - Moisture Associated Skin Damage (MASD). Intrinsic risk factors: Altered mental status, cognitive loss, incontinence, poor nutrition. R3 has a care plan implemented for pressure injuries with appropriate interventions, but did not have an incontinence care plan implemented (Cross reference F690). R3's Clinical Admission note dated 1/23/25 documents: New skin issue. Location: Left gluteus stage 2 pressure injury - partial thickness skin loss with exposed dermis, present on admission 4 x 1.5 x 0 cm (centimeters). Left gluteus stage 2 pressure injury - partial thickness skin loss with exposed dermis, present on admission 2. 5 x 1 x 0 cm. Left gluteus stage 2 pressure injury - partial thickness skin loss with exposed dermis, present on admission 1 x 1 x 0 cm. Left gluteus open lesion, present on admission 0.7 x 0 cm. Right gluteus stage 2 pressure injury - partial thickness skin loss with exposed dermis, present on admission 3.5 x 1 x 0 cm. Coccyx - Moisture Associated Skin Damage (MASD) 7 x 1 cm. Surveyor review of R3's January 2025 Treatment Administration Record (TAR) revealed no treatment was implemented for R3's pressure injuries or MASD when identified on 1/23/25 until 5 days later, after R3 was seen by the wound physician. On 1/27/25 (4 days after admission to the facility), R3 was seen by (name of medical group) Wound Physicians. The initial wound evaluation and management summary documented: Patient presents with wounds on her coccyx, bilateral buttocks. Focus wound exam site 1: Stage 3 pressure wound coccyx full thickness 5.7 x 0.8 x 0.1 cm. Moderate serosanguineous exudate. 20% thick adherent devitalized necrotic tissue. 40% slough. 40% granulation tissue. Surgical excisional debridement procedure: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 2.74 cm of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a dept of 0.2 cm and healthy bleeding tissue was observed. Dressing treatment plan: Leptospermum honey with foam border apply once daily. (continued on next page)

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	525549	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Focus wound exam site 2: Non-pressure wound of the bilateral buttock, partial thickness. MASD 14.3 x 13 x 0.1 cm. Surface area 185.90 cm. Light serosanguineous exudate. Open areas with exposed dermis. Dressing treatment plan: House barrier cream apply Q (every) shift (3 times a day) and as needed for 30 days. Surveyor noted R3's clinical admission note dated 1/23/25 documented several stage 2 pressure injuries and MASD to her coccyx. No treatment was implemented. On 1/27/25, the wound physician identified a stage 3 pressure injury to her coccyx which required mechanical debridement. R3 was hospitalized for a change in condition on 1/30/25 and readmitted to the facility on [DATE]. R3's Clinical Admission note (entered by a Licensed Practical Nurse that no longer works for the facility) dated 2/5/25 documents: Skin issues have not been evaluated. Surveyor noted the documentation and measurements of R3's open areas were the same as previously documented on R3's 1/23/25 Clinical Admission note, including coccyx MASD 7 x 1 cm, even though R3 had a stage 3 pressure injury to her coccyx identified on 1/27/25. Surveyor review of R3's February 2025 TAR revealed no treatment was implemented for R3's pressure injuries upon readmission to the facility on [DATE]. Only house barrier cream to sacrum/coccyx was implemented on 2/7/25, which is not an appropriate treatment for stage 3 pressure injury. On 2/10/25, (5 days after readmission to the facility), R3 was seen by (name of medical group) Wound Physicians. The wound evaluation and management summary documented: Patient has wounds on her coccyx, right buttock. Focus wound exam site 1: Stage 3 pressure wound coccyx full thickness. 5.6 x 7.4 x 0,1 cm. Moderate serosanguineous exudate. 20% thick adherent devitalized necrotic tissue. 40% slough. 40% granulation tissue. Wound progress exacerbated due to hospitalized . Surgical excisional debridement procedure: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 24.86 cm of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a dept of 0.2 cm and healthy bleeding tissue was observed. Dressing treatment plan: Leptospermum honey with foam border apply once daily. Focus wound exam site 2: Non-pressure wound of the left buttock partial thickness. MASD. Wound size 8 x 1 x 0.1 cm. Surface area 8.00 cm. Moderate serous exudate. Open areas with exposed dermis. Dressing treatment plan: Leptospermum honey with foam border apply once daily. Focus wound exam site 3: Non-pressure wound of the left buttock partial thickness. MASD. Wound size 7.5 x 4.5 x 0.1 cm. Surface area 33.75 cm. Moderate serosanguineous exudate. Open areas with exposed dermis. Dressing treatment plan: Leptospermum honey with foam border apply once daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The wound physician notes on 2/10/25 documented R3's wound progress exacerbated due to hospitalization , however Surveyor noted R3's wounds were not comprehensively assessed and measured upon readmission to the facility on [DATE] and no treatment was implemented. R3's clinical admission note dated 2/5/25 documented R3's skin issues have not been evaluated and listed the same information and measurements as on the 1/23/25 clinical admission notes (including MASD to the coccyx even though she had a previously identified stage 3 pressure injury to her coccyx). On 2/7/25, house barrier cream was implemented and not the previously ordered treatment for the stage 3 pressure injury. On 2/10/25, when R3 was seen by the wound physician, the Stage 3 pressure injury to her coccyx had declined, was larger in size and required mechanical debridement. On 2/17/25, R3 was seen by (name of medical group) Wound Physician. The wound evaluation and management summary documented: Patient has wounds on her coccyx, right buttock, left buttock. Stage 3 pressure wound coccyx full thickness, non-pressure wound of left and right buttocks partial thickness. Surveyor noted there was no evidence of decline or increase in size of the wounds. The coccyx and right buttock wounds were debrided during this visit and appropriate treatment continued. On 2/24/25, (name of different medical group) physicians took over care of R3's wounds. Weekly assessments and appropriate treatments completed. As of 3/17/25, the coccyx stage 3 pressure injury measures 1.4 x 0.9 x 0.1 cm. Over 50% granulation with a scattered pattern of beefy red quality. Between 0-25% nonviable material of slough/fibrin. Bilateral buttocks red, blanchable, partial thickness skin breakdown to multiple small areas on bilateral buttocks. Improvement in overall surface area of wound openings and improvement to peri wound skin. On 3/17/25, Surveyor spoke with (different medical group name) Nurse Practitioner (NP)-F. NP-F reported R3 has a stage 3 pressure injury on her coccyx, which she was told was present on admission, and several partial thickness areas of MASD to bilateral buttocks. Surveyor asked what she thought was the cause of the MASD. NP-F stated, probably combination of wetness from incontinence and shearing. NP-F reported all areas are improving and she anticipates the coccyx to heal within the next couple of weeks. Surveyor asked if the facility implemented a check and change schedule related to incontinence. NP-F reported she did not know. Surveyor asked if R3's MASD is a result of wetness from incontinence, would she expect routine or more frequent checking/changing for incontinence. NP-F stated. Of course. I'm sure they have a protocol for weight shifting and skin care incontinence protocol. Surveyor asked if she has communicated the need for weight shifting and skin care/incontinence care. NP-F stated, I have, it would be in my notes. Surveyor confirmed NP-F's progress note dated 2/24/25 documents (in part) . HPI: The pressure ulcer is located on the coccyx and has been present for 5 weeks. The pressure ulcer was present on admission. According to the NPIAP (National Pressure Injury Advisory Panel) staging system, the pressure ulcer is classified as stage 3. Additional factors that contribute to non-healing include bed-bound status, bowel incontinence and bladder incontinence. Provider Comments document Prognosis: Guarded, dependent on offloading and moisture management. Discussed pressure relief and redistribution strategies. Patient is on an appropriate support surface for the patient to use when supine and should be on a weight shifting schedule and skin care/continence schedule per facility protocol. The balance of moisture is critical to wound healing. I have given caregivers instructions about managing skin moisture which include using a skin barrier and wicking agent. Patient wears an adult brief. Consider Foley catheter in future if urine management becomes a problem. R3 did not have an incontinence care plan implemented (Cross reference F690). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 9:00 AM, Surveyor met with Acting Director of Nursing (DON)-C to discuss concerns: R3 admitted to the facility with pressure injuries and MASD to her coccyx. Treatment was not implemented until 5 days later, after R3 was seen by the wound physician. At this time a stage 3 pressure injury was identified on her coccyx which required mechanical debridement of necrotic tissue and slough. R3 was readmitted following hospitalization on [DATE]. The facility did not complete a comprehensive assessment and measurements of R3's wounds and no treatments were implemented until 2 days later, which included only barrier cream and not the previously ordered (appropriate) treatment for stage 3 pressure injury. 5 days later, the wound physician documented R3's coccyx stage 3 pressure injury declined/was larger in size and required mechanical debridement of necrotic tissue and slough. Acting DON-C reported she will review information and see if there is any additional information to provide. No additional information was provided prior to survey exit. On 3/19/25 at 12:30 PM, Nursing Home Administrator (NHA)-A, Acting DON-C, and DON-B were advised of the above concerns.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observation, interview and record review the facility did not ensure that residents who are incontinent of bowel and bladder receive appropriate treatment and services to prevent skin-related complications for 1 of 2 (R3) residents reviewed for bowel and bladder. R3 admitted to the facility with pressure injuries and Moisture Associated Skin Damage (MASD). A care plan was not implemented to manage R3's incontinence. Findings include: R3 admitted to the facility on [DATE] and has diagnoses that include severe hypoxic ischemic encephalopathy, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with hypoxia, anoxic brain damage, Cerebral Infarction, Heart Failure, Major Depressive Disorder, spondylosis lumbosacral region, Hidradenitis Suppurativa and Epilepsy. The facility policy titled Continence and Incontinence - Assessment and Management review date 1/2025 documents (in part) . . Policy Statement 1. The staff and practitioners will appropriately screen for, and manage, individuals with incontinence. 2. Management of incontinence will follow relevant clinical guidelines. Policy Interpretation and Implementation 1. As part of the initial and ongoing assessments, the nursing staff and physician will screen information related to incontinence. 3. Periodically (as required and when there is a change in voiding), staff will define each individual's level of continence, referring to the criteria in the Minimum Data Set (MDS). 4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include the following: Voiding patters (frequency, volume, nighttime or daytime, quality of stream, etcetera). 8. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown or perineal dermatitis). 18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. If the resident does not respond and does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a check and change strategy. c. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort level and to protect the skin. R3's admission bowel and bladder assessment dated [DATE] documents: Always incontinent of bowel and bladder. Functional incontinence - cognitive impairment (brain injury). Does not recognize need to void/defecate. Is there a care plan in place? Yes. R3's Admission MDS dated [DATE] documents: Always incontinent of B&B (bowel and bladder) and dependent for toileting hygiene and bed mobility. The Care Area Assessment (CAA) documented: Is this resident at risk of developing pressure ulcers? Yes. Resident has one or more unhealed pressure ulcer(s) at stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by: Number of stage 3 pressure ulcers = 1. Always incontinent. Moisture Associated Skin Damage = Yes. Describe impact of this problem/need on the resident and your rationale for care plan decision: Check and change. Apply treatment. Surveyor noted although R3 was identified to be always incontinent of bowel and bladder, admitted to the facility with pressure injuries and MASD to her coccyx (which progressed to a stage 3 pressure injury), R3 did not have a care plan implemented to manage bowel and bladder incontinence (Cross reference F686). R3's Kardex as of 3/18/25 documents: Skin integrity - Encourage staff to reposition me every 2-3 hours. Air mattress setting checks. Heel boots to bilateral heels. Staff will provide heel boots at all times. Toileting - I need total assist x 1 for toileting. Surveyor noted although R3 is identified to be always incontinent of bowel and bladder and has a stage 3 pressure injury and MASD, R3's Kardex included no indication of how often R3 is to be checked and changed for incontinence. On 3/17/25 Surveyor spoke with (name of medical group) Nurse Practitioner (NP)-F. NP-F reported R3 has a stage 3 pressure injury on her coccyx, which she was told was present on admission, and several partial thickness areas of MASD to bilateral buttocks. Surveyor asked what she thought was the cause of the MASD. NP-F stated, probably combination of wetness from incontinence and shearing. Surveyor asked if the facility implemented a check and change schedule related to incontinence. NP-F reported she did not know. Surveyor asked if R3's MASD is a result of wetness from incontinence, would she expect routine or more frequent checking and changing for incontinence. NP-F stated. Of course. I'm sure they have a protocol for weight shifting and skin care incontinence protocol. Surveyor asked if she has communicated the need for weight shifting and skin care/incontinence care. NP-F stated. I have, it would be in my notes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor confirmed NP-F progress note dated 2/24/25 documents (in part) . HPI: The pressure ulcer is located on the coccyx and has been present for 5 weeks. The pressure ulcer was present on admission. According to the NPIAP (National Pressure Injury Advisory Panel) staging system, the pressure ulcer is classified as stage 3. Additional factors that contribute to non-healing include bed-bound status, bowel incontinence and bladder incontinence. Provider Comments document Prognosis: Guarded, dependent on offloading and moisture management. Discussed pressure relief and redistribution strategies. Patient is on an appropriate support surface for the patient to use when supine and should be on a weight shifting schedule and skin care/continence schedule per facility protocol. The balance of moisture is critical to wound healing. I have given caregivers instructions about managing skin moisture which include using a skin barrier and wicking agent. Patient wears an adult brief. Consider Foley catheter in future if urine management becomes a problem. On 3/19/25 at 11:02 AM, Surveyor spoke with MDS-O who reported it was her understanding that nursing is responsible for creating care plan related to problem areas identified. On 3/18/25 at 9:00 AM, Surveyor met with Acting Director of Nursing (DON)-C to discuss concerns: R3 admitted to the facility with pressure injuries and MASD to her coccyx. R3 was identified to be always incontinent of bowel and bladder and dependent for toileting hygiene. A personalized care plan was not implemented to manage R3's incontinence and potential effect on her skin. R3's coccyx MASD progressed to a stage 3 pressure injury. Acting DON-C reported she will review information and see if there is any additional information to provide. No additional information was provided prior to survey exit. On 3/19/25 at 12:30 PM, Nursing Home Administrator (NHA)-A, Acting DON-C, and DON-B were advised of the above concerns.