STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525654	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on observations, interviews and record review, the facility did not ensure 3 of 3 residents (R7, R5, and R1) reviewed with pressure injuries (PI) and at high risk of pressure injury development received the necessary treatment and services to promote healing of existing skin impairments or prevent new pressure injuries from developing. R7 developed a stage 2 PI to the right gluteus on 03/27/24, a stage 2 PI to spine on 05/01/24, and a stage 3 PI to the left heel on 05/13/24 which became unstageable on 5/29/24 resulting in actual harm. The facility did not initiate preventative pressure relieving measures, complete weekly comprehensive assessments of the PI, and no treatment changes or physician notification for increasing size of the PIs. This example is cited at actual harm. R1 was readmitted to the facility on [DATE] with 4 PIs (left heel, right heel, right ischial tuberosity and penis). R1 developed a stage 2 PI to the right heel in the facility on 4/24/24. R1 did not have weekly comprehensive assessments of the PIs to determine staging, no updated treatment orders or physician notification, or updated interventions on the care plan for pressure relief for the heels to promote healing. R5 had a facility acquired PI from friction and shearing, to the left lower extremity. A comprehensive assessment of the PI was not completed. Interventions to prevent friction and shearing were not put in place until after the PI developed. This is evidenced by: Facility policy titled Wound Care with no date of review/revision states the following: Documentation: The type of wound care given, date and time the wound care was given, position in which the resident was placed, name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound, and how the resident tolerated the procedure. Reporting: Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*According to the National Pressure Injury Advisory Panel/European Pressure Ulcer Advisory Panel (NPIAP/EPUAP), Weekly assessments provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan. The NPIAP also directs that the professional should reevaluate the pressure injury assessment plan if the pressure injury does not show signs of healing within two weeks and adjust the treatment accordingly. The NPIAP also states that a comprehensive wound assessment should be completed weekly and should consist of the following information: - location of the wound; - category/stage of the wound; - size of the wound; - tissue type(s); - description of the wound bed and periwound; - a description of the wound edges; - the presence of any sinus tracts, undermining, or tunneling; - the presence of exudate or drainage; - the presence of necrotic tissue or slough; - the presence of odor; - the presence/absence of granulation tissue and/or epithelialization; and - the current treatment being utilized. The NPIAP 2019, page 115, . Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. The underlying cause and formation of pressure injuries is multifaceted; however, by definition, pressure injuries cannot form without loading, or pressure, on tissue. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues and, ultimately, in tissue damage . Example 1 R7 was admitted to facility on 11/09/23 with pertinent diagnoses of encephalopathy, type II diabetes mellitus with foot ulcer, dysphagia, cognitive communication deficit, acquired absence of left toe, cellulitis of left lower limb, stage 3 pressure injury, diabetic foot ulcer, dementia, diabetic neuropathy, and left femur fracture. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R7's admission Minimum Data Set (MDS) assessment completed on 11/14/23 stated no skin conditions were present and R7 was at risk for PI. R7's most recent MDS assessment, which was a quarterly, dated 05/16/24 states R7 had two stage 2 PIs and one stage 3 PI. R7's Brief Interview for Mental Status (BIMS) score is 9 out of 15 indicating moderate cognitive impairment. Surveyor reviewed R7's comprehensive care plan and noted the following: ADL: The resident has an ADL self-care performance deficit (initiated 11/9/23) Interventions: -Reposition every 2 hours (initiated: 6/14/24) -Self cares: Max assist for all bathing and dressing (4/19/24) -Transfers: hoyer (4/19/24) -W/C MOBILITY: Use leg rests only for transportation then remove. Encourage w/c mobility to/from his room in resident's hallway. (1/23/24) -BED MOBILITY: extensive assist (11/29/23) SKIN: Resident has pressure area to left heel. (facility acquired). Resident has diagnosis of dementia, type II diabetes, is assist of II and the hoyer for transfers, and repositioning. (Initiated 11/29/23; last revised 6/12/24) INTERVENTIONS: -Apply PRAFO boot to left foot to be worn all day and then protective boots in bed. Check skin over for redness/skin breakdown from brace before and after putting on and off. (6/12/24) This intervention started one month after the PI on the heel was identified. -Avoid friction and shear. Keep linen and clothing wrinkle free to avoid undue pressure points to skin, avoid sliding and pulling (11/10/23) -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. (11/10/23) -Be sure heels are not touching the bed or the backs of the wheelchair. (6/12/24) -Check right heel BID and report any redness, black area/skin concerns. (initiated: 11/10/23) (revised: 06/12/24) This intervention started one month after the PI on the heel was identified. -Complete Braden scale per facility policy (11/10/23) -Do skin care BID- 1.) rinse with saline, pat dry, 2.) Silvadene 1% topical cream on plain aquacel over ulcer. 3.) Cover with ABD pad and roll gauze. (initiated: 11/10/23) (revised: 6/12/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Encourage repositioning every 2-3 hours to offload on pressure areas and to promote healing. (initiated: 5/10/24, revised: 6/12/24 change to repositioning every 1-2 hours) -Inform the resident/resident representative/MD/dietary of any new skin breakdown promptly. (11/10/23) -Resident goes to wound care at least weekly. See documentation on measurements. (initiated: 5/10/24, revised: 6/12/24) Review of dietary orders did not address nutritional, and protein needs to promote healing of wounds. R7's weight on 03/18/24 was 228.8 lbs. and on 06/17/24 weight was 209 lbs. resulting in a weight loss of 8.65% in 3 months. Surveyor reviewed R7's PI documentation: Right gluteus stage 2 PI: in-house acquired on 03/27/24. New open area identified right buttock. Area cleansed well. Border foam applied. MD and Power of Attorney (POA) updated. No physician orders for treatment documented. 03/27/24: 2cm x 1.4cm 04/03/24: 1.45cm x 1cm 04/24/24: 5.5cm x 3.27cm - MD/POA not notified of change. 05/01/24: 5.31cm x 2.23cm 05/08/24: 5.38cm x 2.13cm No assessment of wound bed, characteristics, drainage, or depth for the above measurements. No new interventions to promote healing for the above measurements. 05/15/24: 2.87cm x 1.21cm 05/21/24: 4.85cm x 1.64cm - No physician notification of increase in size of wound. 06/05/24: 2.57cm x 0.81cm 06/12/24: 1.62cm x 0.5cm No assessment of wound bed, characteristics, drainage, or depth for the above measurements. No new interventions to promote healing for above measurements. Spine stage 2 PI: in-house acquired on 05/01/24. 05/01/24: 1.36cm x 0.49cm - MD or POA not notified. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	05/03/24: Daily and as needed for soiled dressing. To coccyx remove soiled dressing, cleanse with NS (normal saline) pat dry and cover with bordered foam. one time a day. Of note, this is not the coccyx, but the lower spine PI. 05/08/24: 1.27cm x 0.61cm No assessment of wound bed, characteristics, drainage or depth for the above measurements. No new interventions for the above measurements. On 05/10/24, care plan was updated to encourage repositioning every 2-3 hours. 05/10/24: Treatment Administration Record documented wound care to coccyx, cleanse with ns (normal saline), pat dry and cover with bordered foam dressing. every day shift every 3 day(s) for coccyx wound change if soiled, saturated or coming loose, until healed. Of note, this is not the coccyx, but the lower spine PI. 05/15/24: 1.49cm x 0.86cm - No physician notification of increase in size. 05/21/24: 1.43cm x 0.53cm 06/05/24: 1.24cm x 0.22cm 06/10/2024: Appointment scheduled for 06/12/24. R7 seen by provider and requested a wound care referral for wound on his back. 06/12/24: 1.29cm x 0.78cm No assessment of wound bed, characteristics, drainage or depth for the above measurements. No new interventions for the above measurements. 06/13/2024 Received new order for Mid thoracic spine dressing change daily, clean wound with saline wound wash, pat dry, SSD (put on like frosting/thick), cover with mepilex/one time a day for wound care. On 06/17/24 at 1:36 PM, Surveyor observed foam dressing in place mid-back with no date. Surveyor observed during wound care moderate amount of greenish-yellow drainage on dressing with no odor. Surveyor observed nickel-size opening. Peri wound area dry, intact, reddened, purple, and white. Surveyor observed to be non-blanchable. Left Heel 05/13/24: 4.22cm x 3.51cm - No assessment of wound bed, characteristics, or depth. New order to cleanse with NS, pat dry, apply border foam daily every day and every evening for stage 3 pressure ulcer to left heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	05/14/24: Received wound care orders for PRAFO boot to be worn all day and then protective boots in bed to offload the heel and Augmentin 875/125 1 tab BID x10 days. Left heel stage 3 PI: in-house acquired on 05/13/24. Received orders for wound care clinic with first visit 05/14/24. No comprehensive assessment including wound bed, depth, characteristics documented. Surveyor did not observe prior to 05/13/24 any skin assessments of the left heel or interventions to relieve pressure from heels to prevent injury. On 5/14/24 Signs of wound infection noted and treated promptly with antibiotics started the same day. 05/15/24: 2.74cm x 1.79cm - No assessment of wound bed, characteristics, or depth. 05/16/24 - final lab on wound culture from 05/14/24 wound clinic visit - two morphologic types of Coryneform bacilli present and light Staphylococcus aureus. No new orders or interventions for the left heel. 05/21/24: 2.58cm x 0.44cm - No assessment of wound bed, characteristics, or depth. 05/29/24 -wound clinic assessment: 75% necrotic tissue and 25% red tissue in the periphery. The necrotic area measures 1.8cm x 1.1cm inside the wound. Measurement of wound is 2.0cm x 2.5cm x 0.1cm. Dull redness surrounding the wound with exfoliation at the edge. The dull redness measures 8x6cm. New wound orders received - left heel unstageable pressure injury wound care: Do daily 1. Rinse with saline. Pat dry. 2. SSD on plain aquacel. 3. Cover with ABD pad and gauze roll. Left heel ulcer infection: Doxycycline 100mg 2x/day x14 days. (wound culture done). Prafo boot LLE on at all times. May wear soft protective boot at night. Follow-up in 2 weeks. Noted documentation in the wound clinic notes that the wound clinic spoke with facility who states wound has been present for at least 2 months. Of note, Surveyor did not find wound culture results in medical record so cannot verify if PI was infected. 06/05/24: 4.26cm x 3.12cm - No assessment of wound bed, characteristics, or depth. 06/12/24: 5.56cm x 3.35cm -No assessment of wound bed or depth. 06/13/24: New order for left heel pressure 1) clean with saline wound wash, pat dry. 2) Silvadene 1% cream (apply like frosting/thick) on plain aquacel, place over ulcer. 3) cover with ABD and rolled gauze. PRAFO boot day and night. 4) heel protector to RLE. On 06/17/24 at 8:08 AM, Surveyor observed R7 in wheelchair in hallway near elevator nursing station. Unable to determine if pressure reducing cushion in place. On 06/17/24 at 11:40 AM, Surveyor observed R7 sitting in wheelchair in same position, near nursing station. Surveyor asked RN E when wound care would be completed for R7 for observation. RN E stated after lunch R7 likes to lie down. On 06/17/24 at 1:36 PM, R7 was put in bed. R7 was in wheelchair for 5 hours and 28 minutes without repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor observed roll gauze dressing in place on left heel dated 6/14. No drainage on outside dressing. During wound care, Surveyor observed left heel to have a large, blackened area with some open areas of heel with red discoloration of skin. Surveyor observed scant serosanguinous drainage present with no odor. On 06/17/24 at 1:36 PM, Surveyor observed foam dressing in place on right buttock with date 6/13. During wound care, Surveyor observed no drainage present. Surveyor observed wound bed intact, darkened discoloration. Surveyor did not observe Registered Nurse (RN) check for blanching. Surveyor observed peri wound area is darkened with 2 areas of bright red noted at 5 o'clock and 11 o'clock position. On 06/17/24 at 1:36 PM, Surveyor observed R7 lying on back in bed, podus boots (heel-protecting boots) on. R7 was on a concave mattress with higher edges to prevent rolling out of bed. No additional pillows or offloading devices observed in place for pressure points. R7 received wound cares and returned to same position of lying on back when cares completed at 2:06 PM. On 06/17/24 at 4:40 PM, Surveyor observed R7 lying on back in same position. R7 was in same position of lying on back in bed for 2 hours and 34 minutes without repositioning. On 06/17/24 at 2:06 PM, Surveyor interviewed Registered Nurse (RN) E about what kind of mattress was in place under R7. RN E stated it was a curved edge mattress to prevent R7 from rolling out of bed. Surveyor asked if it was also a pressure relieving mattress. RN E stated no, she didn't think so. On 06/17/24 at 3:40 PM, Surveyor interviewed Director of Nursing (DON) B and Nursing Home Administrator (NHA) A regarding wound care policy and expectations. Surveyor asked what the expectation is for completing wound care assessment and documentation. DON B stated that wound assessment is completed weekly by the Wound Nurse (WN) and documented with pictures in resident's Electronic Medical Record (EMR). Surveyor asked if any documentation is expected to be completed by RN doing dressing change. DON B stated that the RN would only document the care being completed. Surveyor asked expectations regarding observing changes in wound during cares to be communicated to provider. DON B stated that the provider should be notified immediately. Surveyor asked if pressure reducing mattresses are used in facility. NHA A stated yes. Surveyor asked what is considered a pressure relieving mattress. NHA A stated they are mattresses using air - either a pump or air mattress. Surveyor requested manufacturer's guide for the mattress observed being used by R7 as pressure relieving. NHA A unable to provide documentation by survey exit. Example 2 R1 was admitted to the facility on [DATE] with diagnoses including orthopedic surgery, type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema-bilateral, anemia in chronic kidney disease, type 2 diabetes mellitus with diabetic neuropathy-unspecified, chronic kidney disease stage 5, venous insufficient (chronic) (peripheral), and arteriovenous fistula-acquired. R1 has a surgical history of arterialization of deep vein of the left lower extremity with further surgical amputation that was complicated by infection in January 2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's MDS assessment dated [DATE] states R1 requires substantial/maximum assistance with toileting hygiene, shower/bath, lower body dressing, putting on/taking off footwear, personal hygiene, mobility with rolling left and right, lying to sitting, sitting to lying, sit to stand, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers, partial/moderate assistance with upper body dressing, and is independent with eating. R1's BIMS score is 15 out of 15, which indicates intact cognition. R1's MDS Section M states R1 has a PI, is at risk for pressure injury, has more than one pressure injury. MDS states R1 has one stage 2 PI, and one stage 2 PI was present on admission. MDS states no pressure reducing device for chair, has a pressure reducing device for bed, no turning/repositioning program, no pressure ulcer/injury care, and has a surgical wound. R1 was hospitalized on [DATE] until 04/19/24. R1's readmission MDS dated [DATE] states in section M that R1 is at risk for developing PIs, current number of unhealed PIs listed; two stage 2 PIs with one being present upon admission/entry or entry, one stage 3 PI and was present upon admission/entry or reentry. One unstageable pressure injury due to coverage of wound bed by slough and or eschar and this was present upon admission/entry or reentry. R1's care plan: Resident has potential for impairment to skin integrity related to diabetes, peripheral artery disease, gangrene, surgical amputation of all toes on the left foot. Resident has the following wounds: PI to left heel, PI to right heel, surgical amputation of all toes to left foot-wound vac in place, and PI to tip of penis. Date initiated 04/05/24. Goals: Resident's (R1) skin will show signs of healing by review date. Date initiated 04/05/24 and target date 07/04/24. Interventions: Administer treatments and monitor for effectiveness, be sure to pack tunneling when completing wound care, complete Braden scale per facility protocol, encourage good nutrition and hydration to promote healthier skin, inform resident/representative/physician/dietary of any new skin breakdown promptly, monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to physician, no tub bathing or submerging wound until healed. Pressure reduction mattress to bed, pressure reduction cushion in chair. Repositioning every 2-3 hours and prn. Date initiated 04/05/24. Avoid friction and sheer. Keep linen and clothing wrinkle free to avoid undue pressure points to the skin, avoid sliding and pulling. Date initiated 05/02/24. On 04/05/24 at 6:12 p.m., R1's nursing progress note states R1 arrived at facility at 4:20 p.m., via transport van from hospital. R1 at facility for therapy, wound care, and dialysis services. R1 had surgical amputation to his left great toe, left 2nd toe and left 3rd toe. R1 has a stage 2 pressure ulcer to his coccyx. No measurements or assessment was completed of the coccyx. Surveyor reviewed left heel PI wound documentation: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/24/24, wound assessment documented left heel PI was a stage 3 measuring 4.3cm length x 3.9 cm width. No documentation of pressure relieving device for heels, no updates to care plan, and no physician notification for treatment to promote healing. 05/02/24 at 12:39 p.m., progress note stating Medi honey every other day to left heel. Cover with a dry dressing one time a day every other day. No other documentation in nursing progress notes about left heel PI. Surveyor reviewed first right heel PI wound documentation: On 04/24/24, wound assessment documented right heel stage 2 in house acquired with measurements 1.02 cm length x 0.83 cm width. No documentation indicating: exact date present, no documentation if wound has tunneling or undermining, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. On 05/01/24 at 5:47 a.m., R1's weekly wound assessment states, right heel stage 2 PI house acquired, present 1 week. PI measures 0.7cm length, x 0.7cm width, and depth not applicable. Documentation states wound is improving. No documentation indicating: exact date present, no documentation if wound has tunneling or undermining, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. Surveyor reviewed second right heel PI documentation: 05/01/24 at 5:49 a.m., R1's weekly wound assessment states, right heel stage 2 PI present on admission for 2 weeks. PI measures 3.4cm length x 1.5cm width, and depth not applicable. Documentation states PI is a new wound and physician, resident/responsible party, dietician, and therapy were notified. No documentation indicating: exact date present, no documentation if wound has tunneling or undermining, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. Surveyor reviewed third right heel DTI PI documentation: 05/01/24 at 5:50 a.m., R1's weekly wound assessment states, right heel PI present on admission staged as DTI (deep tissue injury), which has been present for 2 weeks. PI Measures 4.1cm length x 1.7cm width, and depth not applicable. Documentation indicated progress as new and physician, resident/responsible party, dietician, and therapy were notified. No documentation indicating: exact date present, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. Documentation of three PIs on the right heel lacks clarification because of different staging and measurements with no indications as to when each wound developed. Surveyor reviewed right ischial tuberosity PI wound documentation, unknown when acquired since no documentation: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 04/24/24, the wound assessment documented states right ischial tuberosity PI stage 3 measuring 1.85 cm length x 1.39 width, and depth not noted. Surveyor could not find documentation indicating: how it was acquired, how long wound has been present, exact date present, no documentation if wound has tunneling or undermining, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. Surveyor unable to determine if PI was facility acquired. On 05/01/24 at 6:44 a.m., the weekly wound assessment documentation states right ischial tuberosity PI stage 3 measuring 1.2cm length x 1.1cm width, and depth not applicable. Documentation states wound staged by in-house nursing and wound is improving. No documentation indicating: how it was acquired, how long wound has been present, exact date present, no documentation if wound has tunneling or undermining, no description of wound bed, if wound had exudate, no description of peri-wound, no indication if R1 had pain, and no treatment orders documented. Surveyor reviewed penis PI wound documentation: R1's skin care plan initiated on 04/05/24 documented a PI on the tip of the penis. R1 had an indwelling Foley catheter upon admission to the facility. On 04/08/24, R1 was transported to the hospital via ambulance. At the hospital, R1's Foley catheter was changed and no documentation about a PI to tip of penis. On 04/09/24 when physician saw R1 in the facility, physician ordered removal of the indwelling Foley. R1 did not voice any concerns or complaints to the physician about any pain or PI of the penis. On 04/10/24, R1's indwelling Foley catheter was removed. No documentation indicating a PI to the tip of the penis. On 04/30/24, wound assessment completed stating stage 2 PI to tip of penis with measurements of 1.1 cm length x 1.0 cm width and being present on admission. No other documentation of wound. On 05/02/24, physician progress note for facility visit with R1 stated nursing had reported R1 has a scab on the penis near the urethral opening. R1 told physician that the wound/scab has been present since R1 had an indwelling Foley catheter. No drainage noted, and R1 did not report fever or chills. Physician noted area of the urethral opening is intact, without surrounding erythema, edema, warmth, tenderness, or drainage. Physician ordered for facility to apply bacitracin to area. No other documentation noted in R1's medical record regarding PI of the tip of the penis. Resident was hospitalized on [DATE] for hypoglycemia and did not return to the facility. Surveyor unable to visualize wounds to assess accurate staging. On 06/17/24 at 1:30 p.m., Surveyor requested additional information on R1's wounds, treatments, and outcomes. On 06/17/24 at 2:00 p.m., Surveyor interviewed R1 and R1's sister about wound care and treatment while R1 was a resident at the facility. R1 stated care and treatment of R1's wounds was not good. R1 stated the staff did not pay attention to the wounds as they should have. R1 stated R1's heels were not kept off the bed and R1 did not receive boots for R1's feet until transferred to the hospital from dialysis. (This occurred on 05/06/24). R1 stated R1 wound have been in worse shape if not winding up at the hospital. R1 stated R1's condition was worsening while R1 was a resident at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525654	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Lakeside	1016 Lakeshore Dr Rice Lake, WI 54868

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/17/24 at 5:30 p.m., Surveyor interviewed DON B and asked what the expectation is for the wound care documentation and treatments. DON B stated part of the reason DON B came to the facility was to implement a wound care program for the facility. Surveyor asked for clarification on when the right ischial tuberosity PI started. Surveyor asked if it was present on readmission from the hospital on 4/19/24. DON B reviwed documentation and could not answer the question. Surveyor asked if DON B is aware that the weekly documentation only includes length and width of wounds. No descriptions are documented, no depths are measured, resident pain not documented, and no treatment orders documented on the weekly wound care rounds. Surveyor informed DON B that the photographs taken of the wounds are to enhance the documentation of the wounds, but not to replace the documentation. Some of the photographs are blurry and the markings the nurse puts on the photographs to mark where the wound is, covers the wound, or blocks clear view of the wound. DON B states facility is working on a program. On 06/18/24 at 3:49 p.m., Surveyor interviewed infection preventionist/wound care nurse (IP/WC) I. Surveyor asked IP/WC I what the facility policy is on wound care and documentation. IP/WC I stated wounds are measured and photographed every week and the information is documented on the skin and wound form. Surveyor asked about R1's wound care and lack of documentation for treatments being completed, lack of documentation indicating what the treatment is, what the wound is, the description of the wound, date wound identified, and no documentation of treatments of PI/wounds of the left gluteus or the ischial tuberosity. R1's weekly wound/skin forms only had scant information and none of the assessments were comprehensive. IP/WC I did not have an answer. Surveyor asked why R1 did not have any orders to prevent PIs or interventions to relieve heel pressure. IP/WC I stated R1 was in and out of the hospital frequently during R1's stay at the facility. IP/WC I did not offer any further explanation of wound care or prevention. 41945 Example 3 R5 was admitted to facility on 5/28/24 with metabolic encephalopathy, COPD, peripheral vascular disease, generalized edema, congestive heart failure, mild cognitive impairment, reduced mobility, and unspecified stage pressure ulcer of buttock. R5's MDS assessment at admitted d 06/03/24 states R5 is at risk for PI and admitted with three stage 2 PIs on right lateral leg and two stage 2 PIs on coccyx/buttock. R5's BIMS score is 14 out of 15 indicating cognition is intact. R5's BRADEN score for predicting pressure sore risk is 18 indicating R5 is at risk. Surveyor reviewed the comprehensive care plan completed for R5 on admission and noted the following (Initiated 5/29/24): ADL: The resident has an ADL self-care performance deficit r/t weakness, decreased mobility. The resident will improve current level of function in ADLs through the review date. (5/29/24) -BED MOBILITY: extensive assist of 1 (5/29/24) (continued on next page)

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	525654	A. Building B. Wing	06/17/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-TOILET USE: extensive assist of 1 (5/29/24) -TRANSFER: assist of 1 with four wheeled walker (5/29/24) -Encourage the resident to participate to the fullest extent possible with each interaction. (5/29/24) The resident has Peripheral Vascular Disease (PVD). The resident will remain free of complications related to PVD through review date. (5/29/24) -Elevate legs when sitting or sleeping. (5/29/24) -Encourage good nutrition and hydration. (5/29/24) -Encourage resident to change position frequently, not sitting in one position for long periods of time. (05/29/24) -Monitor/document/report PRN any s/sx of complications of extremities: coldness of extremity, pallor, rubor, cyanosis and pain. (05/29/24) SKIN: The resident has potential for impairment to skin integrity r/t decreased mobility. The resident's Skin injuries will show signs of healing by review date. (5/29/24) -Administer treatments and monitor for effectiveness (5/29/24) -Complete Braden scale per facility protocol (5/29/24) -Encourage good nutrition and hydration in order to promote healthier skin. (5/29/24) -Follow facility protocols for treatment of injury. (5/29/24) -Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. (5/29/24) -PRESSURE REDUCTION: Pressure reduction mattress to bed, pressure reduction cushion in chair. (5/29/24) -REPOSITIONING: Every 2-3 hours and PRN (5/29/24) -TOILETING: Q 2-3 hours while awake and PRN during NOC (5/29/24) On 06/17/24, Surveyor completed review of R5's wound care treatment and assessment and noted the following: Right gluteus stage 2 PI admitted with PI on 05/29/24: (continued on next page)

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	525654	A. Building B. Wing	06/17/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	05/29/24: Gluteal cleft/buttock wound; Cleanse with NS, dry, apply Medi honey gel or hydrogel to open areas, then place calcium alginate or hydrofiber, secure with a large sacral foam dressing. Change daily and PRN soiling Once it's healed, use barrier cream bid one time daily for wound care. 06/05/24: 0.81cm x 0.73cm. - No depth, characteristics, wound bed description, or drainage documented. Only documentation of wound assessment. Picture in record obscuring center of wound. On 06/17/24 at 10:01 AM, Surveyor observed foam dressing in place on right buttock with a date of 6/14 written on it. Surveyor observed during care wound bed is intact with slight white area of new skin growth and no drainage. Peri wound area is clean, dry, intact, blanchable, and no redness. On 06/17/24, Surveyor observed wound dressing dated 6/14. Wound care order states to change dressing daily and PRN. Intergluteal cleft stage 2 PI admitted with PI on 05/29/24: 05/29/24: Gluteal cleft/buttock wound; Cleanse with NS, dry, apply Medi honey gel or hydrogel to open areas, then place calcium alginate or hydrofiber, secure with a large sacral foam dressing. Change daily and PRN soiling Once it's healed, use barrier cream bid one time daily for wound care. No wound assessment of measurements. 06/05/24: 0.11cm x 1.07cm x 0.19cm 06/12/24: 0.43cm x 1.2cm x 0.5cm No characteristics of wound bed, description, or drainage documented for above measurements. Right lateral thigh distal stage 2 PI admitted with PI on 05/29/24: 05/29/24: wound order for right lateral leg; keep clean and dry. Paint with betadine daily one time a day for wound care. No wound assessment of measurements. 06/05/24: 2.72cm x 2.37cm 06/12/24: 3.22cm x 2.35cm No characteristics of wound bed, drainage, or depth documented for above measurements. No physician notification of increase in woun