STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation, interview and record review, the facility failed to identify and ensure that residents received the necessary treatment and services, to promote healing and prevent infection for 2 of 9 residents (CR#1 and Resident #2) reviewed for pressure ulcer in that: -The facility failed to identify and treat pressure sore on CR#1's penis, left foot 5th toe, Right Toe Digit 1, great -The facility failed to provide CR#1 with an air mattress for 20 days with multiple diagnoses of Stage 4 pressure ulcers. -The facility failed to initiate precautions for pressure sores when an order was not obtained for air mattress. -The facility failed to prevent progression of the CR#1's Stage 4 Sacral Pressure Ulcer that was not getting better and enlarged from 6x6.2x0.4 cm on 2/27/24 to 10.7x8.9x0.4 cm on 4/15/24, had odor and exhibited signs of infection. -Resident #2's Pressure wounds dressing was not changed as per physician's orders. An Immediate Jeopardy (IJ) was identified on 5/2/24 at 3:46 p.m. While the IJ was lowered on 5/5/244 at 4:27 p.m., to no actual harm with potential for more than minimal harm that is not Immediate Jeopardy at a scope of pattern while the facility continued to monitor the implementation of effectiveness of their plan of removal. These failures placed residents with multiple Stage 4 pressure ulcers and those who are at risk of developing wounds at risk of hospitalization , surgeries, sepsis infection, a decline in health, and pain. Findings included: CR #1 (continued on next page)

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

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident#1's face sheet dated 4/24/24 revealed he was a [AGE] year-old male admitted to the facility initially on 2/2/24 and readmitted on [DATE] with a diagnosis of pain, type 2 diabetes, elevated white blood cell count, pressure ulcer of right lower back unspecified stage, and pressure ulcer of sacral region, unstageable. Record review of CR#1's comprehensive MDS dated [DATE] revealed a BIMS score of 8 indicating moderately impaired cognition. CR#1 required substantial maximal assistance for eating, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear and personal hygiene. CR #1 was dependent on staff for rolling left and right, sitting to lying, lying to sitting on side of bed, and sitting to standing and chair/bed-to-chair was not attempted due to medical condition or safety concerns. CR#1 could not attempt toilet/transfer, tub shower transfer, car transfer and walk 10 feet due to CR#1's current illness. CR#1 had diagnosis of local infection of the skin and subcutaneous tissue, pressure ulcer of unspecified site, Pressure ulcer of sacral region, unstageable, hypertension (high blood pressure), neuralgia and neuritis, and diabetes insipidus. Record review of CR#1's Care plan dated 4/24/24 revealed, CR#1 had an indwelling foley catheter related to impaired skin integrity. He was at risk for skin impairment related to acute skin impairment, impaired mobility, muscle weakness and incontinence with interventions as administer medications as ordered, follow facility policies/protocols for the prevention/treatment of skin breakdown, and monitor nutritional status. CR#1 was identified for a pressure area: Stage: unstageable, Right heel with the goal to have skin remain clean and dry and area will heal over the next 90 days. The interventions included: Encourage by mouth and fluid intake within dietary limits, keep family/responsible party and MD informed of CR#1's progress, assist with turn/repositioning every two hours and prn, Use padding between pressure areas and positioning devices for proper body alignment. Provide pressure relieving device for bed and wheelchair. Monitor labs and report and report to MD, and Dietary consult for proper nutrition resolve pressure area. CR#1 had a stage 4 pressure ulcer Sacrum with interventions such as Drawsheet to be used when positioning patient, Notify physician of abnormal labs, Obtain lab work as ordered, Use of suspension devices, pillows, and /or wedges to reduce pressure on heels and pressure points, and Provide Wound Care as directed by physician order. CR#1 also had stage 3 pressure ulcer (12,16) right ischium with interventions such as: Patients who rely on nursing staff for positioning will be turned and repositioned every 2 hours and as needed, Perform nutritional screening, Adjust diet/supplements as indicated to reduce the risk of skin breakdown, Pressure redistribution support cushion in chair/wheelchair, Pressure redistribution support surface mattress on the bed, Provide Wound Care as directed by physician Order, Use of suspension devices, pillows, and /or wedges to reduce pressure on heels and pressure points, Obtain lab work as ordered, Notify physician of abnormal labs, and Drawsheet to be used when positioning patient. Record review of CR#1's Physician Orders dated 4/30/24 revealed the following orders: *2/20/24 Nectar thickened liquids, puree *2/21/24 Weekly head to toe 1 time weekly *Wound Supplement (30ml) Oral one time daily dated 2/22/24 *Supplement pass (120 cc) Oral one time daily dated 3/1/24 and discontinued 4/8/24 *3/7/24 Wound Treatment- Santyl 3 times daily (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*3/12/24 Wound Treatment-Collagen 1 Time Daily *3/12/24 Wound Treatment- Santyl 3 times weekly *3/13/24 Wound Treatment- Collagen 1 Time daily discontinued 3/27/24 *3/13/24 Wound Treatment- Collagen 1 Time daily *3/13/24 Wound Treatment- Santyl 3 times weekly *3/15/24 Pre-Wound Treatment- Pain intensity Score-Can verbalize 1 time daily *3/15/24 Post Wound Treatment- Pain intensity Score- Can verbalize 1 Time daily * *3/27/24 Wound Treatment- Santyl 1 Time Daily *3/27/24 Podus Boot (S) 1 time daily *4/11/24 Initiate IV Access 1 Time Daily *4/11/24 IV Dressing Change Every 1 Week Further review of CR#1's orders did not reveal orders for an air mattress. Record review of CR#1's February 2024 TAR dated 2/20/24- 2/29/24 revealed: Wound Treatment-Dry Dressing by Shift Starting 2/20/24 Discontinued 2/21/24 Cleanse Wound to Sacrum with normal saline or skin. Cleanser. Pat Dry. Cover with Dry Dressing. Wound Treatment- Apply Betadine Three Times Weekly Starting 2/21/24 Order date 2/21/24 Discontinued 3/6/24. Clean wound to right heel with normal saline pat dry, apply betadine and cover with dry dressing. RP Aware Wound Treatment-Collagen Three Times Weekly Staring 2/21/24 Order [NAME] 2/21/24 Discontinued 3/6/24. Notes: Clean wound o sacrum with normal saline pa dry apply collagen and cover with dry dressing. RP aware. Wound Treatment-Collagen Three Times Weekly Staring 2/21/24 Order [NAME] 2/21/24 Discontinued 3/12/24. Notes: Clean wound o sacrum with normal saline pat dry apply collagen and cover with dry dressing. RP aware. Wound Treatment- Apply Betadine Three Times Weekly Starting 2/21/24 Order Date 2/21/24. Discontinued 3/6/24. Notes: clean wound to right heel with normal saline pat dry apply betadine and cover with dry dressing. RP aware. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wound Treatment- Collagen Three Times Weekly Starting 2/21/24 Order Date: 2/21/24 Discontinued: 3/6/24 Notes: Clean wound to sacrum with normal saline pat dry apply collagen and cover with dry dressing. RP aware. Wound Treatment- Collagen Three Times Weekly Starting 2/21/24 Order Date: 2/21/24 Discontinued: 3/12/24 Notes: Clean wound to right Ischium with normal saline pat dry apply collagen and cover with dry dressing. RP aware. Wound Treatment- Collagen Three Times Weekly Starting 3/6/24 Order Date: 2/21/24 Discontinued: 3/12/24 Notes: Clean wound to sacrum with normal saline pat dry apply collagen and calcium alginate cover with dry dressing. RP aware. Wound Treatment- Santyl Three times weekly Starting 3/7/24 Order date 3/6/24. Discontinued 3/12/24. Notes: clean wound to right heel with normal saline pat dry apply Santyl and cover with dry dressing. RP aware Wound Treatment Collagen One time daily starting 3/13/24 Order date 3/12/24 Discontinued 3/27/24. Notes: Clean wound to sacrum with normal saline pat dry apply collagen and calcium alginate cover with dry dressing. RP aware Wound Treatment- Collagen One time daily Starting 3/13/24 order date: 3/12/24 discontinued 3/27/24 Notes: Clean wound to sacrum with normal saline pat dry apply collagen and calcium alginate cover with dry dressing. RP aware. Wound Treatment-Collagen One time daily starting 3/13/24 order date: 3/12/24 Completed. Notes: clean wound to right ischium with normal saline pat dry apply collagen and cover with dry dressing. RP aware. Wound Treatment-Santyl Three times Weekly Starting 3/13/24 Order date: 3/12/24 Completed. Notes: clean wound to right heel with normal saline pat dry apply iodosorb and cover with dry dressing every other day. RP aware. Podus Boot(s) One time daily Starting 3/27/24 Order Date: 3/27/24 Completed Notes: Apply heel protector boots daily RP aware. Wound Treatment-Santyl One time daily Starting 3/28/24 Order Date: 3/27/24 Completed Notes: Clean wound to sacrum with normal saline pat dry apply Santyl and calcium alginate cover with dry dressing. RP aware Record review of CR#1's Wound Evaluation & Management Summary dated 2/27/24 revealed the following 1.Site 1-Stage 4 Pressure Wound Sacrum Full thickness: *Wound size 6x6.2x0.4cm, *Surface Area: 37.20 cm, *Exudate: Light serosanguinous, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*granulation tissue: 100%, *Wound progress: not at goal .Dressing treatment plan .Alginate calcium apply once daily for 20 days. Collagen sheet apply once daily for 30 days, Secondary Dressings: Gauze island with bdr apply once daily for 9 days, *Plan of Care Reviewed and Addressed: .Float heel in bed; off-load wound; Cleanse with wound cleanser at time of dressing change; Group 2 Mattress; Pressure Off-loading boot; multi vitamin once daily by mouth; Vitamin C 500mg Twice daily by mouth. 2.Site 2-Stage 4 Pressure Wound of the Left heel full thickness: Wound Size 5x6x0.2 cm. This visit's measurements are noted by the clinician to be exactly the same as the previous visit. *Surface Area: 30.00 cm, *Exudate: Light Serous, Thick adherent devitalized necrotic tissue: 80%, granulation tissue: 20%, *Wound progress: not at goal .Dressing Treatment Plan: Primary dressing(s) Santyl apply every two days for 20 days, Secondary dressing(s): gauze island with bdr apply every two days for 9 days. *Plan of Care reviewed and addressed: Float heel in bed; off-load wound; Cleanse with wound cleanser at time of dressing change; Group 2 Mattress; Pressure off-loading boot; Multi vitamin once daily by mouth; Vitamin C 500mg twice daily by mouth. Site 2: Surgical Excisional debridement procedure: Remove necrotic tissue and establish the margins of viable tissue. *Consent for procedure: Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 02/17/2024 to the patient who indicated agreement to proceed with the procedure(s). *Procedure note: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 3.0cm^2 of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 80 percent to 70 percent. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented in the Assessment and Plan section below. 3.Stage 3 Pressure wound of the right ischium . Record review of CR#1's Wound Evaluation & Management Summary dated 4/9/24 revealed: Stage 4 Pressure Wound Sacrum full thickness: *Wound size 8.9x6.8x0.4 cm, *Surface Area: 60.52 cm, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Peri wound radius: Surrounding DTI (Purple/Maroon), *Exudate: Moderate Serous, thick adherent devitalized necrotic tissue: 10%, *Slough: 10%, *Granulation tissue: 80%, *Wound progress: Exacerbated due to generalized decline of patient. Dressing treatment plan: primary dressing(s) Alginate calcium apply once daily for 30 days; Santyl apply once daily for 9 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. Plan of care reviewed and addressed: Float Heels in Bed; Off-Load Wound; Cleanse with wound cleanser at time of dressing change; Group-2 Mattress; Pressure Off-Loading Boot; Multivitamin Once Daily PO; Vitamin C 500mg Twice daily PO. SITE 1: surgical excisional debridement procedure: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 9.08cm^2 of devitalized tissue and necrotic muscle level tissues along with slough and biofilm were removed at a depth of 0.4 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 20 percent to 5 percent. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented in the Assessment and Plan section below. Record review of CR#1's Local hospital labs dated 4/15/24 revealed WBC 26.7, Hemoglobin 8.1, Sedimentation rate 58, Platelet count 504, Procalcitonin 2.53 and lactic acid was 2.3. Record review of CR#1's WOUND EVALUATION & MANAGEMENT SUMMARY dated 4/15/24 revealed: Appetite-Fair .Bed- Group 1 .Stage 4 Pressure Wound Sacrum full thickness- *Wound size 10.7 x 8.9 x 0.4 cm, *Surface area: 95.23 cm, *Exudate: Light serous, Thick adherent devitalized necrotic tissue: *100%, Wound progress: Exacerbated due to generalized decline of patient. Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater depth today. Impaired nutritional status discussed with patient, family, nursing staff, and/or dietitian. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Dressing treatment plan: Primary Dressing(s) Sodium hypochlorite solution (Dakin's) apply once daily for 30 days: 0.25% soaked gauze. Secondary Dressing(s) Gauze Island w/ bdr apply once daily for 17 days. Plan of care reviewed and addressed- *Recommendations: Float Heels in Bed; Off-Load Wound; Cleanse with wound cleanser at time of dressing change; Group-2 Mattress ; Pressure Off-Loading Boot ; Multivitamin Once Daily PO ; Vitamin C 500mg Twice daily PO. SITE 1: Surgical excisional debridement procedure indication for procedure Remove Necrotic Tissue and Establish the Margins of Viable Tissue, Remove Thick Adherent Eschar and Devitalized Tissue. Consent for procedure: Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 02/06/2024 to the patient who indicated agreement to proceed with the procedure(s). Procedure note: 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 19.05cm^2 of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.5 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 80 percent. Hemostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the plan of care are documented in the Assessment and Plan section below. Record review of CR#1's Local Hospitalist History & Physical dated 4/16/24 at 7:26 am by Physician revealed, . previous admissions for infected decubitus ulcers who was discharged last from our facility 2/2nd after debridement of decubitus ulcer and was continued on IV antibiotics for 2 weeks who presents this time from SNF [facility] with leukocytosis. Reportedly patient was placed again IV antibiotics through mid-line in facility. He was found to have significantly elevated WBCs so he was sent to the ER. In our ER he was found to have WBCs 26.7, Anemia with Hgb of 8.1, Lactic acid of 2.3 so he was referred for admission for further evaluation. Spoke with CR#1's family member who reported that patient has been declining recently in facility. She noted to have worsening wounds and worsening mental status. She reported very poor po intake for over the last 2 months. She reported being angry at the facility for not doing enough for him. Assessment and Plan revealed, 1. Sepsis: Secondary to pneumonia and suspected infected sacral decubitus ulcer. Continue IV fluid and IV antibiotics. Admit to tele. Close monitor to VS and wbc's 2. Gram negative pneumonia: Left lower lobe. empiric broad spectrum antibiotics Will add and suction. Pulmonary hygiene, 3. Multiple decubitus ulcers presented on admission: Possible infected sacral decubitus, Continue antibiotics. surgical eval for possible need for debridement, 4. Significant leukocytosis: Secondary to sepsis. Monitor. 5. Lactic acidosis: Secondary to above. Monitor. 6. Chronic Anemia: Likely anemia of chronic disease. Monitor. 7. Possible UTI associated with indwelling foley catheter POA: Exchange foley. Empiric antibiotics. Follow cx 8. History of dysphagia: Speech eval. He was placed on pureed last hospitalization . 9. Acute Metabolic encephalopathy: Likely secondary to pneumonia and sepsis. Record review of CR#1's Hospital assessment dated [DATE] at 2:08 pm revealed: #1 Sacrum: Pt with extensive stage IV pressure ulcer with ~100% black necrotic tissue / bone exposed / foul odor / + undermining / + stringy slough. This site would benefit from surgical consult. #2 (R) Ischium: Unstageable. Site with 100% soft brownish yellow slough coverage / foul odor. This site would benefit from surgical consult. #3 (L) Ischium: Superficial skin breakdown / 100% red/pink tissue. #4 (R) heel: 100% stringy yellow slough coverage / max foul odor / max drainage amount. This site would benefit from surgical consult. Support surface/specialty bed recommendation: Low air loss replacement with bed frame. Recommended consults: General surgeon, RN and Attending MD notified of recommendation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/24 at 8:20 pm revealed: Assessment and Documentation: *Head to Toe skin assessment completed. Yes, *Skin integrity intact. No, Wound 01/27/24 Diabetic Ulcer Right Heel (Active) First Assessment Date/First Assessment Time: 01/27/24 1651, Primary Wound Type: Diabetic Ulcer Orientation: Right Location: Heel. Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM revealed, Current Dressing Status Clean, dry, and intact, Wound 01/27/24 Pressure Injury Midline Sacrum (Active). First Assessment Date/First Assessment Time: 01/27/24 1651, Primary Wound Type: Pressure Injury Orientation: Midline, Location: Sacrum Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM revealed: Current Dressing Status Clean, dry, and intact, Wound 01/27/24 Pressure Injury Left Ischium (Active), First Assessment Date/First Assessment Time: 01/27/24 1651, Primary Wound Type: Pressure Injury Orientation: Left Location: Ischium Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM, Current Dressing Status Clean, dry, and intact, Wound 01/27/24 Pressure Injury Right Ischium (Active), First Assessment Date/First Assessment Time: 01/27/24 1651, Primary Wound Type: Pressure Injury Orientation: Right Location: Ischium Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM, Current Dressing Status Clean, dry, and intact, wound 04/16/24 Other (comment) Penis (Active), First Assessment Date/First Assessment Time: 04/16/24 0830, Present on Original Admission: Yes, Primary Wound Type: Other (comment) Location: Penis. Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM, Wound Base Appearance Red, Peri-wound Assessment Induration; Red, Urethral Catheter Other (Comment) 16 Fr. (Active) Placement Date/Time: 04/16/24 1800 Present on Admission: NO Reason for Insertion: (c) Healing of open sacral or perineal wounds in incontinent patients Inserted/Placed by: (c) Catheter Type: (c) Other (Comment) Tube Size : Catheter . Assessments 4/16/2024 8:20 PM Already in place, Site Assessment Edema, Collection Container Standard drainage bag to dependent drainage, Securement Method Securing device, Daily Review of Reason for Continuing Urinary Catheterization Healing of open sacral or perineal wounds in incontinent patients. Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/24 at 8:20 pm revealed: Dorsal (foot); Left Description (Comments): left foot 5th toe, Assessments Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/2024 8:20 PM, Primary Dressing Open to air, Wound 04/16/24 Other (comment) Dorsal (foot); Right Toe D1, great (Active) Record review of CR#1's Local Hospital 2 RN Skin Assessment Note dated 4/16/24 at 8:10 pm revealed: First Assessment Date/First Assessment Time: 04/16/24 0810 pm, (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a record review and interview on 4/30/24 at 9:46 am with RN, Quality & Patient Safety Dept. of CR#1's hospital records she stated CR#1 admitted to the local hospital on 2/2/24 and had been admitted to the hospital the first time on 1/26/24 and discharged on [DATE] to the Nursing facility. She stated CR#1 had multiple decubitus ulcer present on admission on 1/26/24 on the heel, sacrum and buttocks and readmitted to the hospital on 4/15/24. She stated CR#1 was admitted for pneumonia of left lung, and sepsis secondary to pneumonia, Wbc 26.7, additional pressure ulcers on his scrotum, dorsal left foot, dorsal right foot, right toe, penis, abrasion to upper back and sacrum. She stated record review of pressure ulcer and observation of the pictures revealed large pressure sore, much worse from when he was discharged from the hospital. In a record review and interview on 4/30/24 at 11:02 am of CR#1's local hospital records with BSN, Wound Ostomy Nurse he stated CR#1's ulcer of the right heel could be from the eschar coming off and it was still unstageable. He stated they keep the eschar stable because they did not know the underlying condition of the patient. He stated he did not know the underlying condition of the patient, but it was usually due to sepsis, and/or high blood pressure. He stated CR#1 had sacral debridement on 1/31/24, 4/24/24 surgery on right foot, incision and partial calcinatory with skin biologic. CR#1 was found to have severe protein malnutrition and was diabetic. He stated the dietician met with him on 4/19/24 and CR#1 was tolerating the pureed food. He stated they are discussing whether CR#1 would get an ostomy and PEG tube for optimum healing, but he was receiving nutrition supplements. The Wound Ostomy Nurse stated the type of dressing was important to see how CR#1's wound was being cared for. He stated CR#1's right heel opened up because the Nursing home added Santyl. He stated if CR#1 had poor circulation then you do not want to debride the wound. He stated sepsis was infection to the bloodstream that can lead to multiple organ failure. He did have elevated lactic acid, but it went down. He stated the Nutrition pays a big part of his wound and if he was not getting any nutrition supplements that was huge, no peg, no ostomy and off-loading was the key. He stated if CR#1 was not turning or repositioning that can get bad fast. He stated CR#1 required strict turning and support surface. In a record review and interview on 4/30/24 at 11:46 am at Local Hospital Physician she stated the wounds getting better depends on a lot of things like nutrition, and wound care. She stated CR#1 did not have a feeding tube, and she did not know how much nutrition he was getting. She stated Albumen was 1.7 and pre albumen. She stated CR#1's albumen had increased to 1.4 and CR#1 needed air fluidized. She stated CR#1 was on a specialty bed and was being turned. CR#1 was having contamination of stool and they could not account for what happened to him for the 2 months. He was in the nursing facility. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/30/24 at 7:50 pm with CR#1's family member she stated on 4/15/24, she popped into the Nursing facility unannounced to see CR#1 and on this day, she walked into CR#1's room and his room door was left almost closed. She stated she walked in the room and noticed that CR#1 was laying on his side and he was bare bottom, no diaper on, no depend on, not covered, and she freaked out. She stated there was a fly in the room and her eyes noticed on CR#1's bottom and she saw bone. She stated she went into the hallway asking where the nurse was and there was no one in the hallway. She stated the caregiver said she was changing CR#1 and she had to go get the diaper. CR#1's family member asked the CNA shouldn't she already have the diaper if she was changing him. CR#1's family member stated the CNA said she went to go get the wound nurse. She stated she told the CNA that there was a fly in the room and flies carry disease. She stated she noticed an IV in CR#1's arm and no one told her anything. She stated she holds his Medical Power of Attorney and she spoke with the DON. CR#1's family member stated the in-house Doctor came twice a month and the Doctor mentioned CR#1's wbc was high. She said there were antibiotics is in CR#1's arm and she said she would rather CR#1 go to the hospital to find out what type of infection he is fighting or what he has. CR#1's family member stated she told the nursing facility this at around 11 am or 11:30 am on 4/15/24. CR#1's family member stated the DON did not want to call 911 and said they gave CR#1 antibiotics. CR#1's family member stated before she gave CR#1 a needle they were supposed to call her. She said the DON went to her computer and there was no note. She stated the DON apologized and said someone was supposed to call her. She said she did not give any kind of consent to go to the hospital by 911. CR#1's family member stated the DON did not want to call the ambulance and said the only time they call if it's a dire situation, but she said CR#1 has an infection and they don't know what it is. She stated it was 7 pm and she was waiting, and she was crying and could not even look at CR#1. CR#1 stated she went to her car and called another family member, and it was overwhelming, and they just did not care. CR#1's family member stated the nursing facility wanted to call local transportation company and when CR#1 was checked into the hospital, they took pictures of the wounds. She stated CR#1's bed sore on his bottom, and his foot was a Stage 4 where the bone was exposed. She stated when CR#1 got to the hospital he had pneumonia, he was severely dehydrated and malnutrition. CR#1's family member stated the facility just said that CR#1 was not eating, but it was their job to find another way to get him to eat. She stated they should have called her to ask if she wanted them to do a feeding tube, but no one called her. She stated when CR#1 got to the hospital they said he was 144 lbs and he had to have 2 bags of blood, 2 surgeries this week on both bed sores because they were infected with sepsis. She stated CR#1 was in the hospital for 2 weeks and CR#1 also had a pressure sore on his penis and scrotum that they found on 4/15/24 and she has the pictures the hospital took. She stated when CR#1 got to the facility before he was eating, and he just dropped a lot of weight. She stated CR#1 was found turned over with nothing on his bottom, the curtain was not pulled back, the door was almost closed, and the IV was in his arm. She said the facility did not come to her with the 2nd care plan until she went to talk with them on 4/15/24 and they said maybe you can put him on hospice or maybe put him on a feeding tube on that day. She stated the DON did not ask her about a feeding tube until 4/15/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/30/24 at 2:33 pm with the Wound care Nurse she stated CR#1 admitted , left and went home and came back the next day long-term. She stated CR#1 was bed bound, admitted with wounds, and was a total assist resident. She stated CR#1 admitted with a wound to the sacrum, heels, and ischium. She stated the Wound Care Doctor saw CR#1 every week. She stated the sacrum wound was not improving any, but the ischium was. She stated the wound was beefy red until a week or so before his last stay. She stated the day of CR#1 being transferred to the hospital the Wound Care Doctor just gave orders to try to turn the wound around. The Wound Care Nurse stated CR#1 had 2 family members, but they were aware of what was going on. She stated the other Doctor made rounds that day on 4/15/24 and she does not put a clean dressing on a soiled body, so she put the button (call light) on and waited for the CNA and she came and started gathering materials to do incontinent care. She stated she was rounding with the Doctor and the CNA called her and she went downstairs, and the CNA had finished cleaning him up. She stated when the CNA initially called her, she was in with the [TRUNCATED]