STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675671	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	7887 Cambridge St Houston, TX 77054

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** 46561 Based on interview and record review, the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 (Resident #1) of 5 residents whose records were reviewed for pressure ulcer care. 1. The facility failed to minimize Resident #1's exposure to moisture and keep the skin clean of fecal contamination, after the resident was discovered to have moisture associated skin damage to her sacral region. 2. The facility failed to implement Resident #1's wound care treatment orders to a facility acquired wound to her sacral region, which led to the decline of the wound from a stage III to a stage IV pressure ulcer. Resident #1 was admitted to the hospital with a diagnosis of sepsis, Staphylococcus aureus, and gram-negative rods. An IJ was identified on 07/04/24 at 5:27 pm. The IJ template was provided to the facility on [DATE] at 5:27 pm. While the IJ was removed on 07/07/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal. This failure could place residents at risk of the formation of new or worsening skin breakdowns and a decrease in their quality of life and care. Findings included: Record review of Resident #1's face sheet on 07/02/24 revealed an eighty-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were Myasthenia [NAME] (neuromuscular disorder causing weakness of skeletal muscles), elevated white blood count, Type 2 Diabetes (insulin resistance), hypertension (high blood pressure), and syncope and collapse (fainting and passing out). Record review of Resident #1's care plan dated 05/23/24 revealed that she had urinary incontinence, and her goal was to have no skin break downs. Interventions for this focus were to assist with toileting as needed and to perform peri care as needed. (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 BIMS score dated 05/23/24(clinical assessment to determine resident's strength and needs) a score of 7out of 15 indicating the resident was, moderately impaired. Record review of Resident #1's Admission/Readmission assessment dated [DATE] noted that there was moisture associated skin damage to the peri area. Record review of Resident #1's Braden Scale for predicting pressure score risk and risk factors, completed by physician dated 06/04/24 described the skin as very moist and she was chairfast, as her ability to walk was severely limited or non-existent. Nutrition was noted to be adequate, and friction and shear posed as a potential problem because the resident would occasional slide down in the chair or bed. Additional risk factors were a history of pressure ulcers (prior to facility admittance), urinary or bowel incontinence, bedfast, decreased, or impaired bed/ chair mobility, and diabetes. On a score of 1-18, Resident #1 was identified as a 15, indicating a mild risk. Record review of Resident #1's Progress Notes during a visit with physician on 06/06/24, revealed that her skin had no suspicious lesions and was described as warm and dry. Record review of Resident #1's wound care notes from the WCD documented that he initially viewed the sacral wound on 06/12/24. The wound was debrided at bedside and the new orders given were santyl/calcium alginate and zinc oxide applied to the wound with the recommendation of a low air mattress for wound stabilization. Resident #1's wound to the sacral region was documented as a stage III pressure ulcer. Record review of Resident #1's wound care notes from the WCD, dated 06/19/24, revealed that her wound on the sacral region had declined to stage IV pressure ulcer. Orders were to use Santyl/calcium alginate and zinc oxide applied to the wound with the recommendation of a low air mattress for wound stabilization. Record review of Resident #1's TAR ordered on 06/07/24, revealed to cleanse the sacrum with non-saline wound cleanser, pat dry, apply TAO (triple antibiotic ointment) and zinc oxide, cover with clean dry dressing daily until healed. On 06/19/24, the TAR reflected that the orders for the sacrum were to cleanse with non-saline or wound cleanser, pat dry, apply Santyl/calcium alginate, zinc oxide, and apply dressing. No orders were added on 6/12/24. Record review of Resident #1's facility progress notes stated that on 06/23/24, CNA A reported that during a transfer, Resident #1 began to shake, was drowsy, and eyes rolled to the back of her head. She had a bowel movement that saturated her brief, pants, and ran onto the wheelchair. Resident was sent out to hospital. Record review of Resident #1's hospital admittance record dated 06/26/24 revealed a diagnosis of sepsis, the Sacral wound culture identified Staphylococcus aureus, and the urine culture from 6/23/24 showed Gram-negative rods (bacteria commonly found in infections). (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 07/03/24 at 1:24 pm, CNA A stated that Resident #1 would often have bowel movements and she would need to be changed frequently. She explained that her diarrhea was so bad that when she performed peri care, she would have to change the bedding as well. She stated that the bandages on her sacrum wound were often saturated during peri care and the wound care nurse would redress it if she was there. She explained that on 06/23/24, she saw the wound for the first time and saw feces inside of the wound once she removed the bandage. She alerted WCN A to come clean the wound because CNAs were not allowed to bandage them. In an interview on 07/03/24 at 1:59 pm with Nurse A, she stated that she only saw the wound once upon her initial admission assessment and had no idea of its deterioration or saturation during incontinent care. She stated that she never touched the wound because she said that it was always covered, and the wound was cleaned daily by a WCN. Nurse A explained that Resident #1 used the restroom a lot and the staff tested her for c-diff (bacterium known for causing diarrheal infections), but her results came back negative. She stated that when she returned from the hospital on 06/04/24, she was on antibiotics. She explained that no one had told her that Resident #1's wound was getting worst and although she performed monthly skin assessments, she was not assigned Resident #1's room number. In an interview on 07/03/24 at 2:14 pm with CNA B, she stated that she worked PRN but when she worked with Resident #1, she remembered her having frequent bowl movements. She remembered her having a wound on her bottom but could recall how it looked. In an interview on 07/03/24 at 2:22 pm with Nurse B, he stated he performed Resident #1's readmission skin assessment on 06/04/24 and he did not know she had a sacral wound until after her discharge on 06/23/24. During her readmission skin assessment, she had excoriation and redness to her sacral region, but it was not a pressure sore. Upon her return, she was also prescribed an antibiotic for a chronic UTI . He was not aware if she had frequent bowel movements and he also had never seen the WCD. He expressed that if the wound was covered in fecal matter he would change the bandage, but he never had to. CNA's were not permitted to change bandages but they would alert the nurse if something needed to be done. He stated in his previous years of working at the facility, the WCN would tell the nurse the status of the wound so that they could add it to their 24-hour report. (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 07/03/24 at 4:04 pm with WCN A, she explained that she was originally a floor nurse and was asked to become the WCN on 06/10/24. She was supposed to receive training from WCN B on 06/10/24- 06/14/24, however she only received training 06/10, 06/11, and 06/14. After rounds with the wound WCD on 06/12/24, she was supposed to complete charting and input new orders from the doctor into the computer. These orders were sent to DON B and WCN B. WCN A did not have access to receive orders at that time and were given to her by DON B, WCN did not have time to finish updating the orders the treatment log and DON B told her that she would get WCN B to input them before his last day on 06/14/24. WCN A stated she had a feeling the orders were not in, but DON B ensured her they had already been updated by WCN B. WCN A stated that she continued with the order entered on 06/07/24 and no air mattress was given to Resident #1 until 06/19/24. WCN A stated that she did not feel secure in this position when she first started because she did not receive a lot of training. She recalled a conversation she had with WCN B when she asked him how do you know if the wound was improving or getting worst in which he replied, you don't. She explained that she received her first official wound training on 07/02/24 and she now felt more confident in this position. She stated that every time she conducted wound care, she would change Resident #1 because she was always covered in urine and feces due to loose, f requent stools, and her bandage would be saturated through. She believed she was the only one to change the bandage because she always initialed and dated the bandage. The next day, the same bandage would still be on her wound. On 06/23/24 during a transfer from the bed to wheelchair with CNA A, Resident #1 became very weak and lethargic. CNA A stated that her eyes had rolled into the back of her head and that she had begun to shake, but it had stopped once she entered the room. WCN A checked Resident #1's BP was 96/60. Initially, WCN A instructed CNA A to transfer her back into the bed because she had a history of syncope . In doing so, Resident #1 had a bowel movement that saturated through her brief, bottoms, and onto the wheelchair. The stool was described as yellowish brown, and a stool sample was collected. The Physician was notified, and Resident #1 was sent to the hospital. In an interview on 07/03/24 at 4:49 pm with WCN B, he stated he was hired in October 2023 as the admissions nurse but ended up preforming wound care prior to his last days. He stated he had stepped in the role as the treatment nurse because the census was low and that determined the number of hours he could work. In order to receive more hours, he decided to preform wound care under the supervision of the WCD. His last week at the facility was from 06/10/24 - 06/14/24, and he was instructed to train WCN A on how to treat wounds, input orders, and update notes into the resident portal. On 06/12/24, he did not round with the WCD because he did not work that day and he still believed the wound to be a moisture associated skin damage. Prior to 06/12/24, Resident #1's orders were to put zinc oxide on her sacrum, and he stated that he did not receive orders from the wound doctor because he could not access his email. He explained that all orders and progress notes from the WCD went directly to DON B, and she would print them out and give them to him. He stated that he did not recall Resident #1 having new orders for Santyl/calcium and she was not on a low-pressure mattress prior to his last day on 06/14/24. He stated that inputting orders were the WCN's responsibility, but it would ultimately fall on DON B since she was the only one to receive them. WCN B stated that when he worked with Resident #1, her bandage on the sacral region would not be saturated through, but he knew it would be same bandage from the day before due to his initials and the date he had written on it. (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 07/03/24 at 5:11 pm with DON A, she stated that she started on 06/24/24 but was familiar with facility policy and Resident #1's file. She said that DON B's last day as the DON was on 06/13/24. She explained that WCN B did have access to the orders because only the WCN and the DON had the permissions to access the WCD's portal. She said that WCN B told DON B that he had completed entering the orders in the system, however as the DON , DON A stated she would have followed up to make sure it had been completed. She had noticed that upon her original admittance of 05/22/24 until her second readmittance on 06/04/24, resident #1 had already been on several round of antibiotics and she was also taking an 850mg twice daily dosage of metformin, which had the tendency to create loose stools. She stated all nurses have the responsibility to change bandages and it was crazy that were not changing Resident #1's bandages if saturated after a bowel movement. She explained the detriment in not keeping a sacral wound clean would be risk of sepsis and infections. In regard to WCN A's training, the facility was under the impression that WCN B would extend his resignation a few days longer to complete his training with WCN A, but he changed his mind and proceed to make his last day on 06/14/24. Normally, WCN A would have gone to the facility's sister facility to receive more detailed wound care training, however the facility was temporarily closed due to water damage from a storm that hit the region earlier that season. She was trained and check listed for her skills on 07/03/24 with a regional wound care nurse. DON B was contacted by phone on 07/04/24 at 11:40 am for an interview. She did not answer. A voicemail and text message were left requesting a call back. The Administrator was notified of the IJ on 07/04/24 at 5:27 pm and given the IJ template due to the above failures and a POR was requested. The POR was accepted on Friday 07/05/24 at 1:05 pm, and reflected the following: Failure: o The facility failed to ensure Resident #1 received proper wound care and implement physician's orders. Corrective Action for resident found to be affected: o Resident was discharged to the hospital on June 23,2024. Identification of others having the potential to be affected: o An audit was completed on July 4, 2024 by the DON and ADON to ensure residents with wounds have appropriate wound / treatment orders in place. No new areas identified with no negative findings. o Skin assessments were completed on July 4, 2024 by the nursing admin team to include the Director of nursing, assistant director of nursing, nursing supervisor and wound care nurse for current residents to ensure all wounds have physicians orders in place for treatments for those identified with wounds. No new areas were identified with no negative findings. o Braden Scales were reviewed and updated by the nursing admin team to include the Director of nursing, assistant director of nursing, nursing supervisor and wound care nurse for current residents on July 4, 2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Measures / systemic changes to ensure the deficient practice does not recur: o Education of licensed nursing staff related to wound care / dressing changes to include completing dressing changes as needed on all shifts starting on July 4, 2024. Nursing staff will not be allowed to work until they have received the education which will be provided prior to the start of their shift. o Education of licensed nursing staff related to obtaining and implementing physicians orders for residents with wounds starting on July 4, 2024. Nursing staff will not be allowed to work until they have received the education and will receive education prior to the start of their shift. o Education of licensed and certified nursing staff related to incontinent care and keeping residents clean and dry starting on July 4, 2024. Nursing and certified nursing assistant staff will not be allowed to work until they have received the education and will receive education prior to the start of their shift. o Education of certified nursing staff related to notifying a licensed nurse when a dressing is soiled starting on July 4, 2024. Nursing staff will not be allowed to work until they receive the education which will be completed prior to the start of their shift. o All education will be completed by the Director of nursing or the Assistant Director of Nursing or designee. o Director of Nursing, Assistant Director of nursing or nursing supervisor will observe wound care twice weekly. o Director of Nursing, Assistant Director of Nursing and Nursing Supervisor and wound care nurse were educated by the Regional Director of Clinical Services on July 4, 2024. o Medical Director was notified of the IJ on July 4, 2024. o Root cause analysis completed on July 5, 2024, and taken to QAPI . o QAPI to be conducted on July 5, 2024. Facility Plan to ensure compliance: o QAPI will be completed on July 5, 2024. o Education will be completed prior to nursing staff working. o Education will be provided upon hire for new associates. o New admissions will be reviewed daily to ensure residents admitted with wounds have a physician's order for treatments. o Random rounds will be completed daily by licensed nursing staff to ensure residents are clean and dry and that dressings are clean and dry. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o DON / Designee will audit residents with wounds weekly to ensure proper treatments are in place. Audit will be completed by reviewing residents with wounds physician's orders. o DON / Designee will do random rounds 3-5 times a week visualizing residents with wounds to ensure dressings are clean and dry. o Weekly skin assessments will be monitored 5X per week to ensure completion. In an interview on 07/05/24 at 10:39 am with DON B, she stated that her last day as the DON at the facility was on 06/16/24 but she currently worked PRN. She stated that to her knowledge, Resident #1 was admitted with a wound, but she could not describe how it looked initially, what wound stage it was, or how it had progressed. On 06/15/24, DON B saw the wound for the first time, after a CNA told her that the bandage had fallen off and it needed to be redressed. At the time, the wound had yellow sloughing on it but there was no odor. She asked WCN A what was the treatment orders for the sacral wound and she stated that the WCD gave new orders on 06/12/24. DON B stated that she instructed WCN B to put the updated orders for residents in the system on 06/13/24 and he informed her that it had been completed. DON B recalled that she looked through some of the new orders for wounds, but she did not look through all of them and stated she spot checked the system to see if they had been updated. She explained that normally after the WCD finished rounding at the facility, they wound meet and discuss the orders for each resident. However, that day , she did not arrive to facility until later and did not get to touch base with the WCD. Once the WCD had finished his rounds and uploaded his paperwork, DON B would print the orders off and hand them to the WCN. She stated that she was not 100% sure if WCN B had access to the portal where she retrieved the orders from because WCN B had transitioned into the position because it was open. On 06/12/24, DON B pulled the orders for WCN A because she did not have access to them, and she could not confirm if she had access after she left on 06/16/24 because she did not follow up. She explained that after she saw the wound on 06/15/24, she checked the orders in the system and saw a PRN (she could not recall what it stated) that she felt was not appropriate for the condition of the wound. WCN A told her that there were new orders for Resident #1, and she told her to make sure they were carried out, however she did not contact the WCD about the status of her access. In an interview attempt physician was contacted by phone on 07/05/24 at 10:55 am and on 07/06/24 at 11:00 am. He did not answer, and a voicemail was left regarding a call back. Monitoring/Verification of Plan of removal The POR was reviewed as followed. The facility created a binder and numbered each tab in the binder with the completed documented necessary to fulfill the plan. Saturday, July 06, 2024, at 10:30am Identification of others having the potential to be affected: o An audit was completed on July 4, 2024, by the DON and ADON to ensure residents with wounds have appropriate wound / treatment orders in place. No new areas identified with no negative findings. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Reviewed the POR binder and saw that there were 14 residents out of 39 residents currently at the facility with wounds. The 14 residents with wounds had their treatment order reconciled and examined on 07/04/24 for accuracy. All treatment orders were accurate. o Skin assessments were completed on July 4, 2024, by the nursing admin team to include the Director of nursing, assistant director of nursing, nursing supervisor and wound care nurse for current residents to ensure all wounds have physician's orders in place for treatments for those identified with wounds. No new areas were identified with no negative findings. -Skin sweeps were documented and completed for 36 residents at the facility. The census was 30, but two residents were discharged , and one was at the hospital. o Braden Scales were reviewed and updated by the nursing admin team to include the Director of nursing, assistant director of nursing, nursing supervisor and wound care nurse for current residents on July 4, 2024. Measures / systemic changes to ensure the deficient practice does not recur: -Review of Braden skin assessment reflected that 36 assessment had been completed for each resident in the facility. The updated scores were reflected on the resident roster and a copy of each Braden assessment was provided to the surveyor. Although there was a current census of 39 residents, 2 residents were discharged , and 1 was in the hospital. o Policies and procedures related to wound care and treatments were reviewed and utilized for education. -Review of the policies showed no changes. o Education of licensed nursing staff related to wound care / dressing changes to include completing dressing changes as needed on all shifts starting on July 4, 2024. Nursing staff will not be allowed to work until they have received the education which will be provided prior to the start of their shift. -Review of employee roster showed that there were 48 direct care staff at the facility. Of these staff, the DON stated that all full time and part-time employees had been educated. The number of employees on 07/05/24 revealed that 29 employees had been educated on wound care and dressing changes. The DON informed the investigator that the remainder of employees she was not aware of who they were, or they were active employees. DON Consulted with the corporate hiring staff and got an updated number for the employee roster. A total of 38 direct care staff were identified. Of these 38 staff, 3 staff members were on vacation for 2 weeks and one staff member was on 6 months of medical leave. Out of 34 staff currently working, 6 were left to be interviewed. This consisted of DON B, an interim treatment nurse, and the others were CNA's. Topics covered were what to do when a dressing came off during changing and nurses were responsible for wound care of each shift if needed, treatment order policy and skin integrity, and the PU policy was reviewed. A total 29 signatures were on the sign in sheet for staff. o Director of Nursing, Assistant Director of Nursing and Nursing Supervisor and wound care nurse were educated by the Regional Director of Clinical Services on July 4, 2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-This review reflected that both ADON's, DON, and WCN were educated by the regional director of clinical services. Topics included wound care, physician orders, monitoring of wounds, wound treatment, and policies and procedures. Sunday, July 07, 2024 Reviewed the education of licensed and certified nursing staff related to incontinent care and keeping residents clean and dry starting on July 4, 2024. Nursing and certified nursing assistant staff will not be allowed to work until they have received the education and will receive education prior to the start of their shift. Reviewed the education of certified nursing staff related to notifying a licensed nurse when a dressing is soiled starting on July 4, 2024. Nursing staff will not be allowed to work until they receive the education which will be completed prior to the start of their shift. In an interview on 07/07/24 at 1:03 pm with CNA A, she stated she worked the 6am- 2pm shift. She attended the wound care in-service and was told to always notify the nurses. Staff must notify the nurses immediately if they see any changes in the skin. If giving incontinent care, staff should always let the nurse know that there should be a new bandage on the wound and clean it good. If a resident had wounds, staff were to reposition every 2 hours. The abuse coordinator was the administrator. In an interview o n 07/07/24 at 1:07 pm with CNA C, she stated that she worked the 2pm- 10pm shift. She explained that in the in- service they covered and were taught to make sure when you are with a patient with wounds, clean them, and if you have to take off the bandage, notify the nurse immediately so they can change it. They covered wounds to make sure if they did have a wound, they must be turned and repositioned every 2 hours. Staff must make sure they are comfortable. The abuse coordinator was the administrator and staff reported to the charge nurse too, but especially the administrator. In an interview on 07/07/24 at 1:57 pm with CNA D, she stated she worked 6am -2pm shift. The in-service covered at the facility had a patient with wounds and how to do patient care. If the wound was contaminated by feces, CNAs were to let the nurse know so that the nurse could come and change the bandage. If staff noticed changes to the skin or to a wound, they were to alert the nurse. If a person had a wound on their bottom, aides were to reposition or turn them every 2 hours to get them off the wound. The abuse coordinator was the ED . In an interview on 07/ 07/24 at 2:05 pm with CNA E she stated she worked that the 10pm- 6am shift. For CNA's, they covered that if staff go in and clean a person with wounds, if they have a BM and it goes into the dressing, they taught them how to properly clean it and properly take off the bandage. Aides were to clean them properly and notify the nurse immediately. If staff saw changes in a resident's skin, they were to report it and she would notate it in the resident portal. Aides used the zinc oxide cream and another cream as a preventative measure so residents would not get new wounds. Staff were supposed to reposition every 2 hours. She stated personally she would check on residents every hour because they would flip over because they didn't like to stay in the same position. The abuse coordinator was the administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675671	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Alzheimer's Center of Excellence	7887 Cambridge St Houston, TX 77054

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 an interview on 07/07/24 at 1:33 pm with CNA B, she stated she worked the 2pm- 10pm shift. They had an in-service for incontinent care and wounds. If aides saw a wound developing on a resident or any changes developing on the wound, they should let a nurse know. If the bandage was soiled or had fallen, aids would not replace it, but they should let the nurse know about immediately. As an aid, when a resident had a wound on the bottom, they were to make sure the resident stayed dry and if possible, we would put a wedge on the resident so they can stay off the wound. Staff were to reposition them every 2 hours. The abuse coordinator was the administrator. In an interview on 07/07/24 at 1:54 pm with CNA F, she stated she worked the 2pm- 10pm shift. The in-service covered: staff were to make sure that the dressing was dry. If it was soaked through or off, aids were to go call the nurse so they could change it and put on a new one. Aids should notify the nurse as soon as they noticed any changes to the skin or the wounds. Residents should reposition them every 2 hours. The abuse coordinator was the administrator. In an interview on 07/07/24 at 2:02 pm with Nurse C, she stated she worked the 2pm-10pm shift. The facility in-service covered skin integrity and how they assessed the wound. If a CNA saw a soiled bandage, they should tell her. She would then take it off, clean it, and apply a new dressing according doctors treatment plan. A nurse should change a residents wound dressing whenever it was soiled or whenever it needed to be. A resident with wounds should be repositioned every two hours. Treatment orders for wounds are found in the doctor's medication order and they must follow whatever the WCD prescribed. The abuse coordinator is the Admin . In an interview on 07/07/24 at 3:35pm pm with Nurse D, she stated she worked the 10pm- 6am shift. Nurses were educated on wound policy, reminded that they needed to check to see what wound orders consisted of, not to wait for the wound nurse, and if they should carry out wound care if they saw that it was needed. If they saw anything, they should notify the doctor. If nurses saw a wound dressing that needed to be changed, they needed to check the orders and carry it out. They have an order for everything. Staff should not take anything upon yourself but must carry the order out exactly how it was stated. If changes were noticed, they were to describe the wound and tell the doctor. Aids (CNAs) were to notify the nurses immediately. Nurse D stated they did have an order for creams, but if she saw any redness, she would still notify the doctor. A resident should be repositioned every 2 hours, and if they started to complain, she would work with them for their comfort. The administrator was the abuse coordinator. In an interview on 07/07/24 at 3:42 pm with Nurse E, she stated worked the 6am- 2pm shift. She explained that the in-service covered when the dressing was soiled, the CAN's were to notify the nurse will remove the dressing and preform wound care. Redress the wound. She would retrieve the orders from the TAR and follow them exactly how they are in the TAR. The wound care was daily, but some wounds have orders for as needed. A nurse might change the bandage on a wound if the bandage is soiled or off. Daily and as needed. The CNA should notify us immediately of any skin changes and she would notify the doctor as soon as permissible. A resident should be repositioned as need and every 2 hours. They covered abuse and neglect, and the abuse coordinator was the ED or administrator . (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 07/07/24 at 3:48 pm with WCN A, she stated she worked Monday through Friday and started her shift at 6am until her tasks were completed. She explained that aids were taught what to do when they see the bandage soiled. They were to tell wither herself or the nurse so it could be changed. Nurses must be notified of any changes they see. She stated that she also did skin sweeps to check everyone's skin and the Braden scales skin test. Nurses were allowed to do wound care when they are working, and they have orders in the computer for it. Staff now understood the expectations and WCN A felt they were willing to do everything. She also said that nurse have access to the keys on her cart and they knew what type of medication to use. The orders were in the computer, and she also updated PRN orders for all wounds. Nurses should notify the doctor if they saw any signs of infection, like discharge or saw any changes on the wound itself. The abuse coordinator was the administrator. All residents should be repositioned every 2 hours or sooner. WCN A also clarified that she now had access to get wound orders from the WCD, who directly sent her the information after each visit. In an interview on 07/07/24 at 3:29 with Nurse A, the stated that in the case a CNA told a nurse that the wound was declining, nurse would have to report to wound doctor or the doctor in charge. If the CNA told the nurses that the dressing was coming off, or like if they had a BM, nurses were to change the dressing. All aides (CNAs) must notify us immediately. The treatment card displayed the treatment orders. Nurses preformed skin integrity sweeps on residents weekly and it can be viewed in the computer if there was a scheduled date. Residents with wounds should be repositioned every 2 hours at least. The abuse coordinator was the administrator. In an inter [TRUNCATED]