STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675831	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemere Estates	10880 Edgemere Blvd El Paso, TX 79935

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission for 1 of 6 residents (Resident #3) reviewed for baseline care plan. Resident #3 did not have a baseline care plan developed within 48 hours of admission that addressed his services that were being provided. This failure could place newly admitted residents at risk of not receiving the care and services and continuity of care. Findings include: Record review of Resident #3's face sheet dated 02/05/25, revealed, admission on 01/30/25 to the facility. Record review of Resident #3's hospital history of physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with Type 2 Diabetes Mellitus and pressure ulcer. Record review of Resident #3's admission MDS dated [DATE], revealed, no impairment in cognition with a BIMS score of 13 and the resident was able to recall and make daily decisions. Resident #3 was coded for risk of pressure ulcers and unhealed pressure ulcers. Resident #3 was coded for stage 3 pressure ulcer. Resident #3 was to have pressure reducing devices for chair, for bed, turning/repositioning program, pressure/ulcer/injury care, applications of ointments/medications, and hydration interventions. Record review of Resident #3's Baseline Care Plan was reviewed on 02/05/25, revealed, Resident #3 did not have a baseline care plan generated nor a comprehensive care plan. During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated Resident #3 did not have a baseline care plan done and it should have been done on 01/31/25. The ADON stated she did not know why one was not done but it should have been done by the admitting nurse. The ADON stated the purpose of the baseline care plan was to instruct staff on how to care for the resident immediately on admission. The ADON stated the risk was the resident not getting the care and services needed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/10/25 at 11:45 AM, with Interim-DON, he stated upon admission the admitting nurse should generate a baseline plan within 48 hours. The Interim-DON stated the nurse was responsible for creating the baseline care plan. The Interim-DON stated the purpose of a care plan was to better know how to take care of the resident. The Interim-DON stated it would have an impact on the care of the resident if a baseline care plan was not created. Record review of facility Assessments Policy dated 11/17, revealed, A baseline person center-care plan of care for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care. The baseline care plan must be initiated with 48 hours of admission (including re-admission). The care plan must include initial goals be based on admission orders, physician orders, dietary orders, therapy services, social services, and PASRR recommendations if applicable. The baseline care plan must be derived from the nursing assessment form, fall assessment, Braden assessment, bowel/bladder assessment, pain assessment and medication orders.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43871 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process for 1 (Resident #3) of 3 residents reviewed for discharges. The facility failed to ensure Resident #3 had a safe discharge when he left AMA to his home. This failure could place residents at risk of inappropriate transfers and diminished continuity of care. Findings included: Record review of Resident #3 ' s face sheet dated 02/05/25, revealed, admission on 01/30/25 to the facility. Record review of Resident #3 ' s hospital history of physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with Type 2 Diabetes Mellitus and pressure ulcer. Record review of Resident #3 ' s admission MDS dated [DATE], revealed no impairment in cognition with a BIMS score of 13 and the resident was able to recall and make daily decisions. Resident #3 was coded for risk of pressure ulcers and unhealed pressure ulcers. Resident #3 was coded for stage 3 pressure ulcer. Resident #3 was to have pressure reducing devices for chair, for bed, turning/repositioning program, pressure/ulcer/injury care, applications of ointments/medications, and hydration interventions. Resident #3 was occasionally urinary incontinent and frequently bowel incontinent. Record review of Resident #3 ' s Skin Issues Assessment generated by the Wound Care Nurse dated 01/30/25, revealed, left gluteus/ buttock pressure ulcer/ injury stage 3, 9 cm by 3.5 cm by 0.2 cm. Record review of Resident #3 ' s Order Recap dated 01/30/25, revealed, left buttock stage 3 pressure wound. Cleanse with NS and pat dry with a 4 by 4-inch gauze. Apply collagen powder to the wound bed granulated tissue. Cover with foam border dressing. One time a day related to Pressure Ulcer of Other site, Unstageable. Order dated 01/30/25, revealed nursing Intervention: Turn and reposition every hour every shift. Record review of Resident #3 ' s Grievance/Complaint Report dated 02/03/25, revealed, that the Admission Coordinator started the grievance/complaint report and then was passed to the Social Worker to follow up with. It was noted that No wound care had been given on bed sores, the family was having to conduct incontinence care, and medications were not being given. Review of the Grievance/Complaint Report revealed, there was no follow-up mentioned on the facility follow up or the resolution of what the facility was going to do with wound care not being provided for Resident #3, incontinence care, and medications not being given. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 1:50 PM, with LVN B, she stated she came in Monday morning (02/03/25) and was informed that Resident #3 wanted to be transferred to another facility. LVN B stated the family member had informed her that Resident #3 had a bad weekend. LVN B stated she was not informed by the family member nor Resident #3 on what the concerns were. LVN B stated on 02/04/25 that the family member went to the nurse ' s station and requested the AMA form and signed out Resident #3. LVN B stated she helped put Resident #3 in the car and off he went. LVN B stated she informed the NP who responded with what happened. During an interview on 2/5/25 at 4:03 pm, the ADON stated that the Social Worker knew that Resident #3 was going home, but they (nursing department) themselves had not been informed. The ADON stated that during this time, they had been trying to get in contact with the facility where Resident #3 was supposed to be discharged . The ADON stated that APS should have been called due to the home not being a safe discharge option, considering the clinical care Resident #3 required. During an interview on 02/05/25 at 4:36 PM, with the Social Worker, she stated that she would need to review the policy to determine whether the facility was required to call and confirm if the resident arrived at the facility or home safely. The Social Worker stated that it did not appear that the policy required such a call. The Social Worker stated that Resident #3 ' s family member had informed them that she was going to take him home. The Social Worker stated that if the resident required skilled services, particularly wound care, it would need to be assessed whether his home was a safe and appropriate environment for him. The SW stated that they would refer this matter to the nursing team. The Social Worker stated that it had been one day since Resident #3 ' s discharge, and they had not yet discussed the situation with the nurse. The SW stated that the reason for not discussing it with the nurse was that they had planned to ask whether the resident ' s wound required consideration for continued care. The SW stated that they were unsure if the wound care nurses were present at the time. The SW stated that a referral to Adult Protective Services (APS) would be made if necessary. The SW stated that they needed to consult with nursing staff to determine if a referral was required. The SW stated that, within the past 24 hours, there had been no discussion to determine whether the home was an appropriate setting for Resident #3 or if APS needed to be contacted. During an interview on 2/7/25 at 11:09 am, the NP stated when the resident left AMA, he was initially informed only that he had left. It wasn ' t until later that he was told the reasons behind his departure. The NP stated he should have been notified that Monday (2/3/25) when the facility became aware of issues such as wound care not being completed, medications not being administered, and incontinence care concerns. The NP stated he should have been informed the day the patient left AMA. At that point, they could have spoken with Resident #3, assessed the situation, and potentially found a resolution. The NP stated that waiting to notify him until after the fact limited the options for intervention. The NP stated when a resident leaves AMA, it is ultimately their decision. The NP stated he strongly believed that any resident choosing to leave against medical advice should have the opportunity to speak with their provider before signing the discharge form. The NP stated that conversation could help assess risks and explore alternatives. During an interview on 2/10/25 at 11:01 am, the Administrator stated that if a resident left Against Medical Advice (AMA), the decision to call APS would depend on the patient ' s situation. The Administrator stated that APS was contacted, but they did not know the exact date it was done but it had not been completed at the time of AMA. The Administrator stated that concerns about the SW ' s performance required a Performance Enhancement Plan (PEP). The Administrator stated that the concerns regarding the SW were consistent across various situations. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility ' s Discharging a Resident without a Physician ' s Approval Policy dated 10/22, revealed, A physician ' s order was obtained for discharges, unless a resident or representative was discharging himself or herself against medical advice. If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will: discuss with the resident, (and or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that was not equipped to meet his/her needs and attempt to ascertain why the resident was choosing that location. Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect was necessary. The referral should be made at the time of discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 3 (Resident #7, Resident #10 and Resident #11) of 5 residents reviewed for wounds. The facility failed to provide wound care for Resident #7's arterial wound (arterial ulcers, are painful injuries in your skin caused by poor circulation) of the right second toe. The facility failed to provide wound care for Resident #10's pressure wound to the right second toe. The facility failed to provide wound care for Resident #11's dehiscence wound right forefoot. This failure could affect others by placing them at risk of potential medical complications related to wounds. Findings included: Resident #7 Record review of Resident #7's face sheet dated 02/06/25, revealed, admission on 08/19/24 and re-admission on 01/23/25 to the facility. Record review of Resident #7's hospital history and physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with history of right big toe osteomyelitis (infection of the bone) and having it amputated, heart failure, and myocardial infarction (a condition where blood flow to the heart muscle is blocked, leading to damage or death of heart tissue). Record review of Resident #7's quarterly MDS dated [DATE], revealed, no BIMS score was taken to measure the cognition of the resident. Resident #7 was diagnosed with Diabetes Mellitus and Osteomyelitis. Resident #7 was coded for risk of pressure ulcers/injuries. Treatments coded were pressure reducing device for chair, reducing device for bed, and applications of ointments/medications. Record review of Resident #7's Order Recap dated 01/08/25, revealed, arterial wound of the right second toe. Cleanse wound with NS or wound cleanser. Pat dry with 4 by 4-inch gauze. Apply betadine (a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns) to eschar (a dry, black or brown crust of dead tissue that forms on the surface of a burn, ulcer, or other wound) area. Cover with kerlix (a brand of gauze bandage roll used to protect wounds) and secure with cloth tape. One time a day related to other acute osteomyelitis, other site. Record review of Resident #7's care plan dated 12/06/24, revealed, presented with arterial wound of the right second toe 1cm by 1 cm by 0.3 cm. Provide wound care per treatment order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Administration Report dated 01/01/25-01/31/25, revealed, wound care was not provided on 01/11/25 and 01/25/25. Review of the Administration Report dated 12/01/24-12/31/24, revealed, wound care was not provided on 12/02/24, 12/03/24, 12/07/24, 12/22/24, 12/27/24, 12/28/24, 12/29/24. Resident #10 Record review of Resident #10's face sheet dated 02/06/25, revealed, admission on 02/10/16 and re-admission on 02/01/22 to the facility. Record review of Resident #10's hospital history and physical (was in the facility system) dated 05/24/23, revealed, a [AGE] year-old female (age was updated to reflect 2025) diagnosed with Atherosclerosis (a chronic disease that affects the arteries, causing them to become narrowed and hardened) and hypertension (a condition where the blood pressure in the arteries is persistently elevated above normal levels). Record review of Resident #10's quarterly MDS dated [DATE], revealed, a BIMS score of 2 and severely impaired cognition to be able to recall or make daily decisions. Resident #10 was coded for risk of pressure ulcer/injuries. Treatments were pressure reducing device for chair, reducing device for bed, applications of ointments/medications. Record review of Resident #10's Order Recap dated 10/30/24, revealed, right second toe wound. Cleanse with NS. Apply collagen/silver sheet. Cover with 4 by 4-inch gauze. Secure with cloth tape one time a day related to abrasion to right lower leg. Record review of Resident #10's care plan dated 12/10/24, revealed, an arterial wound of the right second toe 1.2cm by 1.2cm. Measure ulcer on at regular intervals and monitor ulcer for signs of infection. Record review of Resident #10's Administration Report dated 12/01/24-12/31/24, revealed, wound care was not provided on 12/02/24, 12/03/24, 12/07/24, 12/08/24, 12/14/24, 12/22/24, 12/27/24, 12/28/24, 12/29/24. Review of the Administration Report dated 01/01/25-01/31/25, revealed, wound care not provided on 01/03/25, 01/11/25, 01/18/25, 01/19/25, 01/25/25. Review of the Administration Report dated 02/01/25-02/28/25, revealed, wound care not provided on 02/01/25. Resident #11 Record review of Resident #11's face sheet dated 02/06/25, revealed, a [AGE] year-old female diagnosed with traumatic amputation of one left lesser toe and right lesser toe disruption of wound, pressure chronic ulcer of other part of left foot, Atherosclerosis of native arteries of right leg with ulceration of other part of foot, open wound to right foot, pressure ulcer of elbow stage 3, Diabetes. admission on 03/30/21 and re-admission on 08/18/24 to the facility. Record review of Resident #11's quarterly MDS dated [DATE], revealed, there was no BIMS score conducted to measure the cognition for Resident #11. Resident #11 was coded for risk of pressure ulcer/injuries. Treatments were to use pressure reducing device for chair, reducing device for bed, and surgical wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's Order Recap dated 01/29/25, revealed, right forefoot dehiscence wound. Cleanse with NS. Pat dry with 4 by 4-inch gauze. Apply betadine to the area and cover with kerlix. Secure with cloth tape. Record review of Resident #11's care plan dated 12/06/24, revealed, a post-surgical dehisced wound of the right second toe 1cm by 1cm by 1.5cm. Provide wound care per treatment order. Record review of Resident #11's Administration Report dated 12/01/24-12/31/24, revealed, wound care was not provided on 12/02/24, 12/03/24. Review of the Administration Report dated 01/01/25-01/31/25, revealed, wound care was not provided on 01/08/25, 01/09/25, 01/10/25, 01/11/25, 01/12/25. Review of the Administration Report dated 02/01/25-02/28/25, revealed, wound care was not provided on 02/02/25. Observation and interview on 02/05/25 at 2:45 PM, with the Treatment Nurse, she stated the facility had been having issues for several months with wound care not being provided on the weekends. The Treatment Nurse stated she, and the EX -DON were providing in-services and education on providing wound care. The Treatment Nurse stated she had created a binder with the residents who needed to have wound care done for each hallway nurse that was broken down to make it easy for them. The Treatment Nurse stated even with that they were still having issues with wound care. The Treatment Nurse stated she had reported it to the ADON and the Administrator who asked her for a list of residents and that they would follow up with those residents. The Treatment Nurse stated she had not seen anything being done by the Administrator and keeps reporting it in the morning meetings. The Treatment Nurse stated she had been letting them know every Monday and has to go back to re-check all the residents' wounds. The Treatment Nurse stated she had not seen any of the wounds from the residents getting worse. The Treatment Nurse stated on 02/01/25-02/02/25, wound care was not provided for Resident #7 and Resident #11 from 200 hall. The Treatment Nurse stated in the facility system it would let the nurse know when it was time to give the wound care as it comes up green and if it was not completed it would turn red. It was observed on the facility system that Resident #7 and Resident #11 were all red. During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated that yesterday (02/05/25) the facility did an audit and found the same concerning trend to be found with the residents in 400 hall. The ADON stated the only hall to provide wound care for the weekend (02/01/25-02/02/25) was 300 hall. The ADON stated it has been a battle for the pasted couple of months (3) with not having wound care being provided for the residents at the facility. The ADON stated the Treatment Nurse created a binder and divided it between the halls so it would make it easier for the assigned nurses to complete wound care. During an interview on 02/06/25 at 11:22 AM, with CNA C, she stated she did not observe wound care being conducted on the weekend (02/01/25-02/02/25). During an interview on 02/07/25 at 9:47 AM, with LVN G, she stated there have been times she was not able to complete all the wound cares for the residents. LVN G stated she had passed it on in report to the other oncoming nurse but did not verify later on to see if it had been completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/07/25 at 10:39 AM, with the Wound Care Doctor, he stated he was not informed of residents missing wound care. The Wound Care Doctor stated the Treatment Nurse has mentioned some issues but did not tell him the details of those issues. The Wound Care Doctor stated the nurses were to be providing wound care. The Wound Care Doctor stated these issues had not been brought to his attention especially major lapses with wound care. The Wound Care Doctor stated he should have been informed of any missed wound care or changes to significant changes. The Wound Care Doctor stated the risk of deterioration, infection, or necrosis(a type of cell death that occurs when cells are irreversibly damaged and lose their normal functions). During an interview on 02/10/25 at 11:45 AM, with Interim-DON, he stated the Treatment Nurse was to be providing wound care during the weekdays and the nurses on the weekends since there was no Treatment Nurse working. The Interim-DON stated not doing wound care could have a negative effect on the resident where the wound could get worse or infected. The Interim-DON stated he was not notified that wound care was not being provided on the weekends and if known he would have taken action immediately. The Interim-DON stated it should have been expected that the nurses notify him that wound care was not being done. Record review of the facility Skin policy dated 07/22, revealed, A Pressure Injury Prevention Care Plan will be completed by the Treatment Nurse or Charge nurse and interventions implemented for all Residents based upon the Braden Scale score in conjunction with clinical judgement and review of other risk factors. An updated Pressure Injury Prevention Care Plan will be completed upon a change in Braden Scale score or a change in condition. The Director of Nursing or designee will audit and verify system compliance weekly including prevention-focused rounding and education as appropriate. Rounding will be completed by the Charge Nurse, Treatment Nurse and Nurse Manager for observations of pressure sore prevention, including, but not limited to best practices such as off-loading, turning and repositioning. The Quality of Assurance and Performance Improvement Review will include the findings from random audits of documentation completion: Physician Orders, Pressure Injury Care Plan, Non-Pressure Injury Care Plan.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interview, and record review the facility failed to ensure a resident receives care to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable and a resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #3) of 5 residents reviewed for pressure ulcers/wounds. The facility failed to provide wound care for Resident #3's pressure ulcer stage 3 to the left buttock on 02/01/25 and 02/02/25. This deficient practice could place residents at risk for worsening pressure injuries, pain, and a decline in health. Findings include: Resident #3 Record review of Resident #3's face sheet dated 02/05/25, revealed, admission on 01/30/25 to the facility. Resident #3 discharged on [DATE] Record review of Resident #3's hospital history of physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with Type 2 Diabetes Mellitus and pressure ulcer. Record review of Resident #3's admission MDS dated [DATE], revealed, no impairment in cognition with a BIMS score of 13 and the resident was able to recall and make daily decisions. Resident #3 was coded for risk of pressure ulcers and unhealed pressure ulcers. Resident #3 was coded for stage 3 pressure ulcer. Resident #3 was to have pressure reducing devices for chair, for bed, turning/repositioning program, pressure/ulcer/injury care, applications of ointments/medications, and hydration interventions. Record review of Resident #3's Skin Issues Assessment generated by the Wound Care Nurse dated 01/30/25, revealed, left gluteus/ buttock pressure ulcer/ injury stage 3, 9 cm by 3.5 cm by 0.2 cm. Record review of Resident #3's Order Recap dated 01/30/25, revealed, left buttock stage 3 pressure wound. Cleanse with NS and pat dry with a 4 by 4-inch gauze. Apply collagen powder to the wound bed granulated tissue. Cover with foam border dressing. One time a day related to Pressure Ulcer of Other site, Unstageable. - Order dated 01/30/25, revealed nursing Intervention: Turn and reposition every hour every shift. Record review of Resident #3's Administration Report dated 02/01/25-02/28/25, revealed, wound care was not completed for 02/01/25 and 02/02/25 for Resident #3. Record review of Resident #3's progress notes for 02/01/25-02/02/25, revealed, there was no nursing note indicating if wound care was provided or not. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/05/25 at 1:18 PM, with Resident #3's Family member, she stated that wound care was not being done during the weekend as Resident #3 still had the same dressing on since his arrival to the facility. During an interview on 02/05/25 at 1:50 PM, with LVN B, she stated the family member had informed her that Resident #3 had a bad weekend. LVN B stated the family member had mentioned that Resident #3 did not have wound care done on the weekend (02/01/25-02/02/25). LVN B stated she checked if Resident #3 had wound care done on the weekend and confirmed it had not been done. LVN B stated that there was not a Wound Care Nurse on the weekend, but all nurses were able to provide wound care. LVN B stated the weekend nurses were responsible for providing wound care. LVN B stated the risk of not providing wound care could be the wound getting worse or infection. interview on 02/05/25 at 2:45 PM, with the Treatment Nurse, she stated she provided wound care during the weekdays and on the weekends, the nurses were to be providing the wound care. The Treatment Nurse stated the nurses on the weekend would be able to provide wound care for those residents needing wound care. The Treatment Nurse stated Resident #3 had not had his wound care done on 02/01/25 and on 02/02/25. The Treatment Nurse stated the negative outcome could be a delay in the wound in healing. During an interview on 02/05/25 at 3:09 PM, with the Social Worker, she stated the staff was not assisting as they should be with Resident #3. The Social Worker stated the family member felt Resident #3 was not getting the correct wound care treatment. During an interview on 02/05/25 at 3:29 PM, with LVN A, she stated wound care was being provided for Resident #3 on 02/01/25-02/02/25. LVN A stated she had forgotten to document that wound care was provided for Resident #3. LVN A stated she had looked at the MARs earlier that day for Resident #3's orders for wound care and remembered it. LVN A stated from what she remembered she went ahead and conducted the wound care later on in the day without looking at the wound care orders. LVN A stated she forgot to document it on the facility system. LVN A stated she was trained to look at the orders and would look at them earlier in the day and then would give treatment. LVN A stated the risk of not conducting wound care could be a risk of infection. During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated wound care was supposed to be done as ordered. The ADON stated during the weekday the Treatment Nurse conducts the wound care and on the weekend the nurses are able and have to do the wound care. The ADON stated that nurses are trained to look at the orders while gathering the supplies for the wound treatment and cannot be looking at the orders earlier in the day and doing the wound treatment without looking to verify the orders. The ADON stated the risk would be a decline in the resident's condition. During an interview on 02/06/25 at 8:42 PM, with LVN F, she stated she did not provide wound care when she worked the weekend because she was busy doing other things. LVN F stated there could be a negative outcome of not providing wound care which would depend on the situation of the resident. (continued on next page)

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	675831	A. Building B. Wing	02/10/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 02/05/25 at 2:45 PM, with the Treatment Nurse, she stated the facility had been having issues for several months with wound care not being provided on the weekends. The Treatment Nurse stated she, and the EX-DON were providing in-services and education on providing wound care. The Treatment Nurse stated she had created a binder with the residents who needed to have wound care done for each hallway nurse that was broken down to make it easy for them. The Treatment Nurse stated even with that they were still having issues with wound care. The Treatment Nurse stated she had reported it to the ADON and the Administrator who asked her for a list of residents and that they would follow up with those residents. The Treatment Nurse stated she had not seen anything being done by the Administrator and keeps reporting it in the morning meetings. The Treatment Nurse stated she had been letting them know every Monday and has to go back to re-check all the residents' wounds. The Treatment Nurse stated she had not seen any of the wounds from the residents getting worse. The Treatment Nurse stated on 02/01/25-02/02/25, wound care was not provided for Resident #3 and other residents from 200 hall. The Treatment Nurse stated in the facility system it would let the nurse know when it was time to give the wound care as it comes up green and if it was not completed it would turn red. During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated that yesterday (02/05/25) the facility did an audit and found the same concerning trend to be found with the residents in 400 hall. The ADON stated the only hall to provide wound care for the weekend (02/01/25-02/02/25) was 300 hall. The ADON stated it has been a battle for the pasted couple of months (3) with not having wound care being provided for the residents at the facility. The ADON stated the Treatment Nurse created a binder and divided it between the halls so it would make it easier for the assigned nurses to complete wound care. During an interview on 02/06/25 at 11:22 AM, with CNA C, she stated she did not observe wound care being conducted on the weekend (02/01/25-02/02/25). During an interview on 02/07/25 at 9:47 AM, with LVN G, she stated there have been times she was not able to complete all the wound cares for the residents. LVN G stated she had passed it on in report to the other oncoming nurse but did not verify later on to see if it had been completed. During an interview on 02/07/25 at 10:39 AM, with the Wound Care Doctor, he stated he was not informed of residents missing wound care. The Wound Care Doctor stated the Treatment Nurse has mentioned some issues but did not tell him the details of those issues. The Wound Care Doctor stated the nurses were to be providing wound care. The Wound Care Doctor stated these issues had not been brought to his attention especially major lapses with wound care. The Wound Care Doctor stated he should have been informed of any missed wound care or changes to significant changes. The Wound Care Doctor stated the risk of deterioration, infection, or necrosis(a type of cell death that occurs when cells are irreversibly damaged and lose their normal functions). During an interview on 02/10/25 at 11:45 AM, with Interim-DON, he stated the Treatment Nurse was to be providing wound care during the weekdays and the nurses on the weekends since there was no Treatment Nurse working. The Interim-DON stated not doing wound care could have a negative effect on the resident where the wound could get worse or infected. The Interim-DON stated he was not notified that wound care was not being provided on the weekends and if known he would have taken action immediately. The Interim-DON stated it should have been expected that the nurses notify him that wound care was not being done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Skin policy dated 07/22, revealed, A Pressure Injury Prevention Care Plan will be completed by the Treatment Nurse or Charge nurse and interventions implemented for all Residents based upon the Braden Scale score in conjunction with clinical judgement and review of other risk factors. An updated Pressure Injury Prevention Care Plan will be completed upon a change in Braden Scale score or a change in condition. The Director of Nursing or designee will audit and verify system compliance weekly including prevention-focused rounding and education as appropriate. Rounding will be completed by the Charge Nurse, Treatment Nurse and Nurse Manager for observations of pressure sore prevention, including, but not limited to best practices such as off-loading, turning and repositioning. The Quality of Assurance and Performance Improvement Review will include the findings from random audits of documentation completion: Physician Orders, Pressure Injury Care Plan, Non-Pressure Injury Care Plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 resident (Residents #3) of 4 reviewed for medication administration. The facility failed to administer on 02/01/25, to Resident #3's medication of Ciprofloxacin HCL oral tablet 500 mg which to given two times a day for infection and was not given in the morning. The facility failed to administer on 02/01/25, to Resident #3's medication of Sulfamethoxazole-Trimethoprim oral tablet 800-160 mg by mouth two times a day for infection and was not given in the morning. The facility failed to administer on 02/01/25 and on 02/02/25, to Resident #3's medication of Spironolactone oral tablet 25 mg by mouth one time a day for prophylaxis for both days. This deficient practice could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Record review of Resident #3's face sheet dated 02/05/25, revealed, admission on 01/30/25 to the facility. Record review of Resident #3's hospital history of physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with Type 2 Diabetes Mellitus and pressure ulcer. Record review of Resident #3's admission MDS dated [DATE], revealed, no impairment in cognition with a BIMS score of 13 and the resident was able to recall and make daily decisions. Record review of Resident #3's Order Recap dated 01/30/25, revealed, Ciprofloxacin HCL oral tablet 500 mg to be given two times a day for infection. Review of order dated 01/30/25, revealed, Sulfamethoxazole-Trimethoprim oral tablet 800-160 mg by mouth two times a day for infection. Review of order dated 01/30/25, revealed, Spironolactone oral tablet 25 mg by mouth one time a day for prophylaxis. Record review of Resident #3's Administration Report dated 02/01/25-02/28/25, revealed, Ciprofloxacin was not given on 02/01/25. Sulfamethoxazole-Trimethoprim was not given on 02/01/25. On 02/01/25 and 02/02/25, Spironolactone was not given. Record review of Resident #3's Grievance/Complaint Report dated 02/03/25, revealed, Family member stated was not getting all his medications administered by the LVN A. Family member stated she had asked LVN A why and she did not give her an explanation as to why medications were not being given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 1:18 PM, with Resident #3's Family member, she stated on the weekend she had asked LVN A if she was going to give Resident #3 his night medication and was told that the facility did not have his medications. The Family member stated that LVN B had told her on 02/03/25, that she had given Resident #3 his medication and that they had come from another city. During an interview on 02/05/25 at 1:50 PM, with LVN B, she stated that medications were not given for Resident #3 on 02/01/25-02/02/25 (weekend). LVN B stated she did not know why they were missed. LVN B stated it was expected for the nurses to be following physician orders. LVN B stated the nurses were responsible for ensuring the medications were given. LVN B stated the risk was infection or it was getting worse. During an interview on 02/05/25 at 3:29 PM, with LVN A, she stated Resident #3 was receiving his medications. LVN A stated if there were no medications available then the MA would have to let her know so that they could pull from the Nexus (a storage where extra medications are kept). LVN A stated not getting the medications could throw the body out of [NAME] (out of balance or unaligned in some way). During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated it was not reported to her that medications were not being given. The ADON stated the MAs are to be reporting to the nurses if there are not medications and the nurses are to be reporting to the physician if there are not medications on hand. The ADON stated the risk would be a decline in the resident. During an interview on 02/06/25 at 8:08 PM, with MA D, she stated LVN A had told her they did not have access to the Nexus to pull medication from it. MA D stated that Resident #3 was given whatever medications they had on hand and whatever they did not have was not given. MA D stated she was unaware if the physician was notified due to the nurses handling it. MA D stated there could be a risk which depended on the situation. During an interview on 02/06/25 at 8:17 AM, with MA E, she stated Resident #3 did not have medications on the weekend (02/01/25-02/02/25) and had informed LVN A about the medication issue. MA E stated on 01/31/25 and 02/01/25 medications were being pulled from other residents to give to Resident #3. MA E stated she pulled from several residents from among the whole facility. MA E stated they were not able to borrow medications. MA E did not indicate what the risk would be. During an interview on 02/06/25 at 8:42 PM, with LVN F, she stated nursing staff should not be borrowing medication from other residents. LVN F stated the medications are prescribed to someone and giving it to someone else could have an effect on that resident receiving more medication. LVN F stated the risk for Resident #3 since he had blood pressure medications could be his blood pressure goes high. LVN F stated it would also be a medication error. During an interview on 02/07/25 at 9:47 AM, with LVN G, she stated she had not encountered any issues with medications. LVN G stated she has not borrowed any medications from other residents to give to a resident. LVN G stated the risk for borrowing medications was not knowing how a resident would respond and it could exhaust the medications from the residents they borrowed from. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/07/25 at 11:09 AM, with NP, he stated he had not received reports of medications not being available for the residents. The NP stated the nursing staff should not be borrowing medications from other residents to give. The NP stated if the resident had prescribed medications, then he was covering the cost of that medication. The NP stated everything must be properly documented. The NP stated residents should be receiving their pre-approved package of medications. The NP stated that it was concerning that this process was not being followed. The NP stated not giving the medication could have serious consequences. The NP stated if the facility had switched pharmacies and did not have the medication then they should have called them immediately. The NP stated in cases like this they could have provided an alternative medication or found a solution. During an interview on 02/08/25 at 10:04 AM, with LVN A, she stated that she had not instructed anyone to be borrowing medications from other residents. LVN A stated it was against the law and they could not do that. During an interview on 02/10/25 at 11:45 AM, with Interim-DON, he stated medications are to be taken as prescribed by the physician orders. The Interim-DON stated all orders have to be followed and not following the order could have a negative effect on the resident. The Interim-DON stated the risk would depend on the resident's situation and medication given. The Interim-DON stated it was not okay to be borrowing medications from other residents. The Interim-DON stated the risk of borrowing medications could be side-effects. Record review of the facility Administrating Medications Policy dated 04/19, revealed, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The individual administrating medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 3 residents (Resident #3) reviewed for medical records. The facility failed to ensure Resident #3's was having incontinence care was documented by the facility. This deficient practice could place residents at risk of not receiving needed services although services are stated they are being provided. Finding included: Record review of Resident #3's face sheet dated 02/05/25, revealed, admission on 01/30/25 to the facility. On 02/04/25, Resident #3 was discharged from the facility. Record review of Resident #3's hospital history of physical dated 03/22/24, revealed, a [AGE] year-old male diagnosed with Type 2 Diabetes Mellitus and pressure ulcer. Record review of Resident #3's admission MDS dated [DATE], revealed, no impairment in cognition with a BIMS score of 13 and the resident was able to recall and make daily decisions. Resident #3 was occasionally urinary incontinent and frequently bowel incontinent. ADLs revealed, Resident #3 required substantial/maximal assistance (nursing staff does more than half of the work) for toileting hygiene and requires partial/moderate assistance (nursing staff does less than half the work) for rolling left or right on bed, sit to lying, lying to sitting on side of bed, and sit to stand. Record review of Resident #3's Grievance/Complaint Report dated 02/03/25, revealed, Family member was changing Resident #3 and providing incontinence care. Record review of Resident #3's Baseline Care Plan was reviewed on 02/05/25, revealed, Resident #3 did not have a baseline care plan generated nor a comprehensive care plan. Record review of the facility Incontinence Care Protocol dated 09/24, revealed, Goal- Maintain the resident in a clean and dry state and prevent complications of incontinence by maintain and providing incontinent care to the resident at regular intervals. Record review of Resident #3 was reviewed on 02/05/24 and revealed there was no documentation of the facility providing education of incontinence care to Resident #3's family. During an interview on 02/05/25 at 1:18 PM, with the Family member, she stated that the facility staff was not checking on Resident #3 and she was having to change Resident #3 and provide incontinence care on 02/01/25 and 02/02/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/25 at 3:29 PM, with LVN A, she stated she was checking on Resident #3 and would ask if he needed anything and was being told he was good. LVN A stated the family member was telling her that she would take care of the incontinence care for Resident #3. LVN A stated she had educated the family member that the facility was supposed to be doing peri-care for Resident #3. LVN A stated she did not report it to upper management nor was their documentation of the family member not letting the nursing staff conduct peri-care. LVN A stated that if it was not documented it did not happen. LVN A stated it was the responsibility of the nursing staff to be conducting peri-care. LVN A stated the risk could be infection. During an interview on 02/06/25 at 8:56 AM, with the ADON, she stated Resident #3's family member was not allowing the nursing staff to conduct incontinence care on Resident #3. The ADON stated CNA C told her LVN A was aware of this. The ADON stated it was expected for the nurses to call the supervisor so that they know since the resident was under their care. The ADON stated the nursing staff was not providing incontinence care because they failed to report it to her. During an interview on 02/06/25 at 11:22 AM, with CNA C, she stated she had not provided peri-care for Resident #3 due to the family member not letting them do it. CNA C stated every time she would go to check on Resident #3, the family member would say they were okay. CNA C stated she reported the situation to LVN A and stated that she was going to put it in her report that the family member was doing everything for Resident #3. Record review revealed there was no report in the system put in by LVN A. CNA C stated LVN A did not instruct her or guide her with what to do with the lack of care being provided to Resident #3. During an interview on 02/10/25 at 11:45 AM, with Interim-DON, he stated incontinence care was provided by the CNAs and nurses. The Interim-DON stated family or visitors are not to be providing incontinence care and if they insist that was their decision, so they offer assistance as needed. The Interim-DON stated the facility would have to educate the family or visitors on the risk and benefits and what could happen if they decide to provide care and not let the facility staff do it. The Interim-DON stated it should have been reported to upper management so that it could be recorded, and care planned.