STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on interview and record review, the facility failed to ensure care plans were reviewed and revised by the interdisciplinary team after each assessment for 1 of 5 (Resident #1) residents reviewed for care plan timeliness and accuracy in that: The facility failed to ensure Resident #1's care plan accurately addressed his facility acquired sacral wound and MASD (moisture associated skin damage) to his groin. This failure could affect residents by placing them at risk of not having accurate assessments, which could compromise their plan of care. Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old male that was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of spinal stenosis (a condition in which the space inside the bones of the spine get too small), dysphagia(difficulty swallowing foods or liquids), Type 2 Diabetes (a long-term condition in which the body trouble controlling blood sugar), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and chronic kidney failure (a chronic condition that causes permanent damage to the kidneys over time. Resident was bedfast. Record review of Resident #1's discharge summary from local hospital #1 revealed: Resident #1 was discharged from the hospital and admitted to the facility on [DATE]. It was noted that Resident #1 had red area to groin or buttock both lower extremities. Record review of Resident #1's Care plan dated 4/1/2024 reflected he had bowel and bladder incontinence and at risk for skin breakdown. Goal: Resident #1 will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Check as required for incontinence. Wash, rinse and dry perineum. Change clothes PRN after incontinence episodes. Further care plan review initiated on 9/18/2024 reflected Resident #1 had a potential for pressure ulcer development to buttock r/t decreased mobility, weakness, diabetes, and neuropathy. Goal: Resident #1's skin will remain intact, free from redness, blister, or discoloration. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: Administer treatments as ordered and monitor for effectiveness and weekly head to toe assessment. It did not address the sacral wound. Record review of care plan dated 11/24/2024 revealed Resident #1 had actual impairment to skin integrity r/t contact dermatitis. Goal: Resident #1 will not have a re-hospitalization within 30-days. Intervention: Monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, sign and symptoms, maceration etc. to MD. Provide wound care to site daily per WCD recommendations. Use enhanced barrier precautions, and weekly [NAME] consult with recommendations. It did not address the sacral wound. Record review of Resident #1's quarterly MDS dated [DATE] revealed: Section C500- Brief Interview of Mental Status was scored as 08, which meant moderately impaired cognition. Section GG0115- Functional Limitation in Range of Motion was coded as 2 representing upper and lower extremity impairment. Section GG0130- Functional Abilities revealed: Toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene was coded as 2 (Substantial/maximum assistance). Section GG0170 revealed roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer was coded as (01)- which presented dependent- helper does all the effort. Section H0300 revealed Urinary continence was coded 3 for always incontinent (no episodes of continent voiding). Section H0400 revealed Bowel continence was codes 3 for always incontinent (no episodes of continent bowel movements). Section I- Active Diagnosis listed 1- (need for personal care assistance) Section M- Skin condition revealed Risk of pressure ulcer coded 1 was entered representing (Yes). M1040- Other ulcers, wounds and skin problems such as diabetic foot ulcers, open lesions, surgical wounds, MASD (incontinent associated dermatitis, perspiration drainage) Z. was coded which meant none of the above. Section N- Medications G. Diuretic was marked and code indicated Resident #1 was taking and here was an indication for the medication. Record review of Resident #1's Discharge return not anticipated MDS dated [DATE] did not mention wounds to the sacral area nor the MASD to the groin. It said that it was in progress. Record review of LN weekly skin evaluations for Resident #1 revealed: 10/14/2024 - Resident #1 noted with excoriation to groin region. Treatment initiated pending wound care physician evaluation. No new skin breakdown observed. Signed by LVN B (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/18/2024- Site #1 Sacrum Etiology: Trauma/Injury Measurements 3.5cm x1cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated 6. RD to follow Signed by LVN B 10/22/2024- Site #1 Sacrum Measurements 3 cm x1 cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated 6. RD to follow Signed by LVN B (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/1/2024 - Site #1 Sacrum Measurements 2 cm x 1 cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated 6. RD to follow Signed by LVN B 11/12/2024- Site #1 Sacrum Measurements 2 cm x 1 cm x 0.1 cm Procedure: Surgical excisional debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated 6. RD to follow Signed by LVN B 11/22/2024 - Site #1 Sacrum (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Measurements 3 cm x 2 cm x 0.1 cm Procedure: Surgical excisional debridement (11/12/2024) Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Progress: Not at goal MASD to groin region treat with house barrier cream every brief change Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated 6. RD to follow Signed by LVN B 11/28/2024- Site #1 Sacrum Measurements 5 cm x 5 cm x 0.1 cm Procedure: Surgical excisional debridement (11/22/2024) Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Progress: Not at goal MASD to groin region treat with house barrier cream every brief change. Risk factor: Immobility Interventions: 4. Offloading wound while in bed as needed /tolerated 5. Repositioning resident as needed/tolerated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. RD to follow Signed by LVN B Record review of Resident #1's Skin IDT dated 12/11/2024 at 12:50pm, revealed Resident #1 was readmitted to facility following a transfer to the hospital due to altered mental status. Resident has stage 2 wound to the sacrum and MASD to groin region. Prior orders from wound care physician include the application of zinc ointment and daily border dressing changes. These orders are being continued, and wound care physician scheduled to re-evaluate on tomorrow 12/12/2024. Care remained ongoing and compliant with prescribed treatment plan. Record review of Resident #1's Wound Care Doctor A assessments: 10/15/2024- Chief complaint -Wound on sacrum Etiology: Trauma/Injury Wound size: 3.5 x 1 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 30 days 2nd dressing: Gauze Island with border apply once daily for 30 days. 10/22/2024- Chief complaint wound on sacrum. Wound size: 3 x1 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 23 days 2nd dressing: Gauze Island with border apply once daily for 23 days. 10/29/2024- Chief complaint: Wound on sacrum Size 2 x 1 x not measurable due to presence of tissue overgrowth Treatment plan: Zinc ointment apply once daily for 16 days. 2nd dressing: Gauze island with border apply once daily for 16 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 10/25/2024. 11/5/2024- Sacrum wound size: 2x 0.3 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 9 days. 2nd dressing: Gauze island with border apply once daily for 9 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 10/25/2024. 11/12/2024- Sacrum wound size 1.5 x 0.3 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 30 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2nd dressing: Gauze Island with border apply once daily for 13 days. Site 1: Surgical excisional debridement procedure Indication for procedure: Necrotic tissue and establish the margins of viable tissue. 11/19/2024- Sacrum wound: 3 x 2 x 0.1 cm Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater detail today. Reviewed offloading surfaces and discussed surfaces care plan. Considered patient behavior as factor that is complicating wound healing and discussed further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Treatment plan: Zinc ointment apply once daily for 23 days. 2nd dressing: Gauze Island with border apply once daily for 23 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 11/12/2024. 11/26/2024- Sacrum wound size: 5 x 5 x 0.1 Granulation tissue: 60% surface area: 25.00cm Cluster wound: Open ulceration area of 15.00 cm Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater detail today. Patient not following repositioning or offloading recommendations and counseling provided. Considered patient behavior as factor that is complicating wound healing and discussed further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Treatment plan: Zinc ointment apply once daily for 16 days. 2nd dressing: Gauze Island with border apply once daily for 16 days. 12/3/2024- Sacrum wound size: 4 x 4x 0.1 cm surface area: 16.00 cm slough: 20%, granulation tissue 80% Wound progress: Not at goal Duration: 50 days Treatment plan: Zinc ointment apply once daily for 9 days. 2nd dressing: Gauze Island with border apply once daily for 9 days. Site #1 Surgical Excisional Debridement Procedure Indication: Necrotic tissue and establish the margins of viable tissue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 3.2cm' of devitalized tissue including slough, biofilm and non-viable subcutaneous level tissues were removed at a depth of 0.1 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 O 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. Site 2-Unstagebale DTI of the left heel undetermined thickness wound size 2 x 2 x not measurable offloading and boot ordered. 12/12/2024 Chief complaint: Wound on sacrum; right medial thigh; left heel; scrotum. Wound size 8 x 8 x 0.1 Surface: 64.00 cm Slough: 20% ADDITIONAL WOUND DETAIL readmission from hospital DRESSING TREATMENT PLAN Primary Dressing(s) Alginate calcium apply once daily for 30 days Secondary Dressing(s) Gauze island w/ border apply once daily for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations: Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours Site #1- Surgical excisional debridement procedure Indication: Remove necrotic tissue and establish margins of viable skin. PROCEDURE NOTE (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 12.8cm2 of devitalized tissue Including slough, biofilm and non-viable subcutaneous level tissues were removed al a depth of 0.1 cm and heallhy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 20 percent to O percent. Homeostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the pla11 of care are documented in the Assessment and Plan section below. Record review of Resident #1's local hospital #2 record revealed: Principal problem upon admission on 12/5/2024 was altered mental status. Assessment and Plan: Acute toxic metabolic encephalopathy -multifactorial in the setting of an acute UTI, complicated UTI, E-coli UTI General Information: Resident #1 was confused and lethargic. Wound care assessment on 12/6/2024: Sacral stage 3 pressure injury wound- size L 6.0cm x W 6.0cm x D 0.1cm - no undermining - no tunneling/induration - Wound bed is full thickness with some pink and red non granular tissue. The area is denuded most probably from incontinence - edges well defined -small to moderate serosanguinous drainage - no odor - Peri wound redness noted. Left heel DTPI wound- size L 3.0cm x W 3.0cm x D 0cm - no undermining - no tunneling/induration -Wound with purple/ maroon non blanchable intact skin - edges well defined -No drainage - no odor - Peri wound skin is intact Location: Penis, scrotum, inner thighs, groin, posterior thighs and peri area - Type: MASD/ IAD (Moisture Associated Skin Damage/ Incontinence Associated Skin Damage) Appearance: Bright red erythematous rash and inflammation with denuded skin due to: moisture trapping in skin folds and fecal/ urine incontinence. Posterior thighs are full thickness which I will recommend Zinc paste. Exudate: Clear weeping skin due to inflammation, edema, and skin erosions. Current Pressure Support Surfaces: Bed: LAL mattress; microclimate pad; glide sheet with pillows or wedges and Z flex boots. Mobility: Bed bound. Recommendations: Sacrum and left heel wounds- Cleanse with Vashe (Ref # 108824) and pat dry with gauze. Apply Cavilon skin barrier to the peri wound skin, apply Polymem (Ref# 7114) to the wound base and cover with silicone foam dressing every other day and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Clean penis, scrotum, inner thighs, groin and peri area with Coloplast no rinse wash cloths (Ref# 119680) and warm water 2. Pat dry with towel 3. Apply Cavilon advanced skin barrier twice a week and as needed. Goal/Treatment Plan: 1. Dressing Changes as ordered or PRN if soiled. 2. Using wedges or pillow to turn and reposition the pt every 2 hours to offload pressure to wound, even when on specialty bed. 3. Encourage lowering the head of the bed below 30 degrees is tolerable. 4. Ensure patient is on pressure redistribution and microclimate control bed is order is placed. 5. Offload pressure to patient's heels by floating with pillows or by applying specialty boots. 6. Nutritional consultation for wound healing. The following supplements to aid in wound healing are recommended, unless contraindicated: - 1000 mg Vitamin C daily - 220 mg Zinc sulfate daily - Multivitamin daily - Juven 2 times per day - Accurately monitor and document patient's PO intake, so supplements can be adjusted accordingly. 7. Skin care and skin protection from moisture damage - If possible, keep diapers off patient to reduce moisture - Consider using Pure Wick/ Condom catheter for incontinence management - Apply Cavilon Advanced to perineal and perianal area 2x weekly Photos of Resident wounds were taken at the hospital. Record review of the last IDT care plan review for Resident #1 was conducted on 9/17/2024. No wounds were discussed. No other care plan reviews were conducted after 9/17/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/11/2024 at 3:30pm with the Wound Care nurse (LVN B) revealed she had been employed at the facility for about 1 year. She stated she started wound care of Resident #1 after CNA reported observing a skin tear on his sacral area and MASD to groin sometime in October. She said she immediately followed up with the NP about the wounds and house barrier cream was ordered along with a wound doctor consultation. She said she sometimes learned about skin issues from the CNA's and from wound sweeps in which she randomly looked at different residents' skin in search of wounds/tears. She stated the Wound Care Doctor A came to the facility every week on Thursday and did measurements of wounds and debridement as needed. She said all documentation is put into PCC as a nursing note and weekly wound care assessments. She said she followed physician orders for treatment of wounds. She said Resident #1 sacral wound was getting better, but after returning from the hospital it looked bad. She denied that Resident had the buttock, thigh and gluteal wounds before leaving for the hospital stay. She said she did not know why there were no notes concerning the MASD because it was treated with barrier cream since it was brought to her attention in October. She said she did not know why there was not documentation of the MASD until 11/12/2024. She was not sure why Resident #1's care plan had not been updated. She does participate in IDT meetings in which skin condition is discussed. An interview with RP on 12/11/2024 at 8:04 p.m, revealed her to state Resident #1 was admitted to the facility in March 2024. She stated that she usually visited him after work (6pm or so) at least 3 to 4 days a week. She said she had not participated in a care plan meeting for Resident #1 in months. She said not since August or September 2024. She said wounds were not discussed or he did not have them at that time. She denied having a care plan meeting to discuss Resident #1's wounds, goals or interventions. Interview with the DON on 12/13/2024 at 11:16am she stated she had been employed for about 4 months. She said sacral wounds could come from residents' co-morbidities or could be from residents' briefs needing to be changed more often because some residents get wet more than expected. She said the consequence of having a sacral wound is discomfort and pain. She stated the MDS nurse was responsible for updating the care plans but the IDT team met also to discuss any significant changes. An interview with the Executive Director on 12/13/2024 at 11:16 a.m. reflected her to state she could not recall when she first learned about Resident #1's sacral wound. She said that the MASD in his groin area was being treated to her knowledge. She was not sure why it was not in the progress notes because the weekly skin assessment showed up on the nursing progress notes. She said the baseline care plan was to be done within 48 hours, and updated upon significant change, quarterly and annually. She was not sure why the care plan did not address the sacral wound but probably because it was not a stage 3 wound until he returned from the hospital. An interview with the SW on 12/19/2024 at 10:57 a.m., stated the last conversation he had with Resident #1's RP was concerning his wounds on last Friday (12/13/2024). He said she wanted to make sure the facility was taking care of his wounds and keeping him clean. He said Resident #1 was scheduled for a care plan meeting today (12/19/2024), however, he went back to the hospital today. He stated the last care plan meeting was on 9/19/2024. He stated care plan meetings were held quarterly unless there was a hospital stay or upon request from the family. He stated he could not recall the RP asking for a meeting or any concerns prior to last week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on interview, and record review the facility failed to provide care consistent with professional standards of practice promoting healing and prevent new pressure ulcers from developing for 1(Resident#1) of 5 residents reviewed for pressure ulcers. The facility failed to ensure that no new pressure wounds were acquired at the facility. Resident #1 acquired a Stage 3 sacral wound. The facility failed to implement new interventions when the sacral wound was not healing, increasing in size and requiring debridement for necrotic tissue. The facility failed to ensure offloading and timely incontinent care was provided for Resident#1's sacral wound . This failure place residents at risk for wounds, infection, and pain. Findings Included: Record review of Resident #1's face sheet revealed a [AGE] year-old male that was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of spinal stenosis (a condition in which the space inside the bones of the spine get too small), dysphagia(difficulty swallowing foods or liquids), Type 2 Diabetes (a long-term condition in which the body trouble controlling blood sugar), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and chronic kidney failure (a chronic condition that causes permanent damage to the kidneys over time. Resident was bedfast. Record review of Resident #1's discharge summary from local hospital #1 revealed: Resident #1 was discharged from a local hospital and admitted to the facility on [DATE]. It was noted that Resident #1 had red area to groin or buttock both lower extremities. Record review of Resident #1's Care plan dated 4/1/2024 reflected he had bowel and bladder incontinence and at risk for skin breakdown. Goal: Resident #1 will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Check as required for incontinence. Wash, rinse and dry perineum. Change clothes PRN after incontinence episodes. Record review of care plan initiated on 9/18/2024 reflected Resident #1 had a potential for pressure ulcer development to buttock r/t decreased mobility, weakness, diabetes, and neuropathy. Goal: Resident #1's skin will remain intact, free from redness, blister, or discoloration. Intervention: Administer treatments as ordered and monitor for effectiveness and weekly head to toe assessment. It did not address the sacral wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of care plan dated 11/24/2024 revealed Resident #1 had actual impairment to skin integrity r/t contact dermatitis. Goal: Resident #1 will not have a re-hospitalization within 30-days. Intervention: Monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, sign and symptoms, maceration etc. to MD. Provide wound care to site daily per WCD recommendations . Use enhanced barrier precautions, and weekly WCD consult with recommendations. It did not address the sacral wound. Record review of quarterly MDS dated [DATE] revealed: Section C500- Brief Interview of Mental Status was scored as 08, which meant moderately impaired cognition. Section GG0115- Functional Limitation in Range of Motion was coded as 2 representing upper and lower extremity impairment. Section GG0130- Functional Abilities revealed: Toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene was coded as 2 (Substantial/maximum assistance). Section GG0170 revealed roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer was coded as (01)- which presented dependent- helper does all the effort. Section H0300 revealed Urinary continence was coded 3 for always incontinent (no episodes of continent voiding). Section H0400 revealed Bowel continence was codeds 3 for always incontinent (no episodes of continent bowel movements). Section I- Active Diagnosis listed 1- (need for personal care assistance) Section M- Skin condition revealed Risk of pressure ulcer coded 1 was entered representing (Yes). M1040- Other ulcers, wounds and skin problems such as diabetic foot ulcers, open lesions, surgical wounds, MASD (incontinent associated dermatitis, perspiration drainage) Z. was coded which meant none of the above. Section N- Medications G. Diuretic was marked and code indicated Resident #1 was taking and there was an indication for the medication. Record review of Resident #1's MDS revealed that there was no significant change MDS completed although October 14th the WCN weekly assessment stated skin warm and dry to touch with appropriate color. Resident noted to have excoriation to the groin. Treatment initiated. No new skin breakdown noted. The sacral wound was not mentioned. Record review of Resident #1's Discharge return not anticipated MDS dated [DATE] did not mention wounds to the sacral area nor the MASD to the groin. It said that it was in progress. Observations on the following dates revealed Resident #1 was found in the supine position without (wedges/pillows) for offloading the sacral wound: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	12/11/2024- 11:55am 12/11/2024 -2:23pm 12/12/2024 - 11:21am 12/13/2024 - 10:09am Record review of Resident #1's Braden Scale for Predicting pressure ulcers assessments revealed the following: 4/29/2024 - Quarterly assessment was Moderate Risk scored was 13. #1-Sensory perception: Very limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. #2-Moisture: Very moist, but not always. Linen must be changed at least once a shift. #3-Activity: Degree of physical activity: Chairfast: ability to walk severely limited or non-existent. #4-Mobility: Ability to change and control body position: Very limited: makes occasional slight changes in body or extremely position but unable to make frequent or significant changes independently. #5-Nutrition: Usual food intake pattern: Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake include includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding. #6-Friction & Shear: Potential problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintain relatively good position in chair or bed most of the time but occasionally slides down. Signed by LVN A 7/29/2024- Resident #1 was at Moderate Risk the score was 14. Signed by RN A 9/7/2024- Resident #1 was at High Risk the score was 12. It was signed by LVN A 12/13/2024- Resident #1 was at High Risk the score was 12. Resident #1's activity changed from chairfast to bedfast (confined to the bed). It was signed by DON. 12/17/2024- Very High-Risk score the score was 8. #6 moisture changed from very moist to constantly moist- Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. Signed by LVN B Record review of progress note and weekly assessment for Resident #1 revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/14/2024 - Resident noted with excoriation to groin region. Treatment initiated pending wound care physician evaluation. No new skin breakdown observed. Signed by LVN B 10/18/2024- Site #1 Sacrum Etiology: Trauma/Injury Measurements 3.5cm x1cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated 2. Repositioning resident as needed/tolerated 3. RD to follow Signed by LVN B 10/22/2024- Site #1 Sacrum Measurements 3 cm x1 cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated 2. Repositioning resident as needed/tolerated 3. RD to follow (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Signed by LVN B 11/1/2024 - Site #1 Sacrum Measurements 2 cm x 1 cm x 0.1 cm Procedure: Autolytic debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated 2. Repositioning resident as needed/tolerated 3. RD to follow Signed by LVN B 11/12/2024- Site #1 Sacrum Measurements 2 cm x 1 cm x 0.1 cm Procedure: Surgical excisional debridement Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated 2. Repositioning resident as needed/tolerated 3. RD to follow Signed by LVN B (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/22/2024 - Site #1 Sacrum Measurements 3 cm x 2 cm x 0.1 cm Procedure: Surgical excisional debridement (11/12/2024) Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Progress: Not at goal MASD to groin region treat with house barrier cream every brief change Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated 2. Repositioning resident as needed/tolerated 3. RD to follow Signed by LVN B 11/28/2024- Site #1 Sacrum Measurements 5 cm x 5 cm x 0.1 cm Procedure: Surgical excisional debridement (11/22/2024) Description: Light serous exudate 100% granulation Treatment: Cleanse area with NS or wound cleanser, pat dry, apply zinc ointment cover with bordered dressing daily. Progress: Not at goal MASD to groin region treat with house barrier cream every brief change. Risk factor: Immobility Interventions: 1. Offloading wound while in bed as needed /tolerated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Repositioning resident as needed/tolerated 3. RD to follow Signed by LVN B Record review of Resident #1's Skin IDT dated 12/11/2024 at 12:50pm, revealed Resident #1 was readmitted to facility following a transfer to the hospital due to altered mental status (diagnosed with UTI) . Resident #1 hospitalization was from 12/5-12/10/2024. Resident#1 has stage 2 wound to the sacrum and MASD to groin region. Prior orders from wound care physician include the application of zinc ointment and daily border dressing changes. These orders are being continued, and wound care physician scheduled to re-evaluate on tomorrow 12/12/2024. Care remained ongoing and compliant with prescribed treatment plan. Record review of Resident #1's Wound Care Doctor A assessments: 10/15/2024- Chief complaint -Wound on sacrum Etiology: Trauma/Injury Wound size: 3.5 x 1 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 30 days 2nd dressing: Gauze Island with border apply once daily for 30 days. 10/22/2024- Chief complaint wound on sacrum. Wound size: 3 x1 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 23 days 2nd dressing: Gauze Island with border apply once daily for 23 days. 10/29/2024- Chief complaint: Wound on sacrum Size 2 x 1 x not measurable due to presence of tissue overgrowth Treatment plan: Zinc ointment apply once daily for 16 days. 2nd dressing: Gauze island with border apply once daily for 16 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 10/25/2024. 11/5/2024- Sacrum wound size: 2x 0.3 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 9 days. 2nd dressing: Gauze island with border apply once daily for 9 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 10/25/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/12/2024- Sacrum wound size 1.5 x 0.3 x 0.1 cm Treatment plan: Zinc ointment apply once daily for 30 days. 2nd dressing: Gauze Island with border apply once daily for 13 days. Site 1: Surgical excisional debridement procedure Indication for procedure: Necrotic tissue and establish the margins of viable tissue. 11/19/2024- Sacrum wound: 3 x 2 x 0.1 cm Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater detail today. Reviewed offloading surfaces and discussed surfaces care plan. Considered patient behavior as factor that is complicating wound healing and discussed further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Treatment plan: Zinc ointment apply once daily for 23 days. 2nd dressing: Gauze Island with border apply once daily for 23 days. Debridement History: The most recent debridement of this wound was an excisional debridement performed on 11/12/2024. 11/26/2024- Sacrum wound size: 5 x 5 x 0.1 Granulation tissue: 60% surface area: 25.00cm Cluster wound: Open ulceration area of 15.00 cm Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater detail today. Patient not following repositioning or offloading recommendations and counseling provided. Considered patient behavior as factor that is complicating wound healing and discussed further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Treatment plan: Zinc ointment apply once daily for 16 days. 2nd dressing: Gauze Island with border apply once daily for 16 days. 12/3/2024- Sacrum wound size: 4 x 4x 0.1 cm surface area: 16.00 cm slough: 20%, granulation tissue 80% Wound progress: Not at goal Duration: 50 days Treatment plan: Zinc ointment apply once daily for 9 days. 2nd dressing: Gauze Island with border apply once daily for 9 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Site #1 Surgical Excisional Debridement Procedure Indication: Necrotic tissue and establish the margins of viable tissue. 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 3.2cm' of devitalized tissue including slough, biofilm and non-viable subcutaneous level tissues were removed at a depth of 0.1 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 O 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. Site 2-Unstagebale DTI of the left heel undetermined thickness wound size 2 x 2 x not measurable offloading and boot ordered. 12/12/2024 Chief complaint: Wound on sacrum; right medial thigh; left heel; scrotum. Wound size 8 x 8 x 0.1 Surface: 64.00 cm Slough: 20% ADDITIONAL WOUND DETAIL readmission from hospital DRESSING TREATMENT PLAN Primary Dressing(s) Alginate calcium apply once daily for 30 days Secondary Dressing(s) Gauze island w/ border apply once daily for 30 days PLAN OF CARE REVIEWED AND ADDRESSED Recommendations: Off-Load Wound; Reposition per facility protocol; Turn side to side in bed every 1-2 hours Site #1- Surgical excisional debridement procedure Indication: Remove necrotic tissue and establish margins of viable skin. PROCEDURE NOTE (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 12.8cm2 of devitalized tissue Including slough, biofilm and non-viable subcutaneous level tissues were removed al a depth of 0.1 cm and heallhy healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 20 percenl percent to O percent. Homeostasis was achieved and a clean dressing was applied. Post-operative recommendations and updates to the pla11 of care are documented in the Assessment and Plan section below. Record review of Resident #1's local hospital #2 record revealed: Principal problem upon admission on 12/5/2024 was altered mental status. Assessment and Plan: Acute toxic metabolic encephalopathy -multifactorial in the setting of an acute UTI, complicated UTI, E-coli UTI General Information: Resident #1 was confused and lethargic. Wound care assessment on 12/6/2024: Sacral stage 3 pressure injury wound- size L 6.0cm x W 6.0cm x D 0.1cm - no undermining - no tunneling/induration - Wound bed is full thickness with some pink and red non granular tissue. The area is denuded most probably from incontinence - edges well defined -small to moderate serosanguinous drainage - no odor - Peri wound redness noted. Left heel DTPI wound- size L 3.0cm x W 3.0cm x D 0cm - no undermining - no tunneling/induration -Wound with purple/ maroon non blanchable intact skin - edges well defined -No drainage - no odor - Peri wound skin is intact Location: Penis, scrotum, inner thighs, groin, posterior thighs and peri area - Type: MASD/ IAD (Moisture Associated Skin Damage/ Incontinence Associated Skin Damage) Appearance: Bright red erythematous rash and inflammation with denuded skin due to: moisture trapping in skin folds and fecal/ urine incontinence. Posterior thighs are full thickness which I will recommend Zinc paste. Exudate: Clear weeping skin due to inflammation, edema, and skin erosions. Current Pressure Support Surfaces: Bed: LAL mattress; microclimate pad; glide sheet with pillows or wedges and Z flex boots. Mobility: Bed bound. Recommendations: Sacrum and left heel wounds- Cleanse with Vashe (Ref # 108824) and pat dry with gauze. Apply Cavilon skin barrier to the peri wound skin, apply Polymem (Ref# 7114) to the wound base and cover with silicone foam dressing every other day and as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. Clean penis, scrotum, inner thighs, groin and peri area with Coloplast no rinse wash cloths (Ref# 119680) and warm water 2. Pat dry with towel 3. Apply Cavilon advanced skin barrier twice a week and as needed. Goal/Treatment Plan: 1. Dressing Changes as ordered or PRN if soiled. 2. Using wedges or pillow to turn and reposition the pt every 2 hours to offload pressure to wound, even when on specialty bed. 3. Encourage lowering the head of the bed below 30 degrees is tolerable. 4. Ensure patient is on pressure redistribution and microclimate control bed is order is placed. 5. Offload pressure to patient's heels by floating with pillows or by applying specialty boots. 6. Nutritional consultation for wound healing. The following supplements to aid in wound healing are recommended, unless contraindicated: - 1000 mg Vitamin C daily - 220 mg Zinc sulfate daily - Multivitamin daily - Juven 2 times per day - Accurately monitor and document patient's PO intake, so supplements can be adjusted accordingly. 7. Skin care and skin protection from moisture damage - If possible, keep diapers off patient to reduce moisture - Consider using Pure Wick/ Condom catheter for incontinence management - Apply Cavilon Advanced to perineal and perianal area 2x weekly Photos of Resident wounds were taken at the hospital. Record review of the last IDT care plan review for Resident #1 was conducted on 9/17/2024. No wounds were discussed. (continued on next page)

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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 - Actual harm Residents Affected - Few	An interview with the Wound care doctor on 12/12/2024 at 9:20a.m., revealed he had been providing wound care at the facility once a week for 2 years. He stated the sacral wound he was treating was a superficial wound, after returning from the hospital it was a stage 3 pressure wound. He said Resident #1 developed the stage 3 wound in the hospital. He said every time he round, there was a treatment nurse rounding with him. It is the same wound care nurse, LVN B. He said he is currently treating 13-14 residents at the facility. He said if he would have been told about scrotum and other areas, he would have treated the same as today with barrier cream. He stated every week he saw all 13-14 residents. He said every time he round, there was a treatment nurse rounding with him. It is the same wound care nurse, LVN B . He stated today he was at the facility from 6:15am until about 8:15am. He said each resident was assessed, wounds measured, and treated. He said today it took him about 2 hours to treat all residents. An interview with CNA A on 12/12/2024 at 5:07pm, she stated she worked the front of the Hall where Resident #1 resided. She said she helped to shower him on Tuesdays, Thursdays, and Saturdays. She said when someone turned Resident #1, he went back on his back. She said when they placed him in his wheelchair he cried, and so they put him back in bed, and he would only stay in a chair maybe for an hour before he was put back into bed. She could not recall the last time he was placed in a chair or wheelchair. She said Resident #1 had to be turned he could not do anything by himself. He required assistance by 2 people. She said she assisted the WCN with wound care if she needed help. She said Resident #1 had declined since admission. She stated CNAs round every 2 hours for incontinent care and re-positioning. An interview on 12/12/2024 at 5:27pm revealed CNA B had been employed at the facility for 7 years. He said he had been taking care of Resident #1 since he was admitted in March. His usually shift was day shift 6a-6pm, he said all resident briefs are changed as needed. He said they round every 2 hours to check on residents. He said he saw the sacral wound the day the lady came from local veterans' hospital to do skin assessment with the facility's wound care nurse. He could not recall the exact date. He had just given Resident #1 a shower. So, he went back to the room and showed the wound care nurse his sacral area. He said he was taught to complete peri care by: Getting supplies, wipe front to back, pad dry, wipe the bottom again when he turned to the back and pat dry. He said when he changed Resident #1 today, the wound nurse told him the new orders were to place 4x4 gauze between his thighs to prevent the skin from rubbing against the swollen scrotum. He said new orders are in PCC. He said he documented Residents ADL care immediately after he finished providing care. He said neglect is when you do not take care of the residents. For example, you refuse to change or feed them. He said he would report neglect to the Charge nurse and Executive Director. An interview with the DON on 12/13/2024 at 11:16 a.m., she stated she had been employed for about 4 months. She said sacral wounds could come from residents' co-morbidities or could be from residents' briefs needing to be changed more often because some residents get wet more than expected. She said the consequence of having a sacral wound is discomfort and pain. She stated pressure wounds could also be caused by poor nutrition, age, or co-morbidities as she stated. An interview with Clinical Resource A at 11:16 a.m., she stated when wounds were reported they would apply the initial treatment, which could be zinc, barrier cream and request a wound consult. The wound care doctor would take it from there. Sacral wounds could be the result of not being re-positioned properly, briefs not being changed as needed or co-morbidities. She said sometimes their diagnosis can prevent healing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675901	A. Building B. Wing	01/10/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview with the Executive Director on 12/13/2024 at 11:16 a.m. reflected her to state she could not recall when she first learned about Resident #1's sacral wound. She stated Resident #1's decline was the result of co-morbidities, and this could have been the reason for the skin breakdown as well. She said she was in constant communication with the physician from the local VA hospital and she was told that he would continue to decline due to his age and co-morbidities. An interview with NP on 12/16/2024 at 12:59pm, she said she had been caring for patients at the facility for a year. She is at the facility once per week normally on Wednesday mornings. She stated she had 10 residents at the facility. She said she was notified about Resident #1's sacral wound sometime in October and she made a recommendation for wound care, PT and OT consultations. She also ordered that Resident #1 wound be cleansed, pat dry apply xerofoam, cover with boarded dressing and to turn the patient every 2 hours. She said she was not aware of the MASD. She said the facility nurses were to inform her of any skin tears or anything skin related. But, she said she only saw Resident #1 concerning chronic conditions, such as his arthritis, CHF and Diabetes, not wounds. She said if she had known about the MASD she would ordered medication. She said in her professional opinion, sacral wounds are avoidable. She said if adequate offloading, re-positioning, and keeping their briefs dry would prevent skin breakdown even with co-morbidities. She said Resident #1 used to be put in the chair, but it had been about a month or so since she last observed him to be sitting up. She said although she was not at the facility all day, Resident #1 had been in bed when she saw him during the past month. An interview with Physician A on 12/17/2024 at 11:06am, he said he was not the medical director at the facility. He had been coming to the facility since 2010. He said Resident #1 he had dementia and other co-morbidities. He stated that his NP saw him once a week. He stated that his NP would be able to provide more detailed information about Resident #1 as he was in a clinic at the time of the call. He stated although Resident #1 had co-morbidities sacral wounds are absolutely avoidable with offloading, turning the patient and keeping their briefs dry. He said not changing briefs often especially for patients that are bedbound and are lying in bed all the time increases their chance for skin breakdown. He stated it only takes about 2 hours for a wound to develop. He stated for all high-risk patients with mobility issues he put in an order for skin assessments and devices as needed. Record review of Wound Care doctor A evaluations on 11/19/2024 revealed he had reviewed offloading surfaces and discussed surfaces care plan with resident and/or staff. On 11/26/2024 he noted that Resident #1 was not following repositioning or offloading recommendations and counseling provided . Record review of POC (Point of Care provided by CNA's) for Resident #1 dated [DATE] revealed: Turned and re-position (did you turn and reposition)- did not have any documentation on second shift (7p-7a) on: 11/13, 11/15, 11/18, 11/20, 11/24, 11/25, 11/27, 11/28 or 11/30/2024 Incontinent care: did not have any documentation on 11/2, 11/4, 11/5, 11/7, 11/9, 11/10, 11/13, 11/16, 11/18, 11/20, 11/24, 11/25, 11/28, or 11/29/2024. Record review of POC (Point of Care provided by CNAs) for Resident #1 dated [DATE] revealed: Turned and re-positioning was not documented on 7p-7a shifton: 12/2, 12/3, 12/12 or 12/13/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Incontinent care: did not have any documentation on morning shift 7a-7p on 12/1 7p-7a shift did not have any documentation on 12/2, 12/3/2024. Record review of skin and wound monitoring and management policy revised on 12/2023 revealed: It is the policy of the facility that: 1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and 2. A resident having pressure injury receives necessary treatment and services to promote healing, prevent infection and prevent new avoidable pressure injuries from developing. Pressure injury was defined as localized damage to the skin and/or underlying soft tissue usually over bony prominence or related to a medical or other device. The injury can present as intact skin or open ulcer and may be painful.