STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676323	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Crescent	11353 Sugar Park Lane Sugar Land, TX 77478

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (CR#1) out of 9 residents reviewed for reporting. RN A failed to report to the facilities Abuse Coordinator when she assessed CR#1 to have a bruise to his left arm after it brought to her attention by family at the bedside of CR#1 on 07/04/2024 and CR#1 was not able to verbalize how the bruise was sustained. This failure could place residents at the facility from having complaints and concerns reported and investigated for abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of CR#1's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] and with diagnoses which included: metabolic encephalopathy(problem in the brain caused by a chemical imbalance in the blood), nontraumatic ischemic infarction of muscle(spontaneous ischemic necrosis of skeletal muscle), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), chronic diastolic congestive heart failure(condition when the heart can not properly fill with blood during the resting period between each beat), secondary malignant neoplasm of bladder(secondary cancer of bladder), and acquired absence of right leg above knee(amputation). CR#1 discharged to a local hospital on 07/04/2024, after a change of condition. Record review of CR#1's Admission MDS assessment dated [DATE] revealed in section C a BIMS score of 10 indicating he was moderately impaired cognitively. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's undated Care Plan with effective date 06/26/2024 that read in part . Problem: At risk for falls r/t generalized weakness. Goal: CR#1 will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 days review period. Interventions: Keep areas free of obstructions to reduce the risk off falls or injury. Place call bell/light within easy reach. Remind CR#1 to call for assistance. Respond promptly to calls for assist to the toilet Record review of nursing progress note entered by RN A on 07/04/2024 at 22:16(10:16 PM) read in part, per order lorazepam given in the morning patient is sleeping, vitals checked BP (blood pressure)108/66 PULSE 62 OXYGEN with o2 (oxygen) 92/ 4to 5 liters o2 on flow at 3.30pm family visit the room Patient is {every} lethargic repat checked vitals BP IS 102/60 {PUISE}60 O2 90/ we put non breather oxygen 96/ BP 116/62 pulse 60 at 8pm patient is very agitated getting distress checked BP 90/60 OXYGEN 89/ Called on call NP (nurse practitioner) {[NAME]} informed patient condition advice send to hospital called 911.Medication and Face sheet sent out with EMS (emergency medical service). RP (responsible party) aware as well as DON informed. Called ED called, no response. Record review of CR#1's medical records dated 07/05/2024 from a local hospital revealed that CR#1 arrived via emergency services on 07/04/2024 with a chief complaint of shortness of breath. CR#1 tested positive for COVID-19 (Coronavirus Disease 2019 causes respiratory symptoms),and wound/skin assessment had no information for a bruise located to the left arm. Observation on 07/25/2024 at 9:21 a.m., of CR#1 who was not interviewable at a local hospital. He was not observed with a bruise to the arm. Interview on 07/25/2024 9:25 a.m. with nursing staff at local hospital, who said that CR#1 was diagnosed with pneumonia (infection of lungs) and COVID-19, with no information provided about a bruise or concern to the left arm. In a phone interview on 07/25/2024 at 10:36 a.m. with RP (responsible party), she said that on 07/04/2024 she was at the bedside, she saw the bruise to left arm of CR#1, she asked the nurse if the bruise was because of a fall, and the nurse denied fall and said she did not know how CR#1 got the bruise. She said that CR#1 did not look well the nurse assessed him, and he was sent to the hospital by 911 with EMS. She did not follow up with anyone at the facility about the bruise, she only spoke with the nurse assigned, and the focus was to get CR#1 to the hospital where he is currently admitted . She said that CR#1 was unable to talk and could not say how he got the bruise. In a phone interview on 07/26/2024 at 10:43 a.m. with a relative, she said that she saw CR#1 with a bruise to the left arm on 07/04/2024 before he left for the hospital and the nurse working with him was asked about the bruise, but the nurse did not know what happened. She said that she had taken a picture of the bruise at 4:44 p.m. on 07/04/2024 before CR#1 left the facility. She agreed to provide a copy of the photograph. Record review on 07/26/2024 at 10:55 p.m. of a photograph taken on 07/04/2024 at 4:44 p.m. and received from a relative of a bruise to the left arm that started at the forearm and extended up the elbow that was dark red/purple color that the did not include the face of the person pictured. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/26/2024 at 4:35 p.m. with RN A, she said that on 07/04/2024, CR#1 was sent to the hospital via EMS when oxygen saturation was low. She said that there was family at the beside who asked about a bruise to his arm. She said that the bruise did not appear to be new because it was not red or swollen and was dark purple. She pointed to her left arm at the top and bottom of the elbow to show where the bruise was located. She said that she had not seen the bruise before that day, but she thought the bruise was old. She did not enter the inform in her progress note or notify the DON (Director of Nursing), ED (Executive Director), or physician about the bruise because she thought the bruise was old. She said that she should have reported the bruise to the ED was the abuse coordinator. In an interview on 07/29/2024 at 2:22 p.m. with RN A, she said that she worked on 07/04/2024 from 2pm-10p, and CR#1 was assigned to her hall. She said she could not recall who the CNA (Certified Nursing Assistant) was that day. She denied that she saw CR#1 to have a bruise or that the family told her of a bruise. She said that she was confused on 07/26/2024, and she documented all that happened in her progress note. She said that she had been trained on abuse and neglect to include reporting. She said that allegations of abuse and neglect to include an injury of unknown origin. She said that injury of unknown origin would include a bruise that had not been seen previously, with information on how the bruise occurred, and the resident was not able to provide details as to how the bruise got there. She said that the resident should be assessed, progress note completed, incident report completed, and notification to RP, physician, DON, and ED. She said that the information is reported to investigate and see what happened, to see if it was abuse and prevent it from happing again. In an interview with CNA E, on 07/29/2024 at 3:21 p.m., she said that she worked on 07/04/2024 on 2pm-10pm shift. She did not see that CR#1 had a bruise during the shift and no one gave her information that there was a bruise. She said that she had been trained to report a bruise she had not seen before to nurse, DON, and ED immediately. She said that it is reported so there can be an investigation to she what happened and prevent it from happening again. In an interview on 07/29/2024 at 3:24 p.m. with the DON, she said that staff are trained to report an injury of unknown origin to the ED who is the abuse coordinator. She said that once the nurse is provided the information they should assess the resident, contact RP, physician, DON, and ED. She that the nurse should document and complete a incident report. She said that the ED would start an investigation and report to the State Survey Agency (SSA). She said that the investigation is to ruled out abuse or neglect, determine how the injury occurred, and prevent it from reoccurring. She said that she was not aware of CR#1 to have a bruise on the date of discharge. In an interview on 07/29/2024 at 4:04 p.m. with the ADON, she said that an injury of unknown origin is reported immediately to MD, RP, DON, and ED. She said that staff known they can come to her if the DON or ED is not available, so that an investigation can be done to determine the cause of the injury and to rule out abuse and neglect. She said that the ED would report to the SSA. She said that she was never made aware of CR#1 to have a bruise at the time of his discharge. In an interview on 07/29/2024 at 4:25 p.m. with the ED, she said that she is the abuse coordinator, and if there was an injury of unknown origin it should be reported to the her immediately. She said that the nurse should assess, contact RP, physician, and DON. She said that she would start an investigation and report to the SSA. She said that the investigation is completed to determine if there was abuse, try to find the cause of the injury, and put intervention in place to prevent it from occurring again. She was not aware of CR#1 to have bruise at discharge. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/30/2024 at 1:38 p.m. with the RDCS, she said that she is a registered nurse. She said that the ED is the abuse coordinator. She said that an injury of unknown origin should be reported immediately to the ED. She said that the facility uses the Provider Letter (PL) and facilities policy for reporting abuse and neglect. She said that the purpose of the investigation is to rule out abuse or neglect, and implement measure to prevent it from happening again. Interview on 03/21/2024 at 1:33 p.m. the ED said the PL is used for reporting guidelines to the SSA. She said that RN A was pulled from the floor on 07/29/2024, and suspended on 07/30/2024 until an investigation could be completed, and the incident was reported to the SSA. Record review of facility policy for Abuse Protocol dated April 2019 reflected in part, .1. The patient has the right to be free from abuse neglect, mistreatment of resident property, and exploitation . Record review of Long-Term Care Regulatory Provider Letter (PL) 19-17 dated 07/10/2019 reflected in part . A NF (nursing facility) must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Emergency situation that pose a threat to resident health and safety. The following table describes required reporting timeframes for each incident type: Types of Incident: Abuse (with or without serious bodily injury) .When to Report: Immediately, but not later than two hours after the incident occurs or is suspected. An incident that does not result in serious bodily injury and involves: neglect, exploitation, a missing resident, misappropriation, drug theft, fire, emergency situations that pose a threat to resident health and safety, a death under unusual circumstances Immediately, but not later than 24 hours after the incident occurs or is suspected . Attachment 1: Definitions and Examples of ANE and other Reportable Incidents Please note this document is intended as guidance only. The examples in this attachment are not all inclusive. Many other possible scenarios are reportable. Abuse: HHSC rules define abuse as: The negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under Penal Code S21.08 (indecent exposure) or Penal Code Chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault.11 CMS defines abuse as: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.12 . Injuries of unknown source: Note: an injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time.19 . Example of an injury of unknown source that must be reported: A resident has bruising on their left cheek bone area that was determined to be non-serious. No one witnessed the source of the injury. Although the injury was determined to be non-serious, the injury is suspicious because of the location of the injury .

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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** 45604 Based on interviews and records reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 (CR#1) of 9 residents reviewed for base-line care plans. -The facility failed to ensure (CR#1) had a baseline care plan developed within 48-hours after admission with goals and interventions to address wound care. The failure could place newly admitted residents at risks of not receiving the care and continuity of services. Findings included: Record review of CR#1's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] and with diagnoses which included: metabolic encephalopathy(problem in the brain caused by a chemical imbalance in the blood), nontraumatic ischemic infarction of muscle(spontaneous ischemic necrosis of skeletal muscle), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), chronic diastolic congestive heart failure(condition when the heart can not properly fill with blood during the resting period between each beat), secondary malignant neoplasm of bladder(secondary cancer of bladder), and acquired absence of right leg above knee(amputation). CR#1 discharged to a local hospital on 07/04/2024, after a change of condition, Record review of CR#1's Admission MDS assessment dated [DATE] revealed in section C a BIMS score of 10 indicating he was moderately impaired cognitively. He was assessed to have unhealed pressure Ulcers/Injuries in Section M. Record review of CR#1's Baseline Care Plan dated 06/26/2024 was documented as N/A(not applicable, not available) under skin impairment/intervention. In an interview on 07/26/2024 at 4:35pm with RN A, she said that she was the admitting nurse for CR#1, and CR#1 admitted to the facility with a foot and sacral wound that she thought was stage 1. In an interview on 07/29/2024 at 2:22pm with RN A, she said that the baseline care plan is completed by the admitting nurse. She said that CR#1 admitted with wounds, and he was not planned for wounds. She said that it was an oversight. She said that she did not know who reviewed the admission process to ensure it is done accurately. She said that the care plan is used to know what care to provide a resident, and without it care could be missed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/30/2024 at 10:58am with the DON, she said that the admitting nurse completes the baseline care plan, and skin impartments should be captured on the care plan. She said that the ADON and she should audit after a new admission to ensure the baseline care plan is completed and accurate, and she is the oversight. She said that the information on the baseline care plan is used to ensure residents review appropriate care at the time of admission, and it is not accurate care could be inappropriate. She said that CR#1 admitted to the facility with wounds, and it was not care planned. She said that she could not remember if the admission of CR#1 was audited, and if it had the error should have been corrected. In an interview on 07/30/2024 at 1:11pm with the ADON, she said that the admitting nurse completes the baseline care plan, and skin impartments should be captured on the care plan. She said that the DON and she are the oversight to ensure that baseline care plans are completed and accurate. She said that there should be an audit the next working day after each new admission. She said that CR#1 admitted with wounds, it should have been outlined on the baseline care plan to ensure appropriate care and treatments were provided at the time of the admission. She did not remember completing an audit of the admission for CR#1, and if it had the error should have been corrected. Interview on 07/30/2024 at 1:38pm with the RDCS, she said that she is a registered nurse. She said that the admitting nurse should complete the baseline care plan at the time of admission. She said that the ED should conduct a morning meeting with each department head in attendance to review all clinical processes for the residents, and auditing of new admissions should be done to ensure accuracy of the admission process with any discrepancies corrected immediately, to prevent delays in care. She said that the DON is the oversight to ensure that the audits are completed, and the ED is the oversight for the DON. She said that a negative outcome to residents is they do not get appropriate care. Interview on 03/21/2024 at 1:33 PM the ED said the baseline care plan is completed by the admitting nurse and should be completed accurately. She said that audits should be completed by the DON and ADON. She said that the admission for all newly admitted residents should be reviewed during the morning stand up meeting the next working day after the admission to ensure the admission was done accurately. She said that she did not work the day after CR#1 admitted . She said that she is the oversight for the DON and ADON. She said that the purpose of the baseline care plan is for all to see what type of care needs of the resident, and if it is not accurate the resident may not get the appropriate care. Record review of the Policies and Procedures Care Plan - Baseline dated March 2022 read in part .1. The baseline careplan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident .4.c. any services and treatments to be administered by the facility and personnel acting on behalf of the facility; .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 9 residents (Resident #2) reviewed for comprehensive care plans. The facility failed to provide Resident #2 with comprehensive person-centered care plan to address his diagnosis of epilepsy, orders for oxygen therapy, and orders for a feeding tube. This failure could place residents at risk of not having personalized plans developed to address their specific care needs. Findings included: Record review of Resident #2's undated face sheet revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included epilepsy(seizures), dysphasia(disorder where a person has difficulties comprehending language or speaking), aphasia(a language disorder that affects how you communicate), quadriplegia(paralysis below the neck), general anxiety, depression, cerebral infarction(stroke), contracture of right elbow and hand (permanent tightening of the muscles), Parkinson's(disease is a condition where a part of your brain deteriorates), and metabolic encephalopathy(problem in the brain caused by a chemical imbalance in the blood). Record review of Resident #2's quarterly MDS, dated [DATE], revealed the resident was triggered for special treatments in section O for oxygen therapy, in section k for feeding tube, an in section I for epilepsy. Record review of Resident #2's Care Plan with effective date 10/23/2023-current, did not have focus, goals or interventions in place to address oxygen therapy, feeding tube, or epilepsy. Record review of Resident #2's physician orders for Oxygen treatment for Oxygen at 2-4L/min via nasal cannula, and valproic acid 250 mg/5 ml oral solution, levetiracetam 500 mg/5ml, intravenous solution (13ml) vial (ML) enteral tube, carbamazepine 100mg chewable tablet (3) g-tube, and seizure monitoring for epilepsy. Observation 07/26/2024 at 11:46 a.m., of Resident #2 who was not interviewable in his room at the facility with oxygen and feeding tube in place. In an interview on 07/26/2024 at 4:22 p.m. with LVN B, she said that she is the nurse for Resident #2 who had a feeding tube, oxygen therapy, and epilepsy. She reviewed his care plan and stated that he was not care planned to address his feeding tube, oxygen therapy, and epilepsy. She said the comprehensive care plan should be specific to the residents and address all the residents care needs. She said that she had never completed a comprehensive care plan or updated the care plan, and the task is completed by the DON and ADON. She said that care may not be provided if the care plan is not completed accurately. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/29/2024 at 2:22 p.m. with RN A, she said that the nurses do not complete the comprehensive care plan or update them, and she was told it was done by the DON and ADON. She said that the care plan is used to know what care to provide a resident, and without it care could be missed. In an interview on 07/30/2024 at 10:40 a.m. with MDS Nurse C, she said that she is a LVN. She said that comprehensive care plans are completed by the DON and ADON, and they should be centered around the resident to address all care needs triggered by the MDS. She said that the MDS Nurse can start the care plan but cannot complete it. She said that the DON and ADON should be ensuring they are completed and done so accurately. She said she was not sure how the facility ensured the care plans are completed, and without an accurate care plan care staff can fail to complete care needs of the residents. In an interview on 07/30/2024 at 10:58 a.m. with the DON, she said that the comprehensive care plan is completed by the ADON and her. She said that the ADON and she should update the care plan as care needs arise. She said that care plan should be updated after a readmission. She said that the ADON and she should audit after a re admission and daily during the morning stand up meeting by review the 24 hour report to ensure the care plans are completed, updated, and accurate. She reviewed the care plan for Resident #2, and she it was an oversight that the care plan did not address seizures, oxygen therapy, and the feeding tube. She said that the care plan should be person centered so the clinical nursing staff know what care residents need, and if it is not accurate a resident may not receive appropriate care. In an interview on 07/30/2024 at 1:11 p.m. with the ADON, she said that she thought the comprehensive care plan was completed by the MDS Nurses. She said that the DON is the oversight to ensure that care plans are completed and accurate. She said that the care plan is used to ensure appropriate care and treatments were provided to residents. Interview on 07/30/2024 at 1:38 p.m. with the RDCS, she said that she is a registered nurse. She said that the MDS Nurses should complete the comprehensive care plan with the DON as oversight to audit and ensure they are completed with accuracy. She said that the ED is the oversight for the DON. She said that a negative outcome to residents is they do not get appropriate care. Interview on 03/21/2024 at 1:33 p.m., the ED said the care plan is completed by the MDS Nurse and should be completed accurately. She said that audits should be completed by the DON and ADON. She said that she is the oversight for the DON and ADON. She said that the purpose of the care plan is for all to see the care needs of the resident, and if it is not accurate the resident may not get the appropriate care. In an interview on 07/30/2024 at 3 :00 p.m. with MDS Nurse D, she said that she is an LVN. She said that comprehensive care plans can be initiated by the MDS nurse based off what is triggered on the MDS assessment. She said that EMR (electronic medical record) does not always auto-populate all the care areas to the care plan. She said the care plans are completed and updated by the DON and ADON, and they should be person centered and address all care areas triggered by the MDS assessment. She said that care plan is used to give the nursing staff a plan on how to care for the resident appropriately. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Policies and Procedures Care Plans, Comprehensive Person-Centered dated March 2022 read in part .A comprehensive, person=centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident.

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	676323	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Crescent	11353 Sugar Park Lane Sugar Land, TX 77478

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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 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** 45604 Based on record review and interview the facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 of 9 residents (CR#1) reviewed for quality of care. -The facility failed to obtain wound care orders for CR#1's left toes and left foot upon admission on 06/25/2024-06/28/2024. This failure could place residents at risk for delay in needed treatment and care, resulting in further injury, hospitalization , and/or death. Findings included: Record review of CR#1's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] and with diagnoses which included: metabolic encephalopathy(problem in the brain caused by a chemical imbalance in the blood), nontraumatic ischemic infarction of muscle(spontaneous ischemic necrosis of skeletal muscle), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), chronic diastolic congestive heart failure(condition when the heart cannot properly fill with blood during the resting period between each beat), secondary malignant neoplasm of bladder(secondary cancer of bladder), and acquired absence of right leg above knee(amputation). CR#1 discharged to a local hospital on 07/04/2024, after a change of condition. Record review of CR#1's Admission MDS assessment dated [DATE] revealed in section C a BIMS score of 10 indicating he was moderately impaired cognitively. He was assessed to have unhealed pressure Ulcers/Injuries in Section M. Record review of CR#1's Baseline Care Plan dated 06/26/2024 was documented as N/A (not applicable, not available) under skin impairment/intervention. Record review of the Admission Charge Nurse Report dated on 06/25/2024 that was completed by ADON prior to admission to reveal that CR#1 would admit with left leg arterial wound and sacral wound. Record review of clinical progress note completed by RN A dated 06/25/2024 06/25/2024 23:24(11:24 PM) with no details of wounds to present upon admission. Record review of clinical progress note documented by RN F on 06/26/2024 at 3:39 p.m. read in part, resident (CR#1) refused assessment as stated by wound care nurse (LVN G). Record review of clinical progress note documented by LVN G on 06/26/2024 at 8:15 p.m. read in part, resident (CR#1) refused assessment 2x RP/MD informed. Treatment nurse (RN H) will try again in the morning. Record review of clinical progress note documented by RN F on 06/27/2024 at 3:08 p.m. read in part, Nurse (RN H) tried to assess the patient (CR#1). Patient (CR#1) refused the assessment. (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 clinical progress note documented by RN H on 06/28/2024 at 5:44 p.m. read in part, Patient (CR#1) refused skin assessed x2. RP aware and treatment nurse to reattempt. Record review of clinical progress note documented by RN H on 06/28/2024 at 5:50 p.m. read in part, Patient was assessed by treatment nurse. Patient has wound with back eschar to left anterior foot, left great toe and wound also noted in between left toe digits. Patient has a old right AKA (above knee amputation) with surgical incision dry and intact. Patient has a urostomy to right abdomen. Wound Md updated and treatment orders noted. Plan of care ongoing. Record review of wound assessment completed by RN H dated 06/28/2024, revealed CR#1 admitted on [DATE] with left great toe and anterior foot, non-pressure arterial ulcer to be treated with Betadine. Record review of physician orders to Apply Betadine to left foot, left great toe and in-between left digits One Time Daily, and cleanse sacrum with Normal Saline or Skin Cleanser. Pat Dry. Apply Barrier Cream. Leave open to air each shift starting 06/28/2024. Record review of CR#1's medical records dated 07/05/2024 from a local hospital revealed that CR#1 arrived via emergency services on 07/04/2024 with a chief complaint of shortness of breath and tested positive for COVID-19 (Coronavirus Disease 2019 causes respiratory symptoms). CR#1 wound/skin assessment was completed with erythematous (rash) to the buttocks and left foot wound with ischemia (less-than-normal amount of blood flow) and stable necrotic tissue, no undermining, no tunneling, drainage or odor. Record review of CR#1's medical records dated 06/16/2024-06/25/2024 from a local hospital revealed a progress note dated 06/22/2024 that indicated that there was skin excoriation(abrasion) and wound in the rectal area. The nutrition assessment revealed that arterial wounds to L great toe, L medial foot dated 06/25/2024. There were no discharge diagnosis or orders for wounds in the discharge summary. In an interview on 07/29/2024 at 2:22 p.m. with RN A, she said that she worked on 06/25/2024 from 2pm-10pm. She said that CR#1 admitted on [DATE] and she was the admitting nurse. She said that she reviewed the admission documents and hospital records of CR#1 when arrived. She said that she completed an assessment of CR#1, and he admitted with wounds to the left foot, sacrum, and he had right amputation at the knee. She said that CR#1 did not have a discharge diagnosis or treatment orders to address his wounds at admission. She said that she contact the physician to get orders to continue the discharge medications from the hospital but she did not get temporary orders to treat the wounds at the time of admission. She said that she did not document the wounds in the admission progress note. She said that she did not include the wounds in the baseline care plan of CR#1. She said that she did not give the information to the next shift, and she did not give the information to the wound care nurses. She said that the risk to the resident is that he did not have orders to treat wounds until 07/28/2024. She said that CR#1 refused assessments from wound care nurses on 07/26/2024 and 07/27/2024, if he had not the wound care nurse would have got the orders prior to 07/28/2024, and she did not think there was harm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/29/2024 at 2:50 p.m. with RN H, she said that she is one of two wound care nurses. She said that she completes wound care on Monday, Tuesday, Thursday, and Friday, and LVN G completes wound care on Wednesday, Saturday, and Sunday. She said that LVN G and her are scheduled 8am-5pm, but they do not leave until all treatments are done. She said that the wound care completes a separate skin assessment within 24 hours of admission of all newly admitted residents. She said that the admitting nurse should complete a skin assessment, document any wounds in a progress note, and get temporary orders to treat the wound until a wound consult takes place at the time of admission. She said that the admitting nurse should notify the wound care nurse if one is in the building if wounds are present during the admission skin assessment. She said that if there are no discharge orders for a resident that admits with a wound the admitting should get orders at the time of admission. She said that when a resident is newly admitted she reviews the admission progress note, the baseline care plan, and the hospital records for wounds prior to completing her own skin assessment. She said that the wound care nurse do not rely on hospital records as sometimes it is record that a resident has wounds at discharge and the do not or there is no wounds and there are wounds at admission. She said that CR#1 admitted from the hospital and there were no discharge orders or diagnosis to address wounds. She said that RN A did not document in a progress note or baseline care plan that CR#1 had wounds upon admission. She said that CR#1 refused skin assessments from wound care nurses on 06/26/2024 and 06/27/2024. She said that she was to complete the skin assessment on 06/28/2024. She said that she got temporary orders to treat wounds to the left foot, and left toes from the primary doctor until a wound consult could be completed on 06/28/2024 and implemented the orders. She said that RN A should have obtained orders at the time of admission. She said that she did not think there was a delay in treatment as CR#1 refused assessments and other treatments, and without the refusal the orders could have been obtained on 06/26/2024. In an interview on 07/29/2024 at 3:24 p.m. with the DON, she said that CR#1 admitted to the facility on [DATE] with wounds to the left foot and treatment orders were not obtained until 06/28/2024 due to the resident refusing care. She said that RN A should have obtained orders to treat the wounds at the time of admission. She said that she did not think there was a delay as CR#1 refused assessments on 06/26/2024 and 06/27/2024. She said that there should be an audit of newly admitted residents the next working day after admission. She said that she could not remember if the admission of CR#1 was audited, she said that an audit should have identified that there were no wound care treatment orders, and the error should have been corrected. She said that the audit is completed by the ADON and DON, and she is the oversight as the DON. In an interview on 07/29/2024 at 4:05 p.m. with the ADON, she said that CR#1 admitted to the facility on [DATE] with wounds to the left foot treatment orders were not obtained until 06/28/2024. She said that RN A should have obtained orders to treat the wounds at the time of admission, treatment was delayed, and orders should have been in place even if CR#1 refused treatment on 06/26/2024 and 06/27/2024. She said that there should be an audit of newly admitted residents the next working day after admission by DON and her. She said that she could not remember if the admission of CR#1 was audited, she did work on 06/26/2024, audit should have identified that there were no wound care treatment orders, and the error should have been corrected. She said that a delay in treatment could have caused the wounds to worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/29/2024 at 4:25 p.m. the ED said that audits should be completed of a new admission the next working day after admission during the morning meeting to ensure admission was completed accurately, ensure orders are in place, and to prevent delays in treatment. She said that the clinical audit is completed by the DON and ADON, and she is the oversight. She said that she could not remember if there was an audit of the admission of CR#1 on 6/26/24, but the audit should have caught that orders were not in place for wound care. She said that the orders should have been in place from 06/25/2024 even it care was refused to prevent delays in care. In an interview on 07/30/2024 at 12:09 p.m. with Physician I, he said that he is the wound care doctor for the facility, and he did not get to assess the wound of CR#1 prior to his discharge. He said that CR#1 was refusing treatments, the facility should follow their policy, and if policy dictates that orders should be in place at the time of admission that what he would expect to be done. He said that he did not think there would be monumental change in the condition of the wounds from admission until the time orders were provided. Interview on 07/30/2024 at 1:38 p.m. with the RDCS, she said that she is a registered nurse. She said that RN A should have obtain orders at the time of CR#1's admission treat his wounds, the should have been in place even if CR#1 had refused care, and it was a delay in treatment. She said that the ED should conduct a morning meeting with each department head in attendance to review all clinical processes for the residents, and auditing of new admissions should be done to ensure accuracy of the admission process with any discrepancies corrected immediately, to prevent delays in care. She said that the DON is the oversight to ensure that the audits are completed, and the ED is the oversight for the DON. In an interview on 07/30/2024 at 3:41pm with Physician J, she said that she was the primary physician for CR#1while he was admitted to the facility. She said that CR#1 admitted with wounds, and she received the information when contacted to reconcile medications at the time of the admission. She provided temporary orders to treat the wounds on 06/28/2024 with wound consult. She said that orders should have been in place at the time of admission on 06/25/2024 to prevent a delay in treatment, and prevent the wounds from worsening. Record review of facility policy, patient Care Management System 1 Skin dated July 2022 read in part, 1. A head-to-toe skin assessment will be completed on day of admission and documented by the admitting nurse upon admission (including re-admission) of every patient. In addition, the admitting nurse will notify the physician and patient representative o any identified areas, implement treatment/interventions and document in electronic medical record (EMR)

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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** 45604 Based on record review and interview the facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 of 9 residents (CR#1) reviewed for wound care. -The facility failed to obtain wound care orders for CR#1's sacral wound upon admission on 06/25/2024-06/28/2024. This failure could place residents at risk of not receiving adequate care in a timely manner, deterioration of skin, and decreased quality of life. Findings included: Record review of CR#1's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] and with diagnoses which included: metabolic encephalopathy(problem in the brain caused by a chemical imbalance in the blood), nontraumatic ischemic infarction of muscle(spontaneous ischemic necrosis of skeletal muscle), peripheral vascular disease (condition in which narrowed arteries reduce blood flow to the arms or legs), chronic diastolic congestive heart failure(condition when the heart cannot properly fill with blood during the resting period between each beat), secondary malignant neoplasm of bladder(secondary cancer of bladder), and acquired absence of right leg above knee(amputation). CR#1 discharged to a local hospital on 07/04/2024, after a change of condition. Record review of CR#1's Admission MDS assessment dated [DATE] revealed in section C a BIMS score of 10 indicating he was moderately impaired cognitively. He was assessed to have unhealed pressure Ulcers/Injuries in Section M. Record review of CR#1's Baseline Care Plan dated 06/26/2024 was documented as N/A (not applicable, not available) under skin impairment/intervention. Record review of the Admission Charge Nurse Report dated on 06/25/2024 that was completed by ADON prior to admission to reveal that CR#1 would admit with left leg arterial wound and sacral wound. Record review of clinical progress note completed by RN A dated 06/25/2024 06/25/2024 23:24(11:24 PM) with no details of wounds to present upon admission. Record review of clinical progress note documented by RN F on 06/26/2024 at 3:39 p.m. read in part, resident (CR#1) refused assessment as stated by wound care nurse (LVN G). Record review of clinical progress note documented by LVN G on 06/26/2024 at 8:15 p.m. read in part, resident (CR#1) refused assessment 2x RP/MD informed. Treatment nurse (RN H) will try again in the morning. Record review of clinical progress note documented by RN F on 06/27/2024 at 3:08 p.m. read in part, Nurse (RN H) tried to assess the patient (CR#1). Patient (CR#1) refused the assessment. (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 clinical progress note documented by RN H on 06/28/2024 at 5:44 p.m. read in part, Patient (CR#1) refused skin assessed x2. RP aware and treatment nurse to reattempt. Record review of clinical progress note documented by RN H on 06/28/2024 at 5:50 p.m. read in part, Patient was assessed by treatment nurse. Patient has wound to sacrum/buttocks extending to perirectal area. Patient has a old right AKA (above knee amputation) with surgical incision dry and intact. Patient has a urostomy to right abdomen. Wound Md updated and treatment orders noted. Plan of care ongoing. Record review of wound assessment completed by RN H dated 06/28/2024, revealed CR#1 admitted on [DATE] with stage three pressure injury to the sacrum to be treated with barrier cream. Record review of physician orders to cleanse sacrum with Normal Saline or Skin Cleanser. Pat Dry. Apply Barrier Cream. Leave open to air each shift starting 06/28/2024. Record review of CR#1's medical records dated 07/05/2024 from a local hospital revealed that CR#1 arrived via emergency services on 07/04/2024 with a chief complaint of shortness of breath and tested positive for COVID-19 (Coronavirus Disease 2019 causes respiratory symptoms). CR#1 wound/skin assessment was completed with erythematous (rash) to the buttocks and left foot wound with ischemia (less-than-normal amount of blood flow) and stable necrotic tissue, no undermining, no tunneling, drainage or odor. Record review of CR#1's medical records dated 06/16/2024-06/25/2024 from a local hospital revealed a progress note dated 06/22/2024 that indicated that there was skin excoriation(abrasion) and wound in the rectal area There were no discharge diagnosis or orders for wounds in the discharge summary. In a phone interview on 07/25/2024 at 10:36am with RP (responsible party), she said that she was concern that CR#1 developed pressure ulcers while admitted to the facility from 06/25/2024-07/04/2024. She said that CR#1 admitted from a local hospital to the facility with no pressure ulcers at the time of admission, and he readmitted to the same local hospital he was observed with pressure ulcers to his butt and foot. She said that she had not been told that there was a concern for infection. In an interview on 07/29/2024 at 2:22 p.m. with RN A, she said that she worked on 06/25/2024 from 2pm-10pm. She said that CR#1 admitted on [DATE] and she was the admitting nurse. She said that she reviewed the admission documents and hospital records of CR#1 when arrived. She said that she completed an assessment of CR#1, and he admitted with wound to sacrum, and he had right amputation at the knee. She said that CR#1 did not have a discharge diagnosis or treatment orders to address his wounds at admission. She said that she contact the physician to get orders to continue the discharge medications from the hospital but she did not get temporary orders to treat the wounds at the time of admission. She said that she did not document the wounds in the admission progress note. She said that she did not include the wounds in the baseline care plan of CR#1. She said that she did not give the information to the next shift, and she did not give the information to the wound care nurses. She said that the risk to the resident is that he did not have orders to treat wounds until 07/28/2024. She said that CR#1 refused assessments from wound care nurses on 07/26/2024 and 07/27/2024, if he had not the wound care nurse would have got the orders prior to 07/28/2024, and she did not think there was harm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/29/2024 at 2:50 p.m. with RN H, she said that she is one of two wound care nurses. She said that she completes wound care on Monday, Tuesday, Thursday, and Friday, and LVN G completes wound care on Wednesday, Saturday, and Sunday. She said that LVN G and her are scheduled 8am-5pm, but they do not leave until all treatments are done. She said that the wound care completes a separate skin assessment within 24 hours of admission of all newly admitted residents. She said that the admitting nurse should complete a skin assessment, document any wounds in a progress note, and get temporary orders to treat the wound until a wound consult takes place at the time of admission. She said that the admitting nurse should notify the wound care nurse if one is in the building if wounds are present during the admission skin assessment. She said that if there are no discharge orders for a resident that admits with a wound the admitting should get orders at the time of admission. She said that when a resident is newly admitted she reviews the admission progress note, the baseline care plan, and the hospital records for wounds prior to completing her own skin assessment. She said that the wound care nurse do not rely on hospital records as sometimes it is record that a resident has wounds at discharge and the do not or there is no wounds and there are wounds at admission. She said that CR#1 admitted from the hospital and there were no discharge orders or diagnosis to address wounds. She said that RN A did not document in a progress note or baseline care plan that CR#1 had wounds upon admission. She said that CR#1 refused skin assessments from wound care nurses on 06/26/2024 and 06/27/2024. She said that she was to complete the skin assessment on 06/28/2024. She said that she got temporary orders to treat wound to sacrum from the primary doctor until a wound consult could be completed on 06/28/2024 and implemented the orders. She said that RN A should have obtained orders at the time of admission. She said that she did not think there was a delay in treatment as CR#1 refused assessments and other treatments, and without the refusal the orders could have been obtained on 06/26/2024. In an interview on 07/29/2024 at 3:24 p.m. with the DON, she said that CR#1 admitted to the facility on [DATE] with wound to the sacrum, and treatment orders were not obtained until 06/28/2024 due to the resident refusing care. She said that RN A should have obtained orders to treat the wounds at the time of admission. She said that she did not think there was a delay as CR#1 refused assessments on 06/26/2024 and 06/27/2024. She said that there should be an audit of newly admitted residents the next working day after admission. She said that she could not remember if the admission of CR#1 was audited, she said that an audit should have identified that there were no wound care treatment orders, and the error should have been corrected. She said that the audit is completed by the ADON and DON, and she is the oversight as the DON. In an interview on 07/29/2024 at 4:05 p.m. with the ADON, she said that CR#1 admitted to the facility on [DATE] with wound to the sacrum, and treatment orders were not obtained until 06/28/2024. She said that RN A should have obtained orders to treat the wounds at the time of admission, treatment was delayed, and orders should have been in place even if CR#1 refused treatment on 06/26/2024 and 06/27/2024. She said that there should be an audit of newly admitted residents the next working day after admission by DON and her. She said that she could not remember if the admission of CR#1 was audited, she did work on 06/26/2024, audit should have identified that there were no wound care treatment orders, and the error should have been corrected. She said that a delay in treatment could have caused the wounds to worsen. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/29/2024 at 4:25 p.m. the ED said that audits should be completed of a new admission the next working day after admission during the morning meeting to ensure admission was completed accurately, ensure orders are in place, and to prevent delays in treatment. She said that the clinical audit is completed by the DON and ADON, and she is the oversight. She said that she could not remember if there was an audit of the admission of CR#1 on 6/26/24, but the audit should have caught that orders were not in place for wound care. She said that the orders should have been in place from 06/25/2024 even it care was refused to prevent delays in care. In an interview on 07/30/2024 at 12:09 p.m. with Physician I, he said that he is the wound care doctor for the facility, and he did not get to assess the wound of CR#1 prior to his discharge. He said that CR#1 was refusing treatments, the facility should follow their policy, and if policy dictates that orders should be in place at the time of admission that what he would expect to be done. He said that he did not think there would be monumental change in the condition of the wounds from admission until the time orders were provided. Interview on 07/30/2024 at 1:38 p.m. with the RDCS, she said that she is a registered nurse. She said that RN A should have obtain orders at the time of CR#1's admission treat his wounds, the should have been in place even if CR#1 had refused care, and it was a delay in treatment. She said that the ED should conduct a morning meeting with each department head in attendance to review all clinical processes for the residents, and auditing of new admissions should be done to ensure accuracy of the admission process with any discrepancies corrected immediately, to prevent delays in care. She said that the DON is the oversight to ensure that the audits are completed, and the ED is the oversight for the DON. In an interview on 07/30/2024 at 3:41pm with Physician J, she said that she was the primary physician for CR#1while he was admitted to the facility. She said that CR#1 admitted with wounds, and she received the information when contacted to reconcile medications at the time of the admission. She provided temporary orders to treat the wounds on 06/28/2024 with wound consult. She said that orders should have been in place at the time of admission on 06/25/2024 to prevent a delay in treatment, and prevent the wounds from worsening. Record review of facility policy, patient Care Management System 1 Skin dated July 2022 read in part, 1. A head-to-toe skin assessment will be completed on day of admission and documented by the admitting nurse upon admission (including re-admission) of every patient. In addition, the admitting nurse will notify the physician and patient representative o any identified areas, implement treatment/interventions and document in electronic medical record (EMR)