| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 414340 | A. BUILDING _____ B. WING _____ | 4/9/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS OF KENT (THE) | 350 N CENTER ST LOWELL, MI 49331 |

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| F0000 SS= | INITIAL COMMENTS<br><br>Laurels of Kent (The) was surveyed for an Abbreviated survey on 4/9/2025.<br><br>Intakes: MI00150101, MI00150280, MI00150565, MI00150929, and MI00151467.<br><br>Census=96 | F0000 | | |
| F0550 SS= D | Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and | F0550 | F550 Resident Rights/Exercise of Rights<br><br>Resident #9 still resides within the facility. Social Services has followed up with resident and has had no emotional or mental effects from the interaction. Housekeeping staff F received 1:1 education.<br><br>Residents who reside within the facility have the potential to be affected. Inter-viewable residents were queried regarding Resident Rights. Any concerns were addressed immediately.<br><br>Staff were re-educated on Resident Rights policy. Those currently on leave of absence or PRN will be re-educated on their next scheduled workday. Resident Rights policy was reviewed by QA committee and deemed to be appropriate.<br><br>Management team will complete quality rounds to evaluate for inappropriate interaction by staff members weekly x4, then monthly x 3. Concerns will be addressed immediately and findings will be reported to the QA committee for further review and recommendations.<br><br>Administrator is responsible for sustained compliance. | 5/6/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/02/2025 |

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.

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| | reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review the facility failed to ensure dignified verbal interactions between staff and resident for 1 (Resident #9) of 4 residents reviewed for dignity and respect resulting in negative emotional feelings and the potential for decreased self-worth or self-esteem.<br><br>Findings include:<br><br>Resident #9:<br><br>Review of Resident #9's medical diagnoses, print date 4/9/25, included diagnoses of down syndrome and unspecified dementia.<br><br>Review of Resident #9's brief interview for mental status score, dated 3/26/25, was scored 2 which indicated severe cognitive impairment.<br><br>During an observation on 4/9/25 at 8:47 AM, Resident #9 was seated in her wheelchair in her room and was observed calling out verbally, moaning, crying, and stated, "Ow, it hurts". Housekeeping staff "F" entered Resident #9's room as this was happening. Staff "F" asked what resident #9 needed and Resident #9 was unable to clearly state a care need to Staff "F". Staff "F" then stated, "We're not just gonna (going to) sit and cry", told Resident #9 to not call out and to use her call light, and exited the room approximately one to two minutes after entering. There were no other staff or residents in the area at that time and staff "F" didn't offer any | | | |

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| | diversional interventions/activities. No television was observed to be on in the room at the time and staff "F" wasn't observed to go get someone from the nursing staff to assist Resident #9.<br><br>During an observation and interview on 4/9/25 at 9:06 AM, Resident #9 seated in her wheelchair in her room continued to call out, moaned, and cried with her eyes closed. Resident #9 stated, "Not good" when asked how housekeeping staff "F"'s interaction with her made her feel. Resident #9 stated, "Yes" when asked if housekeeping staff "F" had spoken to her like that before.<br><br>During an interview on 4/9/25 at 9:10 AM, Registered Nurse (RN) "Y" reported Resident #9 had lived at an assisted living facility prior to admission at this facility and there was alleged abuse that occurred towards Resident #9. RN "Y" reported Resident #9 has called out off and on since admission to the facility. RN "Y" reported she would remove a staff member from a resident room if she heard a staff member say, "We're not just gonna (going to) sit and cry" to a resident, take that staff member to the Director of Nursing's office and then check back on the resident to see if they were okay.<br><br>During an interview on 4/9/25 at 9:18 AM, housekeeping staff "F" reported Resident #9 likes to sit and cry because she wants attention. Staff "F" confirmed she said to Resident #9, "We're not just gonna (going to) sit and cry". Staff "F" stated, "I know it sounds harsh", but it was better than "straight up yelling". Staff "F" reported she has heard, but not seen, other staff get "over stimulated" and sound "harsh" with their tone with Resident #9 when she called out a lot. Staff "F" noted she only heard these interactions but didn't see them. Staff "F" was unable to recall staff names or details of these observations but reported they (unknown facility staff) "get a little | | | |

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| | loud and harsh" and if you walked by while they interacted with Resident #9 you'd think it's yelling. Staff "F" reported she has a loud tone and had told Resident #9 that if she doesn't use her call light or just sit there and not want help, there isn't much anyone is going to be able to do. Staff "F" reported Resident #9 came from a living environment with more one to one care and Resident #9 isn't used to not being the center of attention. Staff "F" reported when staff go in to Resident #9's room she'll stop calling out, but as soon as staff leaves, she starts back up.<br><br>During an interview on 4/9/25 at 9:24 AM, the Director of Nursing (DON) "B" reported housekeeping staff "F" recently had in-service on customer service and training on how to speak to residents at an all-staff meeting. DON "B" confirmed no staff should say what housekeeping staff "F" said ("We're not just gonna (going to) sit and cry") to Resident #9 or any other resident.<br><br>During an interview on 4/9/25 at 9:54 AM, the Nursing Home Administrator (NHA) "A" reported they don't tolerate talk like that in regards to the way in which housekeeping staff "F" spoke to Resident #9.<br><br>During an interview on 4/9/25 at 11:02 AM, NHA "A" confirmed and showed in-service records that showed housekeeping staff "F" was educated on 4/1/25 on appropriate ways to speak to residents.<br><br>Review of Resident #9's "behavior problem" care plan, dated 3/25/25, stated, "(Resident #9) has an actual behavior problem R/T (related to): yelling and screaming for attention...". This behavior care plan had an intervention, dated 3/25/25, that stated, "Resident prefers the following diversional activities: Coloring with staff, likes watching animas (animals) on tv (television), likes to spend | | | |

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| | time with staff". Review of Resident #9's activities care plan, revised 12/31/2024, stated, "Interests include: coloring, tv (television), word puzzles, bingo, football, news" with intervention of "Ensure tv (television) remote available (likes football, news, Christmas movies, scooby doo, action, variety)" and "Provide encouragement and reassurance".<br><br>Review of Resident #9's psychiatry initial evaluation, stated, "(Resident #9) has a history of suffering sexual, emotional, and physical abuse as an adult...Patient has Down syndrome which may contribute to her cognitive and physical presentation and behavioral issues including yelling, crying...Continue with supportive care, encouraged diversional activities, and provide nonpharmacologic behavior management interventions when needed".<br><br>Review of the facility's dignity policy, revised 3/28/2024, stated, "The facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality..."Dignity" means that when interacting with residents, staff carries out activities that assist the resident in maintaining and enhancing his or her self-esteem and self-worth...Care for residents in a manner that maintains dignity and individuality...".<br><br>Applying the reasonable person concept, one would not want to be told "We're not just gonna (going to) sit and cry" while crying alone in their room, but would prefer supportive responses and/or diversional activity. | | | |
| F0686<br>SS= G | Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional | F0686 | F686 Treatment/Services to Prevent/Heal Pressure Ulcer<br><br>Resident #3 readmitted to the facility on 4/17/25. Skin assessment completed  Stage 4 pressure to sacrum and healed pressure | 5/6/2025 |

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| | standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake MI00151467.<br><br>Based on interview and record review the facility failed to implement interventions, treatment, and monitoring for the prevention of pressure ulcers, prevent the development of pressure ulcers, implement monitoring to prevent the worsening of pressure ulcers, and implement treatment(s) to promote healing of pressure ulcers in 1 of 3 residents (Resident #3) reviewed for pressure ulcers, resulting in Resident #3 developing an unstageable pressure ulcer on the sacrum (tailbone) and an unstageable pressure ulcer on the right ear requiring hospitalization for a wound infection that lead to osteomyelitis (bone infection), gangrene (death of body tissue due to lack of blood flow or a serious bacterial infection) and ultimately the need for surgical intervention.<br><br>Findings include:<br><br>Resident #3<br><br>Review of an "Admission Record" revealed Resident #3 was originally admitted to the facility on 2/15/25 with pertinent diagnoses which included muscle weakness and diabetes mellitus. | | injury to right ear. Care plan updated and currently being follow by the wound certified NP.<br><br>Residents who reside in the facility have the potential to be affected. Skin sweep completed. Any concerns were addressed immediately.<br><br>Nursing staff re-educated on Skin Management program. Those currently on leave of absence or PRN will be re-educated on their next scheduled workday. Skin Management policy was reviewed by QA committee and deemed to be appropriate.<br><br>DON and/or designee will review Clinical Alerts, PCC dashboard, physician orders and complete skin assessments weekly x 4, then monthly x 3. Concerns will be addressed immediately and findings will be reported to the QA committee for further review and recommendations.<br><br>Administrator is responsible for sustained compliance. | |

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| | Review of a "Minimum Data Set" (MDS) assessment for Resident #3, with a reference date of 2/21/25 revealed "Section GG- Functional Abilities and Goals indicated that Resident #3 was dependent and required assistance for toileting, and showers/bathing. Section M: Skin Conditions indicated that Resident #3 was at risk for developing pressure ulcers, and that Resident #3 did not have one or more unhealed pressure ulcers stage 1 or higher."<br><br>Review of Resident #3's "Care Plan" revealed, " (Resident #3) is at risk for impaired skin integrity/pressure injury R/T (related to) decreased mobility, Impaired Bed Mobility, Impaired Nutritional Status,Incontinence bowel and bladder, Psychotropic drug use, history of falls. Start Date: 2/16/25. Interventions: Braden scale per protocol<br><br>Date Initiated: 2/16/2025. Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 02/16/2025. Cue to reposition self as needed. Date Initiated: 2/16/2025. Turn/reposition resident every 2 hours and PRN (as needed).Date Initiated: 3/18/2025..."<br><br>Review of Resident #3's "Total Body Skin Assessment" dated 2/23/25 indicated that Resident #3's did not have any wounds.<br><br>Review of Resident #3 "Nurses Note" dated 3/5/25 and documented by Licensed Practical Nurse (LPN) "E" revealed, " (Resident #3 ) right ear has redness, swelling, and some skin breakdown. Skin prep (skin protectant) applied. (Resident #3) lays with the right side of her head on the pillow often. (Resident #3) also has an open area on her coccyx (tailbone/sacrum area and used interchangeably in hospital and facility documentation), cream and bandage applied." | | | |

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| | It was noted the facility did not initiate any treatment orders for Resident #3's right ear or coccyx on on 3/5/25. Treatment orders were initiated for Resident #3's coccyx wound on 3/15/25 and her right ear wound on 3/20/25.<br><br>Review of Resident #3's "Total Body Skin Assessment" dated 3/10/25 and documented by Licensed Practical Nurse "E" indicated that Resident #3 did not have any new wounds.<br><br>Review of Resident #3 's "Nurses Notes" dated 3/11/25 at 6:38 AM and documented by Registered Nurse (RN) "R" revealed, "(Resident #3) having chills and skin is warm to touch. Checked temp (temperature), 100.4. PRN (as needed) Tylenol PO (by mouth) given. TSB (Tepid Sponge Bath: A method used to cool down or provide comfort to patients during fever) done. Rechecked temp after 1 hour, 99.8. Left a note for NP (Nurse Practitioner) for further assessment and to assess sore in the coccyx area."<br><br>Review of Resident #3's "Nurses Notes" dated 3/11/25 at 7:35 AM and documented by RN "M" revealed, " (Resident #3) presented with fever and tachycardia (a condition where the heart rate exceeds 100 beats per minute when at rest) not controlled with Tylenol. (Resident #3) sent to (local hospital) for possible sepsis..."<br><br>Review of Resident #3's "Hospital Records" dated 3/11/25 revealed, " ... Upon arrival to the emergency department, (Resident #3) was hemodynamically unstable (unstable movement of blood that results in inadequate blood flow), tachycardic to 136, tachypneic (fast, shallow breathing) at 22...Physical exam is notable for skin that is hot to touch diffusely, dry oral mucosa (inside the mouth), disoriented and unable to provide much history ...Patient meets SIRS criteria (series of objective physical and | | | |

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| | laboratory findings indicative of infection) for sepsis... Assessment and Plan: Sepsis-likely secondary to UTI (urinary tract infection) and possible pneumonia...WOC (Wound, Ostomy, and Continence)Nursing note:... WOC consulted for sacrum, R (right) ear... Sacrum. Measurement: Approx 4 x 2 x 0.2 cm, grossly oval, with devitalized (tissue that has lost it's blood supply and is no longer viable) purple/black, moist bed with faint slough (dead tissue within the wound) centrally. Moderate serous (clear to yellow fluid) drainage. Erthyematic (redness) periwound. No induration, fluctuance. (tense area of skin with a wave-like or boggy feeling upon palpation). No purulence (pus) observed. Impression: Deep tissue injury (DTI)....Right Ear: Eschar (dead tissue that sheds or falls off from the skin) covered wound medially and lateral with pale central tissue. Serous exudate (fluid) is scant. Periwound erythema. Impression: Evolving DTI..." It was noted that Resident #3 was hospitalized from 3/11/25- 3/14/25 and then returned to the facility on 3/14/25.<br><br>Review of Resident #3's "Orders" revealed, "Sacrum to brown eschar area cleanse with wound cleanser, pat dry, apply optifoam (type of dressing) daily and PRN. every day shift for sacral wound. Start date: 3/15/2025...Right ear - unstageable pressure injury: Cleanse wound with wound cleanser. Apply medi-honey gel to wound, cover with small foam pad. Change daily. every day shift. Start date: 3/20/25..." It was noted that Resident #3's right ear wound care treatment order was not initiated upon re-admission to the facility on 3/14/25, and began on 3/20/25.<br><br>Review of Resident #3's "Nurses Note" dated 3/17/2025, revealed "sacral wound odorous. no drainage. surrounding tissue red. cleansed with wound cleanser, optifoam applied as per order" | | | |

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| | Review of Resident #3's "Progress Note" dated 3/17/25 and documented by Nurse Practitioner (NP) "CC" revealed, "...Will continue to be followed by the wound team for open wounds on right ear and sacrum..." It was noted that NP "CC" did not assess Resident #3's wounds or initiate new treatment orders.<br><br>Review of Resident #3's "Initial Consult" dated 3/18/25 and documented by Wound Care NP (WC-NP) "DD" revealed, " ... (Resident #3) is seen today for wounds to her sacral area and right ear secondary to pressure. Staff notes she was sent out to acute care last week with blanchable (the ability for the skin to turn white or pale in appearance when pressed and then return to its original color) redness to the sacral area and then returned with an unstageable pressure injury. Right ear wound secondary to positioning as (Resident #3) favors to lean on her right side... She does verbalize some pain to the sacral wound area..."<br><br>Review of Resident #3's "Orders" revealed, " Sacrum, unstageable pressure injury: Cleanse wound with wound cleanser. Cover wound bed with gauze soaked with Dakins (topical antiseptic used as a wound cleanser). Cover with super absorbent dressing. Change daily. every day shift. Start Date: 3/20/2025. It was noted that this treatment was documented as "See nurses note" on 3/21/25 by LPN "T". The nurses note did not indicate if the treatment was completed as ordered.<br><br>Review of Resident #3's " Nurses Note" dated 3/23/25 revealed, " Transferring (Resident #3) to (local hospital) for eval (evaluation) and treatment/NG (naso gastric- tube inserted through the nose and down the throat into the stomach to deliver fluids, nutrients, and medications) tube replacement. Continues to be tachycardic with | | | |

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| | some tremors to right hand developing..."<br><br>Review of Resident #'s "Hospital Records" dated 3/23/25 revealed, " (Resident # 3) ... with a history of diabetes, hypertension, chronic sacral wound presenting from outside facility with concerns sepsis...On arrival to the emergency department patient nonacute distress, vital signs significant for tachycardia at rate of 149, blood pressure of 182/84, tachypnea at a rate of 26, temp of 39.3° C. (102.7 F)...On examination of the patient's sacral wound she appears to have dressings have been soaked with purulent discharge. And wound appears to be mildly erythematous at the edges, appears to have a necrotic center... did review patient's emergency department discharge note from 3/14/2025 which reports that she was initially admitted on 3/11/2025 with the findings consistent with sepsis. On time of admission it appeared that patient had x-ray findings suspicious for pneumonia along with urine cultures that grew positive for polymicrobial infection...This time patient appears to be sirs positive with source likely sacral wound... Hospital course: ...During this hospital stay, plastic surgery was consulted for the sacral wound debridement. Patient was taken to the OR on 03/25. Bone cultures from this showed sacral osteomyelitis...Colorectal surgery was consulted regarding a diverting colostomy (surgical opening in the abdomen called a stoma that allows waste to pass out of the body)... Patient and mother were agreeable to diverting colostomy and patient was transferred to (local hospital) on 03/30 to facilitate...Colorectal surgery performed diverting colostomy without complication on 4/1 without complications...Tissue Pathology dated 3/28/25: Result: Bone and soft tissue, sacrum, biopsy: Gangrene with focal acute osteomyelitis..."<br><br>During an interview on 4/8/25 at 1:59 PM, LPN "V" reported that she cared for Resident #3 | | | |

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| | 414340 | A. BUILDING _____ B. WING _____ | 4/9/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAURELS OF KENT (THE) | 350 N CENTER ST LOWELL, MI 49331 |

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| | frequently, and that she never refused care or treatment, including being repositioned. LPN "V" reported that she could not recall what Resident #3's wound on her sacrum area looked like, but she thought it was just a "small area that needed a dressing". When this writer queried about LPN "V" 's documentation on 3/21/25 for Resident #3's wound care treatment, LPN "V" reported that she did not complete the treatment that day, so she documented it to pass to the next shift. LPN "V" confirmed that the note the had entered did not indicate that she had not completed the wound care treatment, but did remove it from the tasks list to complete.<br><br>During an interview on 4/8/25 at 2:21 PM, Director of Nursing (DON) "B" reported that she assisted the wound care provider weekly with wound rounds. DON "B" confirmed that Resident #3 was first assessed by the wound care provider on 3/18/25. DON "B" reported that she was unaware that LPN " E" had found an open area on Resident #3's coccyx area, and she had not seen the note that he entered regarding this. DON "B" reported that the facility nurses knew to report any new skin conditions to her and the provider, and she did not know why LPN "E" did not follow the facility's process. DON "B" reported that she was first made aware of Resident #3's coccyx wound on 3/11/25, but she did not assess it because Resident #3 was sent to the hospital before she could. DON "B" confirmed that the facility did not have a treatment order in place, and the facility provider and wound care provider did not assess and begin to treat Resident #3's wound on her ear or coccyx area until she returned from the hospital on 3/15/25. DON "B" reviewed Resident #3's "Total Body Skin Assessment" dated 3/10/25 which was documented by LPN "E" and confirmed that LPN "E" did not note Resident #3's open area on her coccyx as a "new wound". DON "B" confirmed that an open area on the coccyx would have been | | | |

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| | considered a new wound. DON "B" reported that she was not sure that the area on Resident #3's coccyx was open, or if LPN "E" had made an error in his documentation. DON "B" confirmed that she did not review Resident #3's hospital records, and did not know what Resident #3's wounds looked like upon admission at the hospital. DON "B" reported that when Resident #3 returned to the facility on 3/14/25, she was assessed by LPN "X", who received verbal orders for wound care to begin on 3/15/25. DON confirmed that Resident #3's wound were first assessed by a provider on 3/18/25 and updated treatment orders were initiated for Resident #3's coccyx wound on 3/20/25.<br><br>This writer attempted to reach LPN "E" via telephone on 4/8/25 at 2:11 PM and 4/9/25 at 7:51 AM. LPN "E" did not return calls prior to survey exit.<br><br>During an interview on 4/9/25 at 8:11 AM, Certified Nursing Assistant (CNA) "U" reported that she frequently cared for Resident #3. CNA "U" reported that on 3/6/25 she had noticed that Resident #3's coccyx area was reddened and it "looked like the top layer of skin was totally gone, it almost looked like her bottom had been scraped across something and there was an open area." CNA "U" reported that she had reported this finding to LPN "X" but she did not know if LPN "X" assessed Resident #3. CNA "U" reported that Resident #3 did not usually refuse cares or treatments.<br><br>This writer attempted to reach LPN "X" via telephone on 4/9/25 at 9:17 AM. LPN "X" did not return call prior to survey exit.<br><br>During an interview on 4/9/25 at 9:53 AM, CNA "G" reported that she had cared for Resident #3 on 3/7/25 and recalled finding the large wound on | | | |

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| | Resident #3's coccyx area when she was assisting Resident #3 in the shower. CNA "G" reported that she had not cared for Resident #3 in awhile, and she had not gotten in report that Resident #3 had a wound, so she was surprised when she saw it. CNA "G" reported that the wound was "very large, around the size of a golf ball, and that the skin was black. " CNA "G" reported that someone had lathered a lot of some kind of cream on the wound, so she left the wound alone, took Resident #3 to her bed, and then went and informed LPN "E". CNA "G" reported that LPN "E" was unaware that Resident #3 had a large wound, and she recalled him grabbing a dressing and that she had to tell him "you will need a much bigger dressing than that."<br><br>During an interview on 4/9/25 at 8:46 AM, CNA "D" reported that she had cared for Resident #3 on 3/10/25. CNA "D" reported that when she completed her first brief change for Resident #3 that night she was shocked to see that Resident #3 had a very large open wound on her bottom (coccyx) area. CNA "D" she was shocked because she had not gotten in report that Resident #3 had a wound, and the wound was "as big as a softball, red in color around the open area". CNA "D" reported that there was no bandage or any type of cream on the wound. CNA "D" reported that she also noticed that Resident #3 was shaky, sweaty, and running a fever, so she immediately reported her concern to RN "R". CNA "D" reported that RN "R" was also unaware that Resident #3 had a wound on her bottom.<br><br>During an interview on 4/9/25 at 9:04 AM, RN "R" reported that she had been made aware on 3/10/25 that Resident #3 had a wound on her coccyx area. RN "R" reported that she went into Resident #3's room when staff were completing incontinence care on her to look at the wound. RN "R" reported that she could not recall if the wound had a bandage on it. RN "R" reported that | | | |

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| | she did not know what size the open area was because the wound was covered with stool, and she did not wait for staff to finish cleaning the stool off of Resident #3 so she could finish assessing the wound. RN "R" confirmed that she would normally not leave an open wound without doing any kind of treatment, but since it was time for her to go home, she did. RN "R" reported that she did leave a note for the NP to assess the wound, but she could not recall if she had informed the oncoming nurse that she left without measuring the wound and completing an accurate assessment of the wound.<br><br>During a follow up interview on 4/9/25, DON "B" reported that she was unable to explain why the facility had not started treatment orders for Resident #3's right ear wound until 3/20/25 when the wound was noted on 3/14/25 when Resident #3 was readmitted to the facility.<br><br>During an interview on 4/9/25 at 11:40 AM, Unit Manager (UM) "EE" confirmed that she was unaware of Resident #3's wounds on her ear and coccyx until 3/11/25. UM "EE" confirmed that she had not observed Resident #3's wounds. UM "EE" reported that she was one of the staff members responsible for reviewing documentation, and that nursing progress notes were reviewed in the morning interdisciplinary (IDT) meetings every day. UM "EE" confirmed that the IDT team did not discuss the note placed by LPN "E" on 3/5/25 regarding Resident #3's ear and open wound on her coccyx. UM "EE" reported that LPN "E" should have notified the facility's provider and DON "B" about the wounds that he found on Resident #3 so the facility could have started treatment for them.<br><br>Review of the facility's "Skin Management" policy dated 9/19/24 revealed, " Policy: It is the policy that the facility should identify and | | | |

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| | implement interventions to prevent development of clinically unavoidable pressure injuries. Overview: Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated, and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes. Practice Guidelines:... 4. Residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing. A physician's order for treatment, and Skin impairment location, measurements and characteristics documented...12.If a new area of skin impairment is identified, notify the resident, responsible party, practitioner, DON/designee and treatment team, if applicable..." | | | |