STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	334100	A. BUILDING _____ B. WING _____	5/9/2025

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MEDILODGE OF EAST LANSING	1843 N HAGADORN RD EAST LANSING, MI 48823

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F0000 SS=	INITIAL COMMENTS Medilodge of East Lansing was surveyed for a re-visit survey on 5/9/25. Census = 74	F0000		
F0686 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for pressure ulcer (wounds caused by pressure) prevention per professional standards of practice, including comprehensive assessment and implementation of planned interventions for one (R 117) of four residents reviewed, resulting in lack of pressure ulcer identification and assessment, lack of implementation of interventions and the provision of care, and pressure ulcer development/worsening. Findings include:	F0686	Element 1 Resident 117 areas to right rear malleolus and left outer ear were assessed by the nurse on 5/9/25 with orders for treatments put in place to include heel boots, low air loss mattress and care plan updated. Resident 117 was discharged on 05/13/2025. Element 2 A skin sweep of current residents including current residents admitted since 4/25/25 was completed by the Director of Nursing/Designee by 5/14/25 for any new skin areas or skin areas missed on admission. Any new areas noted were assessed, had treatment orders entered and care plans updated for interventions to prevent and promote healing of wounds. A one-time audit of current residents with wounds was completed to ensure the wounds have appropriate treatment orders and interventions to prevent and promote healing of wounds including being turned and repositioned. This was completed by the Director of Nursing/Designee by 5/14/25. A one-time audit of residents most recent Braden score was completed by the Director of Nursing/Designee by 5/14/25 and anyone	4/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/27/2025

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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	Resident #117 On 5/8/25 at 12:00 PM, Resident #117 was observed in their room in the facility. The Resident was in bed, positioned on their back with their head and neck leaning to their left side. The Resident's left ear and side of their head was directly against the pillow. Resident #117 had a tracheostomy in place and was non-verbal and did not make eye contact when spoke to. On 5/8/25 at 2:30 PM, Resident #117 was observed in their room in the facility. The Resident was in bed, positioned on their back with their head and neck leaning to their left side. The Resident's left ear and side of their head was directly against the pillow and their heels were positioned directly against the mattress. On 5/8/25 at 5:00 PM, Resident #117 was observed in their room in the facility. The Resident was in bed, positioned on their back with their head and neck leaning to their left side. The Resident's left ear and side of their head was directly against the pillow. The Resident's heels were positioned directly against the mattress. Record review revealed Resident #117 was admitted to the facility on 5/1/25 with diagnoses which included anoxic brain injury, respiratory failure with tracheostomy (surgically created opening in the front of the neck to the trachea to allow for respirations) placement, gastrostomy (surgically created opening in the abdomen to the stomach to allow for the insertion of a feeding tube and direct administration of nutrition), and sacral pressure ulcer. Review of documentation in Resident #117's Electronic		with a Braden of 10 or below was placed on the yellow dot program for turning and repositioning. Element 3 The QAPI Committee has reviewed the Pressure Ulcer Prevention and Management policy and has deemed it to be appropriate by 5/14/25. The Director of Nursing and/or designee re-educated the Wound Care Nurse and the licensed nurses on the Pressure Ulcer Prevention and Management policy by 5/14/25 with emphasis on turning and repositioning, ensuring wound treatments are being completed and appropriate interventions are in place to prevent and promote healing of wounds. Also that all admissions need to have their skin assessed by 2 nurses. Nurse Aides were re-educated on the yellow dot program for turning and repositioning and checking residents kardex to ensure interventions are in place. This was completed by the Staff Development Coordinator/Designee by 5/14/25. Wounds will be reviewed daily in morning clinical M-F to ensure treatments are being completed and weekly in standard of care meeting to ensure appropriate interventions are in place to prevent and promote wound healing. Admissions will be reviewed daily in morning clinical M-F to ensure admission skin assessment is accurate and has been assessed by 2 nurses.	

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	Medical Record (EMR) revealed the Resident was cognitively impaired and dependent upon staff to complete all Activities of Daily Living (ADLs). Review of Resident #117's "Nursing Admission Evaluation" dated 5/2/25 at 2:25 AM revealed the Resident had an "open area" on their "sacrum" and was at risk for skin impairment. Review of Resident #117's EMR revealed a care plan entitled, "Resident has impaired skin integrity as evidenced by: unstageable pressure injury to sacrum related to (blank)" (Initiated: 5/2/25; Revised: 5/7/25). The care plan included the interventions: - "Assist resident with turning and repositioning as needed" (Initiated: 5/2/25) - "Administer medications as ordered" (Initiated: 5/2/25) - "Administer treatment(s) per orders" (Initiated: 5/2/25) - Apply protective barrier cream after incontinent episodes" (Initiated: 5/2/25) - "Encourage/assist as needed to elevate heels off the mattress as tolerated" (Initiated: 5/2/25) - "Notify Nurse of any new areas of skin impairment noted during bathing or daily care ..." (Initiated: 5/2/25) - "boots to bil (bilateral -both) feet" (Initiated: 5/2/25; Revised: 5/9/25) - "Pressure redistribution mattress to bed"		Element 4 The Director of Nursing/designee will audit residents with wounds weekly x4 weeks then monthly thereafter to ensure interventions are in place and treatments are being completed to prevent and promote healing of wounds. The Director of Nursing/designee will audit residents with a Braden of 10 or less and residents with wounds weekly x4 weeks then monthly thereafter to ensure they are being turned and repositioned appropriately to prevent and promote healing of wounds. The Director of Nursing/Designee will audit admission skin assessments weekly x4 weeks then monthly thereafter to ensure all skin issues present on admission are documented appropriately and their skin has been assessed by 2 nurses. Results will be reviewed monthly by the QAPI Committee until substantial compliance is achieved. The Administrator is responsible to maintain compliance.	

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	(Initiated: 5/2/25) Review of "Wound Evaluation" documentation in Resident #117's EMR revealed the following: - 5/1/25 at 7:00 PM: "Pressure ... Stage 3 (full thickness tissue loss wound) ... Present on Admission ... Length: 2.41 cm (centimeters) ... Width: 1.09 cm ..." The attached wound image was reviewed and showed an irregularly shaped open area with a pink colored wound base and no notable depth. The wound and skin in the image appeared clean. - 5/7/25 at 6:31 PM: "Pressure ... Unstageable (full thickness tissue loss with unknown depth due to the base of the wound being covered by slough and/or eschar) ... Deteriorating ... Length: 3.67 cm ... Width: 3 cm ... Deepest Point: < 0.1 cm ... Wound Bed ... Slough ... 100%... Exudate: Light ... Serous ..." The attached wound image was reviewed and showed the wound bed had increased in size and now had depth. The wound bed remained irregularly shaped, and the wound bed was dark purple and white in color. There was visible bowel movement in the wound image. On 5/9/25 at 7:45 AM and 10:00 AM, Resident #117 was observed in their room in bed. At both times, the Resident was positioned on their back with their head/neck leaning to their left side and positioned directly against the pillow. On 5/9/25 at 1:30 PM, Family Member Witness "L" was observed in Resident #117's room. Resident #117 was in bed, positioned on their			

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	back with their right heel positioned directly against the mattress. A heel boot (positioning device) was present on their left foot. The Resident's head and neck were leaning to the left side and positioned directly against the pillow. An interview was completed with Witness "L" at this time. When queried regarding Resident #117's care at the facility, Witness "L" revealed they were upset with multiple aspects of the care Resident #117 had received in the facility. Witness "L" revealed they were upset about the open area on the Resident's ear. When asked what open area, Witness "L" responded that the Resident had an open area on their left ear which is draining and stated, "I have been telling them (facility staff), and they don't do anything." At 1:35 PM on 5/9/25, Registered Nurse (RN) "K" was observed walking in the hall past Resident #117's room and an interview as completed. When asked, RN "K" verbalized they were Resident #117's assigned nurse. RN "C" was asked if Resident #117's skin including pressure ulcers and treatment and replied that the Resident had a pressure ulcer on their sacrum. Upon request, RN "C" entered Resident #117's room and a skin observation was completed. The Resident was observed in bed in the same position. An observation of the Resident's heels was completed with RN "C". A large, dark purplish colored area was present on the Resident's right heel. The area was directly over the bony prominence and encompassed the heel where it had been positioned directly against the mattress. When queried, RN "C" applied pressure to the area and stated it was non-blanchable. When asked what the area was, RN "C" stated, "A DTI (Deep Tissue Injury- pressure ulcer with unknown depth)." When asked if the pressure			

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	ulcer was new and facility acquired, RN "C" replied, "Yes." When queried why the Resident only had one heel boot in place on their right foot, RN "C" looked in the room and was unable to locate a second heel boot. RN "C" revealed they were unsure why the Resident only had one boot. RN "C" proceeded to assess the Resident's left ear. An open area, approximately the size of a pencil eraser was present on the center of the helix (top, outer cartilage). The area was draining a dark colored, thin fluid. When queried regarding the open wound, RN "C" replied, "It's a pressure ulcer." When queried regarding etiology of the pressure ulcer on Resident #113's ear, RN "C" verbalized the pressure ulcer was facility acquired. Review of Resident #117's Health Care Provider (HCP) orders and Treatment Administration Record (TAR) revealed the following wound care orders/Treatments: - Cleanse sacral wound with wound cleanser, apply Xeroform (non-adherent gauze dressing for use with minimally draining wounds to promote a moist wound environment) to cover open area, apply border foam every night shift and as needed for sacral pressure ulcer (Start Date: 5/2/25; Discontinued: 5/7/25) - Cleanse sacral wound with wound cleanser, pat dry. Apply Medihoney (wound care treatment) to wound cover with border foam every night shift and as needed for sacral pressure ulcer (Start: 5/7/25 and 5/8/25) The Resident did not have treatments and/or HCP orders in place for their right heel and/or left ear.			

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	Review of Resident #117's documentation in the EMR revealed the following: - 5/2/25 HCP Note: "Visit Type: History and Physical ... Skin: Diaphoretic (sweaty) ..." - 5/7/25 at 11:08 AM: "Pertinent Charting-Skin ... Event Date: 5/6/25 ... Location of skin area being documented: yeast infection. Description: treatment for yeast started. Interventions: see care plan ..." Note: Resident #117 did not have a new HCP order for an antifungal treatment for yeast on 5/6/25. - 5/7/25 at 2:56 PM: "Dietary Progress Notes ... Skin Condition: wound on sacrum..." - 5/7/25 HCP Note: "Visit Type: Acute ... Skin: warm and dry ..." On 5/9/25 at 2:07 PM, Resident #117 was transferred out of bed and an alternating air mattress for pressure reduction was placed on their bed. An interview was completed with the Director of Nursing (DON) and Administrator on 5/9/25 at 2:30 PM. When queried regarding Resident #117's new pressure ulcers identified on their right heel and left ear, the DON did not provide an explanation but indicated they would look into it. When queried why the Resident did not have an alternating air mattress in place when they had a pressure ulcer on their sacrum upon admission, the DON indicated the regular facility mattresses also provide pressure reduction. The			

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	DON was then queried regarding observations of the Resident's heels directly against the mattress. When queried why the Resident did not have heel boots in place as per their care plan, the DON stated, "I ordered a bunch of new ones (heel boots)" and indicated they were unsure why the resident would not have had them in place. The DON was then asked how often Resident #117 should be turned and repositioned and replied, "Minimum of every two hours." When queried regarding observations of Resident #117 not being turned and repositioned, the DON stated, "They should be." No further explanation was provided. When queried regarding the Resident's sacral pressure ulcer worsening and lack of turning and repositioning, the DON indicated they understood the concern. When queried regarding the open pressure area on the Resident's left ear, Witness "L" stating the wound had been on the ear, and lack of assessment and/or interventions, an explanation was not provided. When asked if the facility has adequate staffing to provide care for the level and acuity of the Residents in the facility, the Administrator responded the facility had hired additional staff who would be starting and training. When queried if they had adequate staff currently to provide care, the DON responded, "Yes." On 5/9/25 at 2:53 PM, the DON provided skin assessment documentation from the Long Term Acute Care (LTAC) hospital Resident #117 was in prior to being admitted to the facility. Review of the provided documentation revealed wound assessment documentation dated 4/23/25 for an unstageable pressure ulcer on the Resident's "Right ankle/Achilles (tendon on the back of heel)/malleolus (bony prominence on the sides of the ankle)" as well as pressure ulcer on the			

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	Resident's sacrum. The wound images included in the documentation were small and very blurry and the wound bed and/or specific location was unable to be seen. When queried regarding the documentation, the DON indicated the heel pressure ulcer was present upon admission and not facility acquired. When asked why the heel pressure ulcer was not documented on the facility admission assessment if it was present upon admission to the facility, the DON indicated they would speak to the nurse and would "be doing education." An interview was completed with Witness "L" on 5/9/25 at 5:00 PM. When queried how often they visit the Resident at the facility, Witness "L" replied they do their best to visit daily and are currently looking for an apartment to rent and move to closer to the facility. When queried regarding staff turning and repositioning the Resident while they are in the facility, Witness "L" stated, "(Resident #117) has only been turned once when I was here. Every time I have come, their head is on the left, but their body is on their back." Witness "L" was asked how long they are typically in the facility when they visit and replied, "I was here from 11:00 AM to after 1:00 PM yesterday and (Resident #117) wasn't turned at all." Witness "L" was asked how long the open wound had been present on Resident #117's ear and stated, "The nurse (Licensed Practical Nurse [LPN] "F") told me they were going to do something about it last week and they didn't do anything. I put Neosporin on it because I can't trust them (facility nursing staff) to do it." Witness "L" further revealed they brought in a travel pillow to attempt to reposition Resident #117's head and get the pressure off of their left ear but revealed the facility staff "don't use it."			

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F0725 SS= E	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate sufficient levels to ensure resident care needs were met and failed to ensure adequate staffing for supervision to prevent falls for (#'s 113, 114, 117) resulting in the potential for unmet care needs for all 34 residents residing on the ventilator (mechanical device which provides respiratory support for individuals unable to breath on their own) and tracheostomy	F0725	Element 1 The facility Assessment has been updated by 5/14/25 and reviewed by the QAPI Committee to ensure staffing levels are appropriate to meet the current resident population needs. Current Residents with a BIMS of 9 or above and responsible parties for residents with a BIMS of 8 or below were interviewed for any negative outcomes related to needs not being met by the Director of Nursing/Designee by 5/14/25. Residents concerns were placed on a Quality Assurance form and ran through the Quality Assurance process by 5/14/25. Element 2 Current Residents and/or responsible parties have been interviewed to ensure that their needs are being met by the Director of Nursing and/or designee by 5/14/25. Any concerns identified have been addressed immediately. Element 3 The QAPI Committee reviewed the policy, Nursing Services and Sufficient Staff and deemed it appropriate by 5/14/25. The Regional Director of Operations has re-educated the Administrator, Director of Nursing and the Scheduler on the Nursing Services and Sufficient Staff Policy, including staffing to meet resident needs. This education will be completed by 5/14/25.	4/25/2025

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	(surgically created opening in the front of the neck to the trachea to allow for respirations) hallways of the facility. Findings include: A review of the Centers for Medicare and Medicaid Services (CMS) PBJ Staffing Report for first quarter reflected the facility triggered for excessively low weekend staffing. Resident #113 Review of the facility provided list of residents with falls revealed Resident #113 had an unwitnessed fall in the facility on 5/4/25 at 2:41 AM. The Resident was transferred to the Emergency Department (ED) on 5/5/25 at 11:00 PM due to a change in mental status. Resident #113 was admitted to the hospital and had not returned to the facility. Record review revealed Resident #113 was admitted to the facility on 5/2/25 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), CVA (Cerebral Vascular Accident -stroke) with resulting right sided hemiparesis (one sided paralysis), tracheostomy (surgically created opening through the front of the neck to the trachea to allow for respiration), gastrostomy (surgically created opening in the abdomen to the stomach to allow for the insertion of a feeding tube and direct administration of nutrition), anxiety, depression, and pain. Review of Resident #113's Electronic Medical Record (EMR) revealed the Resident was alert and orientated to self and time, was sometimes able to make their need known, and was dependent upon staff to complete all Activities of Daily Living (ADLs).		During the morning stand up meeting and as needed, staffing will be reviewed to ensure supervision Adjustments will be made as needed. Element 4 A weekly audit of 10 of residents will be conducted by the Administrator and/or designee to ensure needs are being met timely for 4 weeks and then monthly thereafter until substantial compliance is sustained. Audits will be reviewed by the QAPI committee monthly for 3 months until substantial compliance is met. The Administrator is responsible to maintain compliance.	

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	Record review revealed Resident #113 was assessed to be a risk for falls. A review of facility provided time clock and planned staffing sheet documentation revealed, at the time of Resident #113's fall there were three CNAs in the building, CNA "D", CNA "E", and CNA "J" and three RN's (RN "B", RN "C", and RN "G") working. Per time clock documentation, RN "G" arrived at the facility at 2:00 to take over for RN "H". Further review revealed: - CNA "J" worked a 15-hour shift from 2:28 PM on 5/3/25 to 5:05 AM on 5/4/25. CNA "J" returned to the facility at 2:35 PM and worked until 11:00 PM. - CNA "D" worked a total of 18 hours from 10:07 AM on 5/3/25 to 4:07 AM on 5/4/25. CNA "D" then returned to the facility at 2:15 PM on 5/4/25 and worked until 5/5/25 at 2:16 AM for a total of 12 hours. An interview was completed with CNA "N" on 5/9/25 at 8:30 AM. When queried regarding their role, CNA "N" revealed they were the restorative CNA but were "working the floor" on the vent hallway because they "got pulled." When asked how often they are pulled to work the floor instead of completing their role in restorative, CNA "N" replied, "No able to actually do restorative often." When queried how many CNAs were working, CNA "N" replied there were three including them for both the vent and trach halls since they got pulled. When queried how many residents on their assigned hallway required two-person assistance for care, CNA "N"			

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	responded, "Most of them are." An interview was completed with CNA "D" on 5/9/25 at 12:10 PM. When queried if they worked 18 hours on 5/3/25 to 5/4/25, CNA "D" confirmed they did. CNA "D" stated, "I was supposed to go home. I had (rooms 58 to 81) by myself, and a resident fell." CNA "D" stated, (CNA "E") came in to take over and was sitting at the nurses' station on their phone while I was finishing my rounds." When asked what area of the facility rooms 58-81 are located, CNA "D" responded that those rooms make up the ventilator (machine which assists with and provides respirations) and tracheostomy halls. When asked what they meant by finishing their rounds, CNA "D" revealed they needed to check on and provide incontinence care to all their assigned residents before leaving. When asked why CNA "E" as sitting at the nurses' station and not assisting with care, CNA "D" stated, "(CNA "E") doesn't like to help you if you aren't done with your rounds." CNA "D" was asked if they normally work over and responded they do. CNA "D" revealed they also pick up shifts. When queried how many shifts they pick up and how often they work over, CNA "D" revealed they had "152 hours" on their last paycheck. CNA "D" revealed the facility is short staffed, so they pick up to make sure the people are taken care of. When queried who fell, CNA "D" replied, "(Resident #113) fell out of bed." When asked what happened, CNA "D" stated, "Every time (Resident #113) soils themselves (incontinent in brief), they tried to get out of bed." CNA "D" was asked if Resident #113 would tell them when they were incontinent and replied they did not "express" when they needed to use the restroom, were incontinent, or needed to be			

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	changed but would try to get out of bed. When queried if the Resident used the call light, CNA "D" replied, "(Resident #113) doesn't understand how to use it." CNA "D" was asked if Resident #113 talked and replied, "Yes, non-sensical." When asked to explain what they meant, CNA "D" explained when they would ask Resident #113 a question, the Resident would respond but the answer would be "not related" to the question they asked. When queried regarding Resident #113's fall, CNA "D" articulated they were in a different Resident room providing care when "(CNA "E") came screaming down the hallway." CNA "D" indicated they responded to CNA "E" screaming and proceeded to go to Resident #113's room. CNA "D" was asked where Resident #113's nurse was and revealed there were "only two nurses working that night." CNA "D" stated "(RN "C") was in central and (RN "B") was down vent." When asked how many residents on the ventilator and tracheostomy halls of the facility require two-person assistance to complete ADL care, CNA "D" replied, "Like 99% of the residents are two assist." When queried how they are able to check, reposition, and provide care to all 34 residents on the vent and trach halls by themselves, CNA "D" indicated they do the best they can and stated, "Don't get breaks or lunch" and "still can't get it all (care) done." When queried the last time they observed Resident #113 prior to the fall, CNA "D" was unable to provide a specific time but reiterated they did the best they could when they were the only CNA on the trach and vent hallways. Resident #114 On 5/9/25 at 8:18 AM, Resident #114 was observed in their room in bed wearing only a			

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	brief. The Resident was positioned on their back. Both of the Resident's knees were observed to be sharply bent with the lower part of their leg touching the upper part of the leg. The lateral (outside) aspect of both of the Resident's lower extremities including ankles and feet were positioned directly against the bed. When spoke to, Resident #114 made eye contact but did not respond verbally. At 10:30 AM and 11:35 AM on 5/9/25, Resident #114 was observed in their room the same position in bed as observation at 5/9/25 at 8:18 AM. Record review revealed Resident #114 was originally admitted to the facility on 4/8/24 and readmitted on 3/28/25 with diagnoses which included cerebral infarction (stroke), chronic respiratory failure with tracheostomy, gastrostomy, and pain. Review of the Minimum Data Set (MDS) assessment dated 2/11/25 revealed the Resident was rarely/never understood and was dependent upon staff to complete ADLs. The MDS assessment detailed Resident #114 had one stage three and one unstageable pressure ulcer. Admission MDS dated 4/12/24 revealed the Resident had one stage 3 pressure ulcer. Review of "Wound Evaluation" documentation in Resident #114's EMR revealed the Resident had a stage 4 (Full thickness tissue loss with exposed bone, muscle, and/or tendon) pressure ulcer which had worsened since their admission to the facility. On 5/9/25 at 12:05 PM, an interview was			

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	completed with Certified Nursing Assistant (CNA) "M". When queried regarding Resident #114's pressure ulcers, CNA "M" responded that the Resident had pressure sores on their "bottom and heel." When asked if Resident #114 was supposed to wear heel boots, CNA "M" stated, "No. Well they had one and one was sent to laundry two days ago." CNA "M" was then asked about Resident #114's mobility and responded that they were dependent upon staff. When queried regarding the number of staff required to turn/reposition and provide hygiene care to the Resident, CNA "M" replied, "Two assist." CNA "M" was then asked how many CNAs typically work on the vent and trach units of the facility and responded there was usually one CNA per hall. When queried how many residents require two assists on the vent and trach halls, CNA "M" replied, "Almost all of them." When asked how often dependent residents are supposed to be turned and repositioned, CNA "M" indicated they should be repositioned every two hours. When asked if they are able to turn and reposition residents every two hours, CNA "M" replied, "Can't move them (residents) every two hours." CNA "M" revealed floor CNAs are also responsible for showering and daily care and stated, "There is just not time." An observation of Resident #114's wound was completed with RN "K" on 5/9/25. The sacral wound was approximately circular in shape and approximately the size of a softball with notable depth. An area of visible tunneling was present at approximately the five o'clock position. Significant undermining was present from approximately seven o'clock to 10 o'clock position and from 12 o'clock to the five o'clock position. Slough was present at from the 10 to 12			

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	o'clock position and from the five to the seven o'clock position. The skin surrounding the wound bed was dark in color. When asked if the surrounding tissue was blanchable, RN "K" was observed assessing the surrounding skin and stated the skin at the top (12 o'clock) position was "Not blanchable." When RN "K" was completing the wound care treatment and dressing, they stated, "I can feel the bone" in the wound bed. An interview was completed with the DON and Administrator on 6/9/25 at 4:23 PM. When queried regarding Resident #114's pressure ulcer worsening during their stay at the facility, the DON confirmed the wound worsened but verbalized that the Resident had been to the hospital several times. When asked if Resident #114 was supposed to have heel boots in place, the DON replied, "Yes." The DON was asked why the Resident was observed not wearing heel boots and interview with staff regarding the Resident only having one heel boot available currently. The DON reiterated they recently purchased new heel boots and staff are able to get a different boot if a pair becomes soiled or needs laundered. When asked why staff were not aware of that, the DON was unable to provide an explanation. When queried regarding observations of Resident #114 being positioned on their back at various times, the DON verbalized the Resident should be repositioned every two hours. When queried again regarding staff statements that they were unable to turn and reposition dependent residents every two hours due to high acuity residents with total needs and current staffing levels, the Administrator reiterated new staff had been hired and would be starting soon. When queried			

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	how the facility is preventing pressure ulcer development and/or worsening when Residents are not being turned and repositioned and planned interventions are not being implemented, an explanation was not provided. Resident #117 On 5/8/25 at 12:00 PM, Resident #117 was observed in their room in the facility. The Resident was in bed, positioned on their back with their head and neck leaning to their left side. The Resident's left ear and side of their head was directly against the pillow. Resident #117 had a tracheostomy in place, was non-verbal and did not make eye contact when spoke to. On 5/8/25 at 2:30 PM and 5:00 PM, Resident #117 was observed in their room in the facility. The Resident was in bed, positioned on their back with their head and neck leaning to their left side. The Resident's left ear and side of their head was directly against the pillow and their heels were positioned directly against the mattress. Record review revealed Resident #117 was admitted to the facility on 5/1/25 with diagnoses which included anoxic brain injury, respiratory failure with tracheostomy (surgically created opening in the front of the neck to the trachea to allow for respirations) placement, gastrostomy (surgically created opening in the abdomen to the stomach to allow for the insertion of a feeding tube and direct administration of nutrition), and sacral pressure ulcer. Review of documentation in Resident #117's Electronic Medical Record (EMR) revealed the Resident was cognitively impaired and dependent upon staff to complete all Activities of Daily Living (ADLs).			

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	Review of Resident #117's EMR revealed the Resident was admitted with a Stage 3 (full thickness tissue loss wound) pressure ulcer (wound caused by pressure) on their sacrum which worsened and was currently classified as an unstageable (full thickness tissue loss with unknown depth due to the base of the wound being covered by slough and/or eschar) pressure ulcer. On 5/9/25 at 7:45 AM and 10:00 AM, Resident #117 was observed in their room in bed. At both times, the Resident was positioned on their back with their head/neck leaning to their left side and positioned directly against the pillow. On 5/9/25 at 1:30 PM, Family Member Witness "L" was observed in Resident #117's room. Resident #117 was in bed, positioned on their back with their right heel positioned directly against the mattress. A heel boot (positioning device) was present on their left foot. The Resident's head and neck were leaning to the left side and positioned directly against the pillow. An interview was completed with Witness "L" at this time. When queried regarding Resident #117's care at the facility, Witness "L" revealed they were upset with multiple aspects of the care Resident #117 had received in the facility. Witness "L" revealed they were upset about the open area on the Resident's ear. When asked what open area, Witness "L" responded that the Resident had an open area on their left ear which is draining and stated, "I have been telling them (facility staff), and they don't do anything." At 1:35 PM on 5/9/25, Registered Nurse (RN) "K" was observed walking in the hall past Resident			

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	#117's room and an interview as completed. When asked, RN "K" verbalized they were Resident #117's assigned nurse. RN "C" was asked if Resident #117's skin including pressure ulcers and treatment and replied that the Resident had a pressure ulcer on their sacrum. Upon request, RN "C" entered Resident #117's room and a skin observation was completed. The Resident was observed in bed in the same position. An observation of the Resident's heels was completed with RN "C". A large, dark purplish colored area was present on the Resident's right heel. The area was directly over the bony prominence and encompassed the heel where it had been positioned directly against the mattress. When queried, RN "C" applied pressure to the area and stated it was non-blanchable. When asked what the area was, RN "C" stated, "A DTI (Deep Tissue Injury- pressure ulcer with unknown depth)." When asked if the pressure ulcer was new and facility acquired, RN "C" replied, "Yes." When queried why the Resident only had one heel boot in place on their right foot, RN "C" looked in the room and was unable to locate a second heel boot. RN "C" revealed they were unsure why the Resident only had one boot. RN "C" proceeded to assess the Resident's left ear. An open area, approximately the size of a pencil eraser was present on the center of the helix (top, outer cartilage). The area was draining a dark colored, thin fluid. When queried regarding the open wound, RN "C" replied, "It's a pressure ulcer." When queried regarding etiology of the pressure ulcer on Resident #113's ear, RN "C" verbalized the pressure ulcer was facility acquired. An interview was completed with the Director of Nursing (DON) and Administrator on 5/9/25 at			

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	2:30 PM. When queried regarding Resident #117's new pressure ulcers identified on their right heel and left ear, the DON did not provide an explanation but indicated they would look into it. When queried why the Resident did not have an alternating air mattress in place when they had a pressure ulcer on their sacrum upon admission, the DON indicated the regular facility mattresses also provide pressure reduction. The DON was then queried regarding observations of the Resident's heels directly against the mattress. When queried why the Resident did not have heel boots in place as per their care plan, the DON indicated they were unsure why the resident would not have had them in place. The DON was then asked how often Resident #117 should be turned and repositioned and replied, "Minimum of every two hours." When queried regarding observations of Resident #117 not being turned and repositioned, the DON stated, "They should be." No further explanation was provided. When queried regarding the Resident's sacral pressure ulcer worsening and lack of turning and repositioning, the DON indicated they understood the concern. When queried regarding the open pressure area on the Resident's left ear, Witness "L" stating the wound had been on the ear, and lack of assessment and/or interventions, an explanation was not provided. When asked if the facility has adequate staffing to provide care for the level and acuity of the Residents in the facility, the Administrator responded the facility had hired additional staff who would be starting and training. When queried if they had adequate staff currently to provide care, the DON responded, "Yes, because have to." On 5/9/25 at 2:53 PM, the DON provided skin			

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	assessment documentation from the Long Term Acute Care (LTAC) hospital Resident #117 was in prior to being admitted to the facility. Review of the provided documentation revealed wound assessment documentation dated 4/23/25 for an unstageable pressure ulcer on the Resident's "Right ankle/Achilles (tendon on the back of heel)/malleolus (bony prominence on the sides of the ankle)" as well as pressure ulcer on the Resident's sacrum. The wound images included in the documentation were small and very blurry and the wound bed and/or specific location was unable to be seen. When queried regarding the documentation, the DON indicated the heel pressure ulcer was present upon admission and not facility acquired. When asked why the heel pressure ulcer was not documented on the facility admission assessment if it was present upon admission to the facility, the DON indicated they would speak to the nurse and would "be doing education." When queried if the lack of comprehensive skin assessment and documentation was related to insufficient staff, a response was not provided. An interview was completed with Witness "L" on 5/9/25 at 5:00 PM. When queried how often they visit the Resident at the facility, Witness "L" replied they do their best to visit daily and are currently looking for an apartment to rent and move to closer to the facility. When queried regarding staff turning and repositioning the Resident while they are in the facility, Witness "L" stated, "(Resident #117) has only been turned once when I was here. Every time I have come, their head is on the left, but their body is on their back." Witness "L" was asked how long they are typically in the facility when they visit and replied, "I was here from 11:00 AM to after 1:00			

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	PM yesterday and (Resident #117) wasn't turned at all." Witness "L" was asked how long the open wound had been present on Resident #117's ear and stated, "The nurse (Licensed Practical Nurse [LPN] "F") told me they were going to do something about it last week and they didn't do anything. I put Neosporin on it because I can't trust them (facility nursing staff) to do it." Witness "L" further revealed they brought in a travel pillow to attempt to reposition Resident #117's head and get the pressure off of their left ear but revealed the facility staff "don't use it." Witness "L" stated they were "very frustrated, disappointed, and discouraged" with the care. Witness "L" stated, "(Resident #117) is weak and needs help. Isn't that their job?" An interview was completed with CNA "O" on 5/9/25 at 9:25 AM. When asked how many CNAs were working on the vent and trach hallways of the facility, CNA "O" replied, "Today, three." CNA "O" was asked if that was the normal number of CNAs and replied, "Normally have two (CNAs) for rooms 50-81 (trach and vent hallways)." CNA "O" was asked if the majority of residents on the vent and trach hallways required two assist for cares and replied, "Yes." When queried how they are able to provide care and turn/reposition dependent residents every two hours, CNA "O" replied, ""Cant. The residents (on the vent and trach hallways) are to heavy." CNA "O" stated, "Just do the best I can but they (residents) don't get turned." An interview was completed with CNA "M" on 5/9/25 at 12:03 PM. When queried, CNA "M"revealed they were working on the vent/trach hallway of the facility. When asked how many residents they were assigned to care			

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	for today, CNA "M" revealed it was a better day than normal because they had three CNA's rather than two. CNA "M" stated they had "12 residents." When asked how many of the 12 required two person assistance for care, CNA "M" replied, "Nine or 10 out of the 12 are two assists." When asked how they are able to provide care to their assigned residents, on a day with typical staffing, CNA "M" replied, "I cant do it. It's impossible to actually turn people every two hours. Plus, we have showers and regular care." CNA "M" continued, "Vents and trach's are heavy. Just cant do it all." Review of facility provided policy/procedure entitled, "Nursing Services and Sufficient Staff" (Reviewed/Revised: 1/1/22) revealed, "It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered ..."			