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| M 000 | Initial Comments<br><br>Level IV<br><br>The State Agency (SA) conducted an annual recertification survey, as well as Complaint Investigations (CI), MS #23421 and MS #23434, at the facility, from 11/27/23 through 12/5/23. During the survey, the SA determined the facility was not in compliance with the State Minimum Standards for the Aged and Infirm and cited M500, M610, M625, and M1570. The SA investigated the complaints related to Pressure Ulcer (PUs) and cited M500 and M615.<br><br>The SA identified a Level IV Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 8/29/23 when Resident #53, who had existing PUs, was admitted to the facility, and was not assessed by a qualified nurse or practitioner until 9/18/23, causing the wound to worsen.<br><br>The IJ and SQC existed at:<br><br>45.17.2- Resident Rights- M500 - Scope/Severity -Level IV<br>45.21.3-Pressure Sores - M615 - Scope/Severity Level IV<br><br>The facility Administrator was notified of the IJ and SQC on 12/1/23 at 2:55 PM.<br><br>The facility provided an acceptable Removal Plan on 12/4/23, in which they alleged all corrective actions to remove the IJ were completed on 12/4/23 and the IJ removed on 12/5/23.<br><br>The SA validated the Removal Plan on 12/5/23 and determined the IJ was removed on 12/5/23, prior to exit. Therefore, the scope and severity (s/s) for 45.17.2- Resident Rights- M500 and | M 000 | | |

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| M 000 | Continued From page 1<br><br>45.21.3-Pressure Sores - M615 were lowered from a "Level IV" to a s/s of "Level II" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance | M 500 | | 1/2/24 |

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| M 500 | Continued From page 2<br>with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; | M 500 | | |

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| M 500 | Continued From page 3<br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); | M 500 | | |

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| M 500 | Continued From page 4<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level IV<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to protect the residents' right to be free from neglect for five (5) of 22 residents reviewed as evidenced by facility staff:<br><br>1. Did not provide Pressure Ulcer (PU) assessments and care and treatment to prevent | M 500 | 1. On 11/29/2023, assigned Unit Manager and assigned Certified Nursing Assistant (CNA) attempted to assist Resident #41 with getting up for afternoon activities. Resident #41 declined, stating that he did not feel up to it, but would try again tomorrow. On 11/29/2023, Activity Director engaged with resident performing in room activity. On 11/30/2023, Resident #41 was assisted by staff and attended | |

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| M 500 | Continued From page 5<br>complications and worsening of PUs (Resident #53 and Resident #89)<br>2. Turn and reposition a resident (Resident #87)<br>3. Ensure incontinent residents were clean and dry (Resident #1 and Resident #31).<br><br>The facility's neglect to provide wound assessments, documentation, and wound care treatment resulted in harm to Resident #53 and Resident #89 and put all other residents at risk for skin breakdown in a situation that was likely to result in serious harm, injury, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 8/29/23 when Resident #53, who had existing PUs, was admitted to the facility, and was not assessed by a qualified nurse or practitioner until 9/18/23, causing the wound to worsen.<br><br>The facility Administrator was notified of the IJ and SQC and was presented with an IJ Template on 12/1/23 at 2:55 PM. The facility provided an acceptable Removal Plan on 12/4/23, in which they alleged all corrective action to remove the IJ was completed on 12/4/23 and the IJ was removed on 12/5/23.<br><br>The SA validated the Removal Plan on 12/5/23 and determined the IJ was removed on 12/5/23, prior to exit. Therefore, the scope and severity for 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation F600 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. | M 500 | Activities.<br>2. Facility assessed 95 residents on 12/14/2023 and determined 57 residents require assistance transferring from bed or assistance to Activities have the potential to be affected.<br>3. Facility Quality Assurance Performance Improvement (QAPI)Committee (consisting of Administrator, Director of Nursing (DON), Infection Control Preventionist (IFCP), Medical Director (MD), Social Services (SS), Activity Director (AD), Assistant Director of Nursing (ADON), Certified Dietary Manager(CDM), and Therapy Director (DOR)) met on 12/20/2023 to review cited regulation. The facility policy on Resident Rights in participation of Activities of choice was reviewed and no changes were made.<br><br>On 12/20/2023, all present Certified Nursing Assistants (CNA) , Licensed Practical Nurses (LPN), and Registered Nurses (RN) for all Morning, Evening, and Night shifts were in-serviced by Nurse Educator on Resident Self-Determination and Resident Rights as it pertains to the resident has the right to be assisted to Activities and Facility Events. Staff will be in-serviced prior to receiving resident care assignment.<br><br>40 residents of the 57 residents who require assistance transferring from bed or requires assistance to Activities, were determined to be interviewable. On 12/14/2023, 100% of the 40 residents were audited by Social Services and determined that all resident rights as they | |

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| M 500 | Continued From page 6<br>Findings include:<br><br>A review of the facility's policy "Freedom of Abuse, Neglect, and Exploitation Standard", revised 11/2019, revealed " ... The purpose of this written Freedom of Abuse, Neglect, and Exploitation Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents ... Neglect means failure of the facility, its employees ...to provide ...services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ..."<br><br>Resident #53<br><br>During an observation and interview, on 11/28/23 at 10:30 AM, Resident #53 was sitting up in his wheelchair and he stated that he had a large wound on his bottom. He commented that he thought he would have additional wounds after this past weekend, because he had to lay in bed in his bowel movements and urine for long periods of time on the night shift.<br><br>At 2:00 PM on 11/28/23, during the resident council meeting, the residents complained that it took a long period of time on the night shift for staff to answer call lights and change them. Resident #53 attended the resident council meeting and stated that he could validate those complaints because it happened to him all the time. He explained that the bandage to his wound would come off and the nurses did not redo the wound care or replace the bandage.<br><br>During an interview with Licensed Practical Nurse (LPN) #1/Wound Care Nurse, on 11/28/23 at 3:15 PM, he explained that when a resident was admitted to the facility, the initial body | M 500 | pertain assistance in attending and participation in activities are being provided.<br><br>4. Social Services (SS) will continue weekly assessments beginning 12/14/23 by way of interview/observation for all residents who require assistance transferring from bed or requires assistance to Activities weekly for a period of 6 months to determine Resident Rights are being met. Any concerns identified will be noted, assessed and corrected immediately through Nursing Administration.<br><br>Facility will reconcile the results of these interviews with the daily Activity Attendance Log in the weekly High Risk Meeting beginnng 12/14/2023 for a period of 6 months to determine all residents identified are assisted to and able to participate in any and all activities of choice. Any concerns identified will be noted, assessed and corrected immediately.<br><br>SS will report the results of these interviews and activity attendance logs will be monitored and reported monthly in QAPI Meeting beginning on 1/2/2024 to determine continued compliance for a period of 6 months. Any concerns identified will be noted, assessed and corrected immediately. | |

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| M 500 | Continued From page 7 | M 500 | | |

assessment was completed by Registered Nurse (RN) #3 (RN)/Admission Nurse, and she staged, measured, and documented Pressure Ulcers (PUs). LPN #1 reported that he provided a resident list to the Wound Care Physician of residents that he needed to see. The Wound Care Physician assessed and measured PUs weekly on Mondays and LPN #1 added the physician's measurements to the Wound/Skin Log. He stated that he began documenting on the Wound/Skin logs when RN #4, who was the previous wound care nurse, left the facility on 10/4/23. LPN #1 explained that a "Random Skin Sweep" was a skin assessment that could be used at any time to document any newly identified skin issues. He further explained that a "Weekly Skin Sweep" had to be completed by an RN whenever a nurse documented on the Medication Administration Record (MAR) that the resident had a skin issue. LPN #1 confirmed that Resident #53 had only one (1) PU on his bottom that he had upon admission to the facility. He reported that the resident was currently seen by the Wound Care Physician.

A record review of the "Admission Record" revealed the facility admitted Resident #53 on 08/29/23 with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease.

Record review of the facility's "Brief Interview for Mental Status (BIMS) Evaluation", dated 12/2/23, revealed a score of 13, which indicated Resident #53 was cognitively intact.

A record review of the "Random Skin Sweep" dated 08/29/23, which was the date of admission, revealed Resident #28 had a "Pressure" area to the "Left buttock" that measured 8 centimeters

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| M 500 | Continued From page 8 | M 500 | | |

(cm) length, 5 cm width, and 4 cm depth and a "Skin Tear" to the "Right lateral foot" that measured 3 cm length, 6 cm width, and the depth was listed as "UTD" (Unable To Determine). "Skin Impairment Findings" revealed "Skin injuries as listed above. Left buttock cleaned with NS (Normal Saline), calcium alginate rope, and bordered gauze applied. Right lateral foot cleaned with NS and bordered gauze applied. (Proper Name of Wound Care Physician) to F/U (Follow Up) with resident." The document was signed by RN #4, who was the previous Wound Care Nurse for the facility and was no longer employed by the facility.

A record review of "Braden Scale for Predicting Pressure Sore Risk", dated 08/29/23, revealed Resident #53 had a score of 13, which indicated he had a moderate risk of developing PUs.

A review of the medical record revealed there was no other Random or Weekly Skin Sweeps documented.

During an interview at 4:00 PM on 11/28/23, with the Director of Nursing (DON), she explained that PU wound documentation and skin assessments were to be completed weekly on the Wound/Skin Log by LPN #1.

A record review of the facility's "Wound/Skin Log", dated 9/04/23, revealed Resident #53 had a Stage IV PU to his Left Buttock that measured 7 cm X 2 cm X 10.75 cm. These measurements were documented six (6) days after Resident #53's admission to the facility and indicated the PU had increased in depth. The log also indicated the resident had a Stage IV PU to his Right Lateral Foot that measured 2 cm X 1.5 cm X and the "D (cm)" was UTD. This wound had

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| M 500 | Continued From page 9 | M 500 | | |

been classified upon admission as a "Skin Tear" and this was the first documentation that the area was a "Pressure" type and "Stage" IV. The "Wound/Skin Log" documentation did not indicate who had completed the logs and did not include a description of the PU characteristics, the progress toward healing and identification of potential complications, if infections was present, the presence of pain, or a description of dressings and treatment.

A record review of the facility's "Wound/Skin Log", dated 9/11/23, revealed Resident #53 had a Stage IV PU to his left buttock that measured 6.2 cm x 1.6 cm x 10.6 cm and had a "Type or Stage" of PVD (Peripheral Vascular Disease) to his right foot that measured 1.7 cm x 1.5 cm x UTD. The documentation of PVD was inconsistent with the "Wound/Skin Log" dated 9/4/23, which indicated the wound to the right foot was a PU.

A record review of the "Order Recap Report", with "Order Date: 08/29/2023 - 11/30/2023), revealed Resident #53 had a Physician's Order, dated 9/18/23, for "Wound consult with skilled wound care surgical group ..."

A record review of a "Surgical Note", dated 09/18/23, revealed Resident #53 was seen by the Wound Care Physician 20 days after he was admitted to the facility. The Physician visited the resident because he was asked for his opinion on how to manage the wound located at the left buttock and sacrum. The "Wound Location" was listed as "Left Buttock and Sacrum", and the "Etiology" was listed as "Pressure injury/ulcer - Wound Stage: 4 - Pressure Injury". The note also revealed that the wound area measured 6.2 cm x 1.6 cm x 10.5 cm, which was deeper than the initial measurement upon admission. The

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wound required the Physician to perform a muscle tissue debridement, which was the removal of dead tissue from the wound. The wound description indicated that the wound had undermining (separation of the wound edges from the surrounding healthy tissue) of 13 cm, had no odor, and had a copious amount of serosanguineous (thin fluid with a light pink tinge) exudate. The tissue of the wound was 20% slough (nonviable skin tissue), 80% granulation (development of new skin tissue), and there was no necrotic or dead tissue present in the wound. This was the first wound assessment that included a complete wound description of the PU characteristics for Resident # 53 since the resident was admitted to the facility on 8/29/23. The wound progress was listed as "Undetermined: first visit". The wound to the Right Lateral Foot was listed as "PVD". The "Assessment and Plan" revealed, "The patient has a wound found on the left buttock and sacrum ...there was a sign of tissue decline which will entail continuing supervision and will likely require future debridement ...continue offloading ...turn per facility protocol. A low air loss mattress is recommended ..."

A record review of the "Order Recap Report", with "Order Date: 08/29/2023 - 11/30/2023), revealed Resident #53 had a Physician's Order, dated 8/29/23 and discontinued on 9/19/23, for "Sacrum pressure injury - clean with NS, Pat dry, apply Calcium Alginate and cover with bordered gauze daily and prn (as needed) for soiled or dislodgement ..."

During an observation and interview with Certified Nurse Aide (CNA) #14 and Resident #53 at 5:05 AM on 11/29/23, she explained that she was going to change Resident #53. Resident #53

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commented that was the second time he had seen staff all night and he had not been changed since about 11 PM. The observation revealed that Resident #53's brief was saturated and there was no protective bandage noted covering the PU, nor was there a bandage in his brief indicating the bandage had become dislodged during the night. CNA #14 provided incontinence care and applied a clean brief, but the PU to the sacrum/buttocks did not have a bandage on it, which left the packed wound exposed. CNA #14 confirmed that the resident's brief had been saturated and there was no bandage on the PU wound. She stated she was unsure of the last time she had changed his brief or when the bandage had come off the resident. She said would notify the nurse that the resident did not have a bandage on his PU. CNA #14 explained that they did not document when residents are turned on the "tasks", but Resident #53 was good about turning himself. She confirmed that Resident #53 was incontinent of bowel and bladder.

During an interview with Registered Nurse (RN) #5, at 5:25 AM on 11/29/23, she explained the CNAs should round every two (2) hours to ensure residents were clean and dry, but she did not check behind them to confirm the rounds are completed. She confirmed CNA #14 had let her know that Resident #53's bandage was off his PU site, and she advised that she would replace the dressing after she completed her medication pass.

During an interview with RN #3/Admission Nurse, at 8:25 AM on 11/29/23, she explained she was not a wound care nurse. She stated that she had been helping with the assessment of new wounds, admissions, and hospital returns or any

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other residents the wound care nurse needed help with. She confirmed that she only measured the wounds and she attempted to assess them, but she did not feel comfortable about staging PUs. She said that the Wound Care Physician assessed all wounds until they were healed, and that LPN #1 printed the physician's assessment and that would become part of the resident's medical record. She confirmed that she had never staged PUs and that when a resident was admitted to the facility with an existing PU, the facility used the hospital's discharge wound orders and staging documentation.

During an interview with the Director of Nursing, on 11/29/23 at 3:00 PM, she explained she did not know who completed the Wound/Skin Logs before LPN #1 took over after RN #4 had left. She said that different nurses had helped and had completed the logs but there was no signature or identifying information to indicate who completed the measurements. She explained that as far as she knows, those logs were completed with the measurements from the Wound Care Physician's weekly assessments which are completed when he rounds. She confirmed the logs indicated PU measurements but did not include any other assessment information regarding the wounds. She said that she received a copy of the PU logs weekly, but she did not review the logs to determine if the PUs were healing or deteriorating, and she did not keep the logs on file. The DON stated that LPN #1 provided the Wound Care Physician with a list of residents that needed to be seen during his weekly visits, but she was unsure how or who determined which residents should be seen by the physician.

During an interview with LPN #1, on 11/30/23 at

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10:35 AM, he explained that if a resident was admitted to the facility with an existing PU and had wound treatment orders from the hospital, he would not always refer that resident to the Wound Care Physician. He reported the facility did not have a protocol on when a resident should be seen by the Wound Care Physician. He stated that if a wound was not responding to the treatment orders, he would notify the Wound Care Physician and schedule a consultation for the next Monday. LPN #1 stated that RN #3 documented measurements on the Wound/Skin Log for the residents that the Wound Care Physician did not see. He explained that when a new wound was identified, he got an RN to assess the area and he relied on the RN to complete the Random Skin Sweep documentation. He explained when Resident #53 was admitted to the facility, he was not referred to the Wound Care Physician immediately because the resident had treatment orders for wound care that came with him from the hospital. However, when he noticed that the wound was not responding to the treatment, he referred the resident to the Wound Care Physician. He confirmed Resident #53's wound was deep with tunneling and undermining present. He was not aware that the RNs had not documented anything on the Wound/Skin logs.

During an interview with the Assistant Director of Nursing (ADON), at 11:10 AM on 11/30/23, she explained she was not involved in Resident #53's wound care and had never observed his PU. The facility had a Wound Care Physician that came every Monday, and the Nurse Practitioner was in the facility Monday through Friday. She explained that a PU assessment and documentation should include the PU stage, measurement, description of the appearance of the PU, drainage, odor, and

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healing or deterioration of the PU. All PU wounds and notifications must be documented, and if it was not documented, then it was not completed. The ADON said that she was unsure of the protocol regarding notifying or consulting with the Wound Care Physician when a resident acquired a new PU, but she knew he was provided with a list of residents that he needed to visit. She explained that the facility conducts a "Stand Up" meeting every morning during the week and discussed all concerns in the facility, including PU concerns. The ADON stated she was unaware that RN #3 was not comfortable in staging PUs, but there were other RNs in the facility that could assist, and RN #3 should have asked them for help. The ADON said that if a PU was not staged or assessed appropriately, the wounds may not be treated appropriately and may worsen.

During an interview with the DON, at 12:00 PM on 11/30/23, she explained she expected the nurse to call the Physician or Wound Care Physician if a wound worsened in any way. She also expected all PU assessments and findings to be documented in the medical record, and that if there was no documentation, then it was not done and that she was aware that documentation was a problem. The DON explained that any changes in a resident or a resident's PU should be documented. She confirmed that the facility did not have a system in place to determine when a resident required a consultation with the Wound Care Physician. LPN #1 was responsible for communicating with the Wound Care Physician, who was available as needed. LPN #1 completed the wound/skin logs weekly, but the DON was unaware that PUs were not completely assessed if they are not being seen by the Wound Care Physician. She thought every resident with a wound was seen by the Wound Care Physician

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but was not aware of the system. She was not aware that RN #3 was not comfortable with staging wounds, because she has been completing admission wound assessments for a long time. The DON said she would have put someone else in the position that was more comfortable if she had known. She confirmed that RN #3 has just recently been filling in with wound assessments other an admission assessments since RN #4 had been employed at the facility. There were other RNs in the facility that could assess and measure if RN #3 had asked for help. The DON was not aware Resident #53 was not seen by the Wound Care Physician and that his wound had gotten deeper from the time he was admitted on 8/29/23 until he was seen by the Wound Care Physician on 9/18/23. She reported since there was no longer a RN in wound care, other RNs assisted in completing Wound/Skin logs as necessary.

Resident #89

During a phone interview with the Complainant, on 11/28/23 at 12:20 PM, she explained she became involved when the resident was admitted to an acute care hospital from the facility with a diagnosis of Sepsis (serious condition in which the body responds improperly to infection) related to a PU to the sacrum. She explained the hospital physicians were concerned that the facility's staff were not turning and repositioning the resident as often as needed and not keeping him dry and clean. She reported the resident's brother and sister had voiced concerns to her and the physicians that staff were not turning Resident #89 frequently and the resident remained wet for long periods of time. The Complainant advised that Resident #89 required wound surgery during

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his hospital stay and he currently remained in the acute care hospital at the time of the interview.

During a phone interview with the Resident Representative (RR), on 11/28/23 at 01:00 PM, , he explained Resident #89, who was his brother, had been in the facility for six (6) weeks and had gotten a bad wound that became septic and required surgery. He explained he stayed at the facility for long periods of time to be with brother and the staff did not turn or change him enough. The staff would not touch the resident for hours, and when they finally came to change him, Resident #89 would be soaked with urine. He said that his brother did not have any wounds when he was admitted to the facility and that he did not have a catheter. He explained the facility discussed inserting a catheter on the day the resident was so sick and was transported to the hospital. The RR felt like if the facility had kept his brother dry and had turned him often, he would not have gotten the PU.

A record review of the "Admission Record" revealed the facility admitted Resident #89 on 09/28/23 with diagnoses that included Traumatic Subdural Hemorrhage with Loss of Consciousness of Unspecified Duration.

A record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/5/23, revealed Resident #89 required a Staff Assessment for Mental Status and his cognition was severely impaired. A review of Section GG revealed that Resident #89 was dependent on staff for all functional abilities. A review of Section M revealed Resident #89 was at risk for developing pressure ulcers/injuries, but he did not have any unhealed pressure ulcers/injuries.

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| M 500 | Continued From page 17<br><br>A record review of the "Braden Scale for Predicting Pressure Sore Risk", dated 9/28/23, revealed Resident #89 had a score of 12 which indicated he had a high risk of developing PUs.<br><br>A record review of the "Nursing Random Skin Sweep", dated 09/28/23, which was the date of admission to the facility for Resident #89, revealed he had skin tears to his left ear, left upper chest, and right upper chest. The document was signed by RN #4, the previous Wound Care Nurse. There was no documentation regarding any skin or PUs to the resident's sacrum or buttocks.<br><br>A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 9/28/23 for "Weekly skin assessments ..." Review of the report revealed there were no Physician Orders that addressed any skin issues or PU treatments to the sacrum upon Resident #89's admission date of 9/28/23.<br><br>A record review of the "Wound/Skin Log", dated 10/8/23 (Sunday), which was 10 days after the Resident #89 was admitted to the facility, revealed he had a PU to the sacrum that measured 6.5 cm x 4.0 cm x UTD. The onset date was recorded as "9/28/23" which was the date of admission and conflicted with the "Nursing Random Skin Sweep" that was completed on 9/28/23 and the Physician's Orders. This was the first documentation that referred to the PU. The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. | M 500 | | |

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| M 500 | Continued From page 18<br>There was no indication of who had completed the wound/skin log.<br><br>A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 10/10/23 and ended on 11/8/23, for "Sacrum Pressure Injury - Clean with NS, Pat dry apply Zinc Oxide and cover with bordered gauze daily and prn ..." This order was received two (2) days after the wound/skin log, dated 10/8/23, indicated Resident #89 had a PU that measured 6.5 cm x 4.0 cm x UTD.<br><br>A record review of the "Weekly Skin Sweep", dated 10/12/23, revealed Resident #89 had a PU to the sacrum that measured 2.0 cm length, 1.0 cm width, and UTD for the depth. The measurements conflicted with the measurements documented on the "Wound/Skin Log" that had been completed four (4) days prior. The documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. The document was signed by RN #3, the Admission Nurse.<br><br>A record review of the "Wound/Skin Log", dated 10/16/23, revealed Resident #89 had a PU to the sacrum that measured 6 cm x 4 cm x UTD, which indicated an increase in the size of the wound from the "Weekly Skin Sweep" completed on 10/12/23, which was four (4) days prior. The onset date was recorded as "9/28/23". The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who | M 500 | | |

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| M 500 | Continued From page 19<br>had completed the wound/skin log.<br><br>A record review of the "Wound/Skin Log", dated 10/23/23, revealed Resident #89 had a PU to the sacrum that measured 6.25 cm x 4 cm x UTD. The onset date was recorded as "9/28/23". The measurements indicated the wound had increased in size since the log dated 10/16/23. The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log.<br><br>A record review of the "Wound/Skin Log", dated 11/6/23, revealed Resident #89 had a PU to the sacrum that measured 6.5 cm x 4.2 cm x UTD. The measurements indicated the wound had increased in size from the documentation on the log dated 10/23/23. The onset date was recorded as "9/28". The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log. There was an additional "Wound/Skin Log', dated 11/6/23, which indicated Resident #89 had a PU to the sacrum that measured 6.5 cm x 4.5 cm x UTD and the onset date was "9/28/23".<br><br>A record review of the "Weekly Skin Sweep", dated 11/8/23, revealed Resident #89 had a PU to the sacrum that measured 3.0 cm length, 2.0 cm width, and UTD for the depth. These measurements were inconsistent with the measurements provided two (2) days prior on the wound/skin log dated 11/6/23. | M 500 | | |

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| M 500 | Continued From page 20<br><br>A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 11/8/23, for "Sacrum Pressure Injury - clean with NS, pat dry apply Santyl/Calcium Alginate and cover with bordered gauze daily and prn ...", and a Physician's Order, dated 11/9/23, for "Low air loss mattress for sacral wound". There was a Physician Order, dated 11/13/23, to "consult skilled wound care for evaluation of sacrum wound ..."<br><br>A record review of a "Surgical Note", dated 11/13/23, revealed Resident #89 was seen by the Wound Care Physician. The Physician visited the resident for management of wounds located on the sacrum. The "Wound Location" was listed as "Sacrum", and the "Etiology" was listed as "Pressure injury/ulcer - Wound Stage: 4 - Pressure Injury". The note also revealed that the wound measured 6.0 cm x 4.0 cm x UTD prior to his debridement, and 6.0 cm x 4.0 cm x 0.5 cm after the debridement procedure. The wound required the Physician to perform a muscle tissue debridement with the "Preoperative Indications" listed as "Biofilm, Devitalized tissue, and Slough. There were no signs of infection. The wound description indicated that the wound had no odor and had a moderate amount of serosanguineous exudate. The Peri wound area was unhealthy and unstable. The tissue of the wound was 80% slough and 20% granulation. This was the first wound assessment that included a complete wound description of the PU characteristics, for Resident # 89, which was 36 days after the PU was first documented on the Wound/Skin Log dated 10/8/23.<br><br>During an interview with RN #3/Admission Nurse, | M 500 | | |

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| M 500 | Continued From page 21<br>at 8:25 AM on 11/29/23, she confirmed that she had completed the Weekly Skin Sweep for Resident #89 on 10/12/23 and that she did not stage the PU or provide descriptive characteristics of the PU. She explained that she had assumed the wound care team would follow Resident #89, but she did not follow up to ensure he was seen by the team. She explained that the wound care team at that time consisted of LPN #1 and the Wound Care Physician. She was unable to recall what the PU looked like when she had measured it. She confirmed that she only measured the PU and did not complete or document a full assessment of the wound. She said she was unaware that the Wound Care Physician was not seeing the resident when she completed the documentation on 10/12/23.<br><br>During an interview with the DON, on 11/29/23 at 3:00 PM, she explained she was not aware that RN #3 had not assessed or staged the PU to the sacrum for Resident #89 and that the Wound Care Physician had not assessed or staged the PU for more than four (4) weeks after the PU was first identified by facility staff on 10/8/23.<br><br>During an interview with the Administrator and the DON, at 3:10 PM on 11/29/23, the Administrator explained that he could not determine who had completed the Wound/Skin logs that were provided. He explained that RN #4 was the previous wound care nurse and her last day at the facility was 10/04/23. The DON and the Administrator were unable to explain the PU measurement inconsistencies of the Wound/Skin logs and the Weekly Skin Sweeps for Resident #89.<br><br>During an interview with LPN #1, on 11/30/23 at 10:35 AM, he explained when Resident #89 was | M 500 | | |

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admitted to the facility, he did not have any PUs. He was unable to recall how he found out that Resident #89 had a PU, but he did recall asking RN #3 to measure the wound. LPN #1 described the PU when he first saw it as measuring approximately 2 cm x 3 cm, the area was discolored, but the skin was intact. He thought the wound was classified as "Moisture Associated Skin Damage" (MASD), because whenever he provided the treatments to the sacrum, Resident #89 was soiled with urine. He stated that he had instructed CNAs that the resident needed to be kept dry, changed in a timely manner, and turned more frequently, however he did not conduct and document a formal in-service. LPN #1 said that Resident #89's family would be with the resident daily and he would talk to them regarding resident's PU, but he never completed any documentation regarding the PU. LPN #1 said that when the wound was first found, the physician was notified, and new orders were received for zinc oxide, because the skin was intact. He stated that he continued to treat the PU with zinc oxide and did not notify the Wound Care Physician that the wound size was increasing. He confirmed he had no documentation of the wounds, including the progression or deterioration of the wound. When he noticed the PU to the sacrum had slough, he notified the Wound Care Physician and received orders to discontinue the zinc oxide and start a new treatment. He said that he felt like the PU measurements obtained on the Random and Weekly Skin Sweeps were accurate because he assisted RN #3/Admissions Nurse when she measured the wounds. He confirmed Resident #89's wound had deteriorated and increased in size from the time it was first identified on 9/28/23 until the time he was seen by the Wound Care Physician on 11/13/23. He confirmed that on

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| M 500 | Continued From page 23<br><br>11/13/23, the PU to the sacrum was classified as a Stage IV. LPN #1 stated that he would not have done anything differently with the resident's wound. He confirmed that Resident #89 did not have a low air loss mattress to help with pressure reduction until 11/9/23.<br><br>During an interview with the Assistant Director of Nursing (ADON), at 11:10 AM on 11/30/23, she explained she was unaware that Resident #89 had a PU because she was not involved in his care. She stated that it appeared someone dropped the ball, but she didn't know who. She explained that for a resident to develop a Stage 4 PU in less than two (2) months of admission, the resident did not receive adequate care and should have been referred to the Wound Care Physician before a month had passed, especially since the resident had comorbidities, restricted mobility, and was at a high risk for skin breakdown.<br><br>During an interview with the DON, at 12:00 PM on 11/30/23, she stated she was not aware that Resident #89's PU had increased in size before the Wound Care Physician had gotten involved with his care.<br><br>During a phone interview with the Nurse Practitioner (NP), at 12:45 PM on 11/30/23, she explained that she had not observed Resident #89's PU, but she would have if she were asked to do so.The NP stated that she reviewed the Wound/Skin Logs, but not in detail.<br><br>During a phone interview with the Wound Care Physician, at 1:25 PM on 11/30/23, he confirmed that he saw Resident #89 on 11/13/23 for the first time. He stated the resident was not very alert or responsive and had comorbidities, restricted | M 500 | | |

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mobility, a tracheostomy, and had thinning skin. He said that when he observed the PU on 11/13/23, the sacrum was noted with devitalized tissue, consisting of slough and granulation, and was unstageable due to the slough. The wound was debrided and then staged as a Stage IV PU. He understood from the wound care nurse that the PU started out as MASD, but he felt the etiology of the wound was pressure due to his restricted mobility and the resident was completely dependent upon staff for offloading. He stated that all wounds should be assessed by the facility's protocol. He said that he rounded weekly at the facility and conducted complete assessments of the wounds for residents on his list. He stated that he was available via Tele-Med and could make visits as needed to the facility.

During a phone interview with the Medical Director, at 1:50 PM on 11/30/23, he explained that he never observed Resident #89's PU. He stated he was available to the facility staff for any questions or concerns about residents and wounds. The staff usually informed him when a resident's condition worsened, and he discussed any PU or wound issues with the Wound Care Physician through the electronic medical records portal. He stated that wounds should be assessed daily and if there were any changes, the facility should notify the physician and document accordingly.

During an interview with LPN #6 /Weekend Wound Care Nurse, on 12/02/23 at 10:05 AM, she stated that Resident #89's PU started out with redness and then had slough in the wound. She confirmed that she did not notify the Wound Care Physician or the Attending Physician regarding the change in the wound. She stated that Resident #89 was dependent upon staff for

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turning and repositioning.

Resident # 87

During an observation on 11/27/23 at 10:27 AM, Resident #87 was lying in bed with the head of bed elevated. He was positioned on his back at a 45-degree angle. The resident was nonverbal and unable to make his needs known.

During an interview on 11/28/23 at 9:00 AM, with the resident's sister, she complained that the facility was not providing good care to her brother. She reported that she came to the facility to visit him daily and the staff failed to turn and reposition him. She stated that she was concerned that he may get a pressure sore or pneumonia. Resident #87 had been on his back for two (2) hours, since 7:00 AM.

During an observation on 11/28/23 at 1:00 PM and 3:00 PM, Resident #87 was positioned on his back with the head of the bed elevated.

During an observation on 11/29/23 at 05:00 AM, Resident #87 was positioned on his back with head of the bed elevated to a 45-degree angle.

During an interview on 11/29/23 at 5:15 AM, with CNA #2, she confirmed the facility did not have a turning schedule, and turning was not documented as part of their "tasks. CNA #2 said she had not turned the resident.

During observations on 11/29/23 at 08:00 AM and 10:30 AM, Resident #87 was positioned on his back with the head of the bed elevated.

During an interview on 11/29/23 at 11:00 AM, with the DON, she confirmed the facility did not have a

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schedule for residents to be turned, but she would consider implementing one.

A record review of the "Admission Record" revealed the facility admitted Resident #87 on 08/07/23 with diagnoses including Nontraumatic Intracerebral Hemorrhage, Chronic Respiratory Failure with Hypoxia, and Hemiplegia and Hemiparesis.

A record review of the Quarterly MDS with an ARD of 11/10/23 revealed Resident #87's cognition was severely impaired.

Resident #1

On 11/29/23 at 5:15 AM, during an observation of Resident #1 and interview with CNA #13, Resident #1's brief was saturated with urine and had a strong urine odor. CNA #13 stated that she was not assigned to the resident but confirmed that the resident's brief was saturated with urine and had a strong urine odor.

On 11/29/23 at 8:49 AM, in an interview with LPN #2/Unit Manager, she stated that Resident #1 was incontinent of bowel and bladder, and she expected all staff to make rounds every two (2) hours to turn residents and keep them clean and dry.

Record review of the "Admission Record" revealed the facility admitted Resident #1 on 8/11/23 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non dominant side and Morbid Severe Obesity.

Record review of the MDS with an ARD of 10/12/23 revealed Resident #1 required a staff

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assessment for mental status and her cognition was severely impaired. A review of Section G revealed Resident #1 required total dependence by staff for toileting.

Resident #31

On 11/27/23 at 2:40 PM, in an observation and interview with Resident #31, revealed there was a urine odor noted in the room and the resident stated that she stayed wet for long periods of time.

On 11/29/23 at 5:22 AM, an observation and interview with CNA #13 and Resident #31, revealed the resident's brief was heavily soiled, and there was a strong urine odor. Resident #31 stated she was changed once last night before she fell asleep and that she usually got changed once on the 11 PM to 7 AM shift. CNA #13 stated she was not the CNA for the resident, but she confirmed that Resident #31's brief was heavily soiled urine and had a strong urine odor.

Record review of the "Admission Record" revealed the facility admitted Resident #31 on 6/23/23 with a diagnoses that included Traumatic Brain Injury.

Record Review of the Quarterly MDS with an ARD of 9/26/23 revealed Resident #31 had a BIMS score of 15, which indicated she was cognitively intact. A review of Section G revealed she was dependent upon staff for toileting hygiene.

On 11/29/23 at 10:42 AM, in an interview with the DON, she stated that she expected the CNAs to complete rounds every two hours or every hour, if a resident required it more often. She explained

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that when residents are wearing a heavily saturated brief, it could cause skin breakdown, urinary tract infections, or other infections. She stated if a resident had a wound, it could delay wound healing.

On 12/01/23 at 9:40 AM, in an interview with CNA #1/Lead CNA, she stated that she worked on all halls and all shifts at the facility. She explained that she expected the CNAs to make rounds every two (2) hours and change the resident if needed. She stated that if a resident was found to have a heavily saturated brief and had a strong urine odor, she would think that the resident had not been changed all night.

The facility provided an acceptable Removal Plan on 12/4/23, in which they alleged all corrective action to remove the IJ was completed on 12/4/23 and the IJ was removed on 12/5/23.

Removal Plan

On December 1st, 2023, at approximately 3:30pm Pine Forest Health and Rehabilitation received 5 Immediate Jeopardies during an Annual and Complaint Survey from the Mississippi Department of Health Licensure and Certification and provided the facility with the Immediate Jeopardy Templates.

Brief Summary of Events:

Pine Forest Health and Rehabilitation failed to put into place appropriate interventions to ensure proper assessment, staging, treatment and clinical care plans to treat and prevent the development and worsening of new and existing pressure ulcers.

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Corrective Actions:
1. An Emergency QAPI Meeting was held at approximately 12/1/2023 at 5 PM to review the cited deficient practices and to determine a root cause analysis for the lack of appropriate interventions. This meeting included the Administrator, Director of Nursing/Infection Preventionist, Medical Director, Respiratory Director, & Business Office Manager. The following items were reviewed, coordinated, and corrected to allege compliance and remove the Immediate Jeopardy. The root cause analysis determined the cause of these occurrences was the facility's failure to be properly train staff on the policies for assessing, staging, preventing, and communicating wound and skin care issues for residents who could be at risk for skin breakdown or are already noted with skin/wound breakdown.

2. The facility did a complete policy review on Care Planning Standard, Skin Management Standard, and Employee Competency Standard. The facility conducted 100% in-services and education using outsourced, Qualified Trainers and Online Software as it pertains to each department and the correlated policies pertaining to the immediate jeopardies. The facility also did a 100% inservice on all staff on the Identification and Reporting of Resident Abuse and Neglect. No individual was allowed to work beginning at approximately 7PM on 12/1/2023 until they were able to successfully complete all prescribed In-services.

3. The facility outsourced a Qualified RN Trainer to properly train with return demonstration all individuals who are responsible for the assessment, staging, and provision of wound care for the Facility. Upon completion and approximately 7:30PM on 12/1/2023, the Facility

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| M 500 | Continued From page 30<br>began to conduct body audits on 100% of in-house residents to determine proper assessment, staging, and treatment of wounds and finished on 12/4/2023. All noted pressure areas were assessed, staged, and determined to have a proper assessment. The wound care physician was notified of all findings and coordinated a Telehealth Visit on all residents with pre-existing wounds to confirm appropriate assessment, staging, and treatment of all existing pressure ulcers. There were no changes noted after having concluded all consult Telehealth visits. The attending physician and facility Medical Director was then notified of all Wound Care Physician's Assessments and concurred with prescribed consultation on all noted patients. Resident #53 was determined to have a pressure ulcer in an optimal condition of healing. Resident #89 remains in the hospital.<br><br>4. Both MDS Nurses were immediately trained following the QAPI Meeting regarding the ability to properly develop and/or revise resident care plans interventions for residents with pressure ulcers, ensuring those who were admitted to the facility without pressure ulcers did not acquire pressure ulcers and that existing pressure ulcers did not get worse, or residents did not develop complications from pressure wounds. After completing each Telehealth visit from Wound Care Physician and receiving noted confirmation for Medical Director/Attending Physician on all residents with Pressure ulcers, the facility began assessing and updating all care plans on 12/1/2023 and completed 12/4/2023 on coordination with development and prevention of pressure ulcers according to the prescribed orders. Resident #53 was noted to have a proper care plan regarding his healing pressure ulcer. Resident #89 remains in the hospital. | M 500 | | |

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| M 500 | Continued From page 31<br><br>5. The facility determined to move forward by having the trained Unit RN Managers conduct weekly body audits on all residents as it pertains to their individual Units A & B and report the assessment of those daily audits to the Wound Care Team, consisting of the Wound Care Physician, Treatment Nurse, MDS Nurse, and Director of Nursing. All new admits/readmitting residents will their initial assessment conducted by the Unit Manager, who will be responsible for communicating the results of the audit to the Wound Care Team, Consisting of the Wound Care Physician, Treatment Nurse, MDS Nurse and Director of Nursing. The Director of Nursing has been delegated to report the reconciliation of this weekly review in High Risk and monitored monthly for no less than 1 year by the QAPI Committee.<br><br>6. The Facility alleges compliance on 12/5/2023. The facility alleges that all corrective actions to remove the Immediate Jeopardy were completed on 12/4/2023 and the Immediate Jeopardy was removed on 12/5/2023.<br><br>The SA validated the facility's Corrective Actions on 12/5/23:<br><br>The SA validated through interviews and record review that an Emergency QAPI meeting was held on 12/01/2023 with all members in attendance.<br><br>The SA validated through interviews and record reviews all policies on Care Planning Standards, Skin Management Standards, and Employee Competency Standards were reviewed with no corrections made. The facility conducted 100% in-services and education including Identification | M 500 | | |

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| M 500 | Continued From page 32<br>and Reporting of Resident Abuse and Neglect.<br><br>The SA validated through interviews and record reviews the facility outsourced a Qualified RN Trainer to properly train and return demonstration all individuals who are responsible for the assessment, staging, and provision of wound care for the Facility. The facility completed 100% body audits of in-house residents to determine proper assessment, staging, and treatment of wounds and finished on 12/04/23. The Wound Care Physician was notified of all findings and coordinated a Telehealth Visit on all residents with pre-exiting wounds to confirm appropriate assessment, staging, and treatment of all exiting pressure ulcers. The Medical Director was notified of all findings. Resident #53 was determined to have a pressure ulcer in an optimal condition of healing. Resident #89 remains in the hospital.<br><br>The SA validated through interviews and record reviews both MDS Nurses were immediately trained following the QAPI meeting regarding the proper development and/or revise resident care plans interventions for residents with pressure ulcers, ensuring those who were admitted to the facility without pressure ulcers did not acquire pressure ulcers and that existing pressure ulcers did not get worse, or residents did not develop complications from pressure wounds. The facility assessed and updated all care plans and completed them on 12/04/23.<br><br>The SA validated through interviews and record reviews the facility trained Unit RN Managers conduct weekly body audits on all resident as it pertains to their individual Units A and B and report the assessment of those daily audits to the Wound Care Team, consisting of the Wound | M 500 | | |

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| M 500 | Continued From page 33<br>Care Physician, Treatment Nurse, MDS Nurse, and DON. The DON has been delegated to report the reconciliation of this weekly review in High Risk and monitored monthly for no less than one (1) year by the QAPI Committee.<br><br>The SA validated through interviews and record reviews and no associate can return to work until they have received this in-service training.<br><br>The SA validated that all corrective actions were completed on 12/04/2023 and the IJ was removed as of 12/05/2023. | M 500 | | |
| M 615 | 45.21.3 Pressure sores<br><br>Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.<br><br>This Statute is not met as evidenced by:<br>Level IV<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were assessed and received care and treatment for Pressure Ulcers (PUs) to prevent complications and worsening of PUs for two (2) of four (4) residents reviewed for PUs. Resident #53 and Resident #89.<br><br>The facility's failure to provide wound assessments, documentation, and wound care treatment resulted in harm to Resident #53 and Resident #89 and put all other residents at risk for | M 615 | 1. Resident #53 was identified and assessed by a Registered Nurse(RN). Resident was found to have proper wound care treatment for the prevention of development and worsening of new and existing pressure ulcers as determined by Wound care Physician, via Telehealth visit on 12/2/2023. Resident was successfully discharged home from Facility on 12/7/2023.<br>Resident #89 returned to the facility on 12/13/2023 and was assessed for wounds by Wound Care Physician via Telehealth visit on 12/13/2023. All treatment orders | 1/2/24 |

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| M 615 | Continued From page 34<br>skin breakdown in a situation that was likely to result in serious harm, injury, impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 8/29/23 when Resident #53, who had existing PUs, was admitted to the facility and was not assessed by a qualified nurse or practitioner until 9/18/23, causing the wound to worsen.<br><br>The facility Administrator was notified of the IJ and SQC and was presented with an IJ Template on 12/1/23 at 2:55 PM. The facility provided an acceptable Removal Plan on 12/4/23, in which they alleged all corrective action to remove the IJ was completed on 12/4/23 and the IJ removed on 12/5/23.<br><br>The SA validated the Removal Plan on 12/5/23 and determined the IJ was removed on 12/5/23, prior to exit. Therefore, the scope and severity for 42 CFR 483.25 (b) (1) (i) (ii) Pressure Ulcers was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>Resident #53<br><br>On 11/28/23 at 10:30 AM, during an observation and interview, Resident #53 was sitting up in his wheelchair and he stated that he had one (1) large wound to his bottom. He commented that he thought he would have additional wounds after this past weekend, because he had to lay in bed | M 615 | for Resident #89 were provided and are currently maintained.<br>2. An audit of 95 residents on 12/1/2023 determined 95 have the potential for skin breakdown.<br>3. Facility Quality Assurance Performance Improvement (QAPI) Committee (consisting of Administrator, Director of Nursing (DON), Infection Control Preventionist (IFCP), Medical Director (MD), Social Services (SS), Activity Director (AD), Assistant Director of Nursing (ADON), Certified Dietary Manager (CDM), and Therapy Director (DOR)) met on 12/20/2023 to review cited regulation. QAPI Committee reviewed the policy, Resident Abuse and Neglect and Treatment/Prevention of Pressure Ulcers with no recommended changes to the policy.<br>A 100% body audit of 95 residents was conducted on 12/4/2023 by Director of Nursing (DON), Wound Care RN, Assistant Director of Nursing (ADON), RN Unit Manager #1 and RN Unit Manager #2. The results of that audit determined there were no new areas noted/untreated nor without updated Physician Orders.<br>On 12/1/2023, Facility conducted training for all 3 Treatment Nursing Staff, Including 2 Unit Managers, ADON, and DON by Outsourced Qualified Trainer on proper assessment, staging, and wound care necessary to prevent the development and worsening of new and existing pressure ulcers.<br>4. Beginning 12/4/2023, Trained Unit Mangers or Nursing Management will be responsible for conducting weekly body assessments as part of their ongoing | |

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| M 615 | Continued From page 35<br>in his bowel movements and urine for long periods of time on the night shift.<br><br>On 11/28/23 at 3:15 PM, during an interview with Licensed Practical Nurse (LPN) #1/Wound Care Nurse, he explained that when a resident was admitted to the facility, the initial body assessment was completed by Registered Nurse (RN) #3 (RN)/Admission Nurse, and she staged, measured, and documented Pressure Ulcers (PUs). LPN #1 reported that he provided a resident list to the Wound Care Physician of residents that he needed to see. The Wound Care Physician assessed and measured PUs weekly on Mondays and LPN #1 added the physician's measurements to the Wound/Skin Log. He stated that he began documenting on the Wound/Skin logs when RN #4, who was the previous wound care nurse, left the facility on 10/4/23. LPN #1 explained that a "Random Skin Sweep" was a skin assessment that could be used at any time to document any newly identified skin issues. He further explained that a "Weekly Skin Sweep" had to be completed by an RN whenever a nurse documented on the Medication Administration Record (MAR) that the resident had a skin issue. LPN #1 confirmed that Resident #53 had only one (1) PU on his bottom that he had upon admission to the facility. He reported that the resident was currently seen by the Wound Care Physician.<br>A record review of the "Admission Record" revealed the facility admitted Resident #53 on 08/29/23 with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease.<br><br>Record review of the facility's "Brief Interview for Mental Status (BIMS) Evaluation", dated 12/2/23, revealed a score of 13, which indicated Resident | M 615 | assigned duties on 100% of residents for the purpose of assessing, staging, and providing wound care necessary to prevent the development and worsening of new and existing pressure ulcers.<br>Beginning 12/7/2023, Weekly body assessments will be reviewed by the Interdisciplinary Team during weekly High-Risk Meeting to assure full compliance in assessing, staging, and wound care necessary to prevent the development and worsening of new and existing pressure ulcers. Any concerns identified will be noted, assessed and corrected immediately.<br>Beginning 1/2/2024, The Director of Nursing will report monthly to The Facility QAPI Committee, who will review and evaluate Facility Body Audits Monthly to determine compliance in proper assessment, staging, and wound care necessary to prevent the development and worsening of new and existing pressure ulcers as a part of continued agenda for a period of 1 year. Any concerns identified will be noted, assessed and corrected immediately. | |

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#53 was cognitively intact.

A record review of the "Random Skin Sweep" dated 08/29/23, which was the date of admission, revealed Resident #28 had a "Pressure" area to the "Left buttock" that measured 8 centimeters (cm) length, 5 cm width, and 4 cm depth and a "Skin Tear" to the "Right lateral foot" that measured 3 cm length, 6 cm width, and the depth was listed as "UTD" (Unable To Determine). "Skin Impairment Findings" revealed "Skin injuries as listed above. Left buttock cleaned with NS (Normal Saline), calcium alginate rope, and bordered gauze applied. Right lateral foot cleaned with NS and bordered gauze applied. (Proper Name of Wound Care Physician) to F/U (Follow Up) with resident." The document was signed by RN #4, who was the previous Wound Care Nurse for the facility and was no longer employed by the facility.

A record review of "Braden Scale for Predicting Pressure Sore Risk", dated 08/29/23, revealed Resident #53 had a score of 13, which indicated he had a moderate risk of developing PUs.

A review of the medical record revealed there was no other Random or Weekly Skin Sweeps documented.

At 4:00 PM on 11/28/23, during an interview with the Director of Nursing (DON), she explained that PU wound documentation and skin assessments were to be completed weekly on the Wound/Skin Log by LPN #1.

A record review of the facility's "Wound/Skin Log", dated 09/04/23, revealed Resident #53 had a Stage IV PU to his Left Buttock that measured 7 cm X 2 cm X 10.75 cm. These measurements

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were documented six (6) days after Resident #53's admission to the facility and indicated the PU had increased in depth. The log also indicated the resident had a Stage IV PU to his Right Lateral Foot that measured 2 cm X 1.5 cm X and the "D (depth) (cm)" was UTD. This wound had been classified upon admission as a "Skin Tear" and this was the first documentation that the area was a "Pressure" type and "Stage" IV. The "Wound/Skin Log" documentation did not indicate who had completed the logs and did not include a description of the PU characteristics, the progress toward healing and identification of potential complications, if infections were present, the presence of pain, or a description of dressings and treatment.

A record review of the facility's "Wound/Skin Log", dated 9/11/23, revealed Resident #53 had a Stage IV PU to his left buttock that measured 6.2 cm x 1.6 cm x 10.6 cm and had a "Type or Stage" of PVD (Peripheral Vascular Disease) to his right foot that measured 1.7 cm x 1.5 cm x UTD. The documentation of PVD was inconsistent with the "Wound/Skin Log" dated 9/4/23, which indicated the wound to the right foot was a PU.

A record review of the "Order Recap Report", with "Order Date: 08/29/2023 - 11/30/2023), revealed Resident #53 had a Physician's Order, dated 9/18/2023, for "Wound consult with skilled wound care surgical group ..."

A record review of a "Surgical Note", dated 09/18/23, revealed Resident #53 was seen by the Wound Care Physician 20 days after he was admitted to the facility. The Physician visited the resident because he was asked for his opinion on how to manage the wound located at the left buttock and sacrum. The "Wound Location" was

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listed as "Left Buttock and Sacrum", and the "Etiology" was listed as "Pressure injury/ulcer - Wound Stage: 4 - Pressure Injury". The note also revealed that the wound area measured 6.2 cm x 1.6 cm x 10.5 cm, which was deeper than the initial measurement upon admission. The wound required the Physician to perform a muscle tissue debridement, which was the removal of dead tissue from the wound. The wound description indicated that the wound had undermining (separation of the wound edges from the surrounding healthy tissue) of 13 cm, had no odor, and had a copious amount of serosanguineous (thin fluid with a light pink tinge) exudate. The tissue of the wound was 20% slough (nonviable skin tissue), 80% granulation (development of new skin tissue), and there was no necrotic or dead tissue present in the wound. This was the first wound assessment that included a complete wound description of the PU characteristics for Resident # 53 since the resident was admitted to the facility on 8/29/23. The wound progress was listed as "Undetermined: first visit". The wound to the Right Lateral Foot was listed as "PVD". The "Assessment and Plan" revealed, "The patient has a wound found on the left buttock and sacrum ...there was a sign of tissue decline which will entail continuing supervision and will likely require future debridement ...continue offloading ...turn per facility protocol. A low air loss mattress is recommended ..."

A record review of the "Order Recap Report", with "Order Date: 08/29/2023 - 11/30/2023), revealed Resident #53 had a Physician's Order, dated 8/29/23 and discontinued on 9/19/23, for "Sacrum pressure injury - clean with NS, Pat dry, apply Calcium Alginate and cover with bordered gauze daily and prn (as needed) for soiled or

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dislodgement ..."

At 5:05 AM on 11/29/23, during an observation and interview with Certified Nurse Assistant (CNA) #14 and Resident #53, the CNA explained that she was going to change him. Resident #53 commented that was the second time he had seen staff all night and he had not been changed since about 11 PM. The observation revealed that Resident #53's brief was saturated and there was no protective bandage noted covering the PU, nor was there a bandage in his brief indicating the bandage had become dislodged during the night. CNA #14 provided incontinence care and applied a clean brief, but the PU to the sacrum/buttocks did not have a bandage on it, which left the packed wound exposed. CNA #14 confirmed that the resident's brief had been saturated and there was no bandage on the PU wound. She stated she was unsure of the last time she had changed his brief or when the bandage had come off the resident. She said would notify the nurse that the resident did not have a bandage on his PU.

At 5:25 AM on 11/29/23, during an interview with RN #5, she explained the CNAs should round every two (2) hours to ensure residents were clean and dry, but she did not check behind them to confirm the rounds are completed. She confirmed CNA #14 had let her know that Resident #53's bandage was off his PU site, and she advised that she would replace the dressing after she completed her medication pass.

At 8:25 AM on 11/29/23, during an interview with RN #3/Admission Nurse, she explained she was not a wound care nurse. She stated that she had been helping with the assessment of new wounds, admissions, and hospital returns or any

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other residents the wound care nurse needed help with. She confirmed that she only measured the wounds and she attempted to assess them, but she did not feel comfortable about staging PUs. She said that the Wound Care Physician assessed all wounds until they were healed, and that LPN #1 printed the physician's assessment and that would become part of the resident's medical record. She confirmed that she had never staged PUs and that when a resident was admitted to the facility with an existing PU, the facility used the hospital's discharge wound orders and staging documentation.

On 11/29/23 at 3:00 PM, during an interview with the DON, she explained she did not know who completed the Wound/Skin Logs before LPN #1 took over after RN #4 had left. She said that different nurses had helped and had completed the logs but there was no signature or identifying information to indicate who completed the measurements. She explained that as far as she knows, those logs were completed with the measurements from the Wound Care Physician's weekly assessments which are completed when he rounds. She confirmed the logs indicated PU measurements but did not include any other assessment information regarding the wounds. She said that she received a copy of the PU logs weekly, but she did not review the logs to determine if the PUs were healing or deteriorating, and she did not keep the logs on file. The DON stated that LPN #1 provided the Wound Care Physician with a list of residents that needed to be seen during his weekly visits, but she was unsure how or who determined which residents should be seen by the physician.

On 11/30/23 at 10:35 AM, during an interview with LPN #1, he explained that if a resident was

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admitted to the facility with an existing PU and had wound treatment orders from the hospital, he would not always refer that resident to the Wound Care Physician. He reported the facility did not have a protocol on when a resident should be seen by the Wound Care Physician. He stated that if a wound was not responding to the treatment orders, he would notify the Wound Care Physician and schedule a consultation for the next Monday. LPN #1 stated that RN #3 documented measurements on the Wound/Skin Log for the residents that the Wound Care Physician did not see. He explained that when a new wound was identified, he got an RN to assess the area and he relied on the RN to complete the Random Skin Sweep documentation. He explained when Resident #53 was admitted to the facility, he was not referred to the Wound Care Physician immediately because the resident had treatment orders for wound care that came with him from the hospital. However, when he noticed that the wound was not responding to the treatment, he referred the resident to the Wound Care Physician. He confirmed Resident #53's wound was deep with tunneling and undermining present. He was not aware that the RNs had not documented anything on the Wound/Skin logs.

At 11:10 AM on 11/30/23, during an interview with the Assistant Director of Nursing (ADON), she explained she was not involved in Resident #53's wound care and had never observed his PU. The facility had a Wound Care Physician that came every Monday, and the Nurse Practitioner was in the facility Monday through Friday. She explained that a PU assessment and documentation should include the PU stage, measurement, description of the appearance of the PU, drainage, odor, and healing or deterioration of the PU. All PU wounds

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and notifications must be documented, and if it was not documented, then it was not completed. The ADON said that she was unsure of the protocol regarding notifying or consulting with the Wound Care Physician when a resident acquired a new PU, but she knew he was provided with a list of residents that he needed to visit. She explained that the facility conducts a "Stand Up" meeting every morning during the week and discussed all concerns in the facility, including PU concerns. The ADON stated she was unaware that RN #3 was not comfortable in staging PUs, but there were other RNs in the facility that could assist and RN #3 should have asked them for help. The ADON said that if a PU was not staged or assessed appropriately, the wounds may not be treated appropriately and may worsen.

At 1:10 PM on 11/30/23, during an interview with RN #3, she reported she did not tell the DON that she was not comfortable staging wounds. She confirmed she did not know the protocol or system for a resident being admitted with an existing PU or for a resident who acquired a PU while in the facility to be referred to the Wound Care Physician. She stated she was only filling in since there was no RN currently in the wound care role. She stated that she had not been asked to assess any wounds, but only to measure wounds. She confirmed that the facility had daily stand-up meetings, but wounds were not discussed in detail until the monthly Quality Assurance (QA) meetings.

At 12:00 PM on 11/30/23, during an interview with the DON, she explained she expected the nurse to call the Physician or Wound Care Physician if a wound worsened in any way. She also expected all PU assessments and findings to be documented in the medical record, and that if

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there was no documentation, then it was not done and that she was aware that documentation was a problem. The DON explained that any changes in a resident or a resident's PU should be documented. She confirmed that the facility did not have a system in place to determine when a resident required a consultation with the Wound Care Physician. LPN #1 was responsible for communicating with the Wound Care Physician, who was available as needed. LPN #1 completed the wound/skin logs weekly, but the DON was unaware that PUs were not completely assessed if they are not being seen by the Wound Care Physician. She thought every resident with a wound was seen by the Wound Care Physician but was not aware of the system. She was not aware that RN #3 was not comfortable with staging wounds, because she has been completing admission wound assessments for a long time. The DON said she would have put someone else in the position that was more comfortable if she had known. She confirmed that RN #3 has just recently been filling in with wound assessments other than admission assessments since RN #4 left employment at the facility. There were other RNs in the facility that could assess and measure if RN #3 had asked for help. The DON was not aware Resident #53 was not seen by the Wound Care Physician and that his wound had gotten deeper from the time he was admitted on 8/29/23 until he was seen by the Wound Care Physician on 9/18/23. She reported since there was no longer a RN in wound care, other RNs assisted in completing Wound/Skin logs as necessary.

At 1:25 PM on 11/30/23, during a phone interview with the Wound Care Physician, he confirmed that he was a consultant for the facility and was not involved in resident care plan or facility

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meetings. He stated LPN #1 faxed a list to his office of residents that he needed to see when he comes to the facility. He did not know the facility's policy regarding wound care or the system the facility used to determine which residents he should see, but he felt the wound care nurse (LPN #1) knew to consult him if a wound worsened and he could be consulted at any time via Tele-Med (Telephone Medical) services.

Resident #89

On 11/28/23 at 12:20 PM, during a phone interview with the Complainant, she explained she became involved when the resident was admitted to an acute care hospital from the facility with a diagnosis of Sepsis (serious condition in which the body responds improperly to infection) related to a PU to the sacrum. She explained the hospital physicians were concerned that the facility's staff were not turning and repositioning the resident as often as needed and not keeping him dry and clean. She reported the resident's brother and sister had voiced concerns to her and the physicians that staff were not turning Resident #89 frequently and the resident remained wet for long periods of time. The Complainant advised that Resident #89 required wound surgery during his hospital stay and he currently remained in the acute care hospital at the time of the interview.

On 11/28/23 at 1:00 PM, during a phone interview with the Resident Representative (RR), he explained Resident #89, who was his brother, had been in the facility for six (6) weeks and had gotten a bad wound that became septic and required surgery. He explained he stayed at the facility for long periods of time to be with brother and the staff did not turn or change him enough.

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The staff would not touch the resident for hours, and when they finally came to change him, Resident #89 would be soaked with urine. He said that his brother did not have any wounds when he was admitted to the facility and that he did not have a catheter. He explained the facility discussed inserting a catheter on the day the resident was so sick and was transported to the hospital. The RR felt like if the facility had kept his brother dry and had turned him often, he would not have gotten the PU.

A record review of the "Admission Record" revealed the facility admitted Resident #89 on 09/28/23 with diagnoses that included Traumatic Subdural Hemorrhage with Loss of Consciousness of Unspecified Duration.

A record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/5/23, revealed Resident #89 required a Staff Assessment for Mental Status and his cognition was severely impaired. A review of Section GG revealed that Resident #89 was dependent on staff for all functional abilities. A review of Section M revealed Resident #89 was at risk for developing pressure ulcers/injuries, but he did not have any unhealed pressure ulcers/injuries.

A record review of the "Braden Scale for Predicting Pressure Sore Risk", dated 9/28/23, revealed Resident #89 had a score of 12 which indicated he had a high risk of developing PUs.

A record review of the "Nursing Random Skin Sweep", dated 09/28/23, which was the date of admission to the facility for Resident #89, revealed he had skin tears to his left ear, left upper chest, and right upper chest. The

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document was signed by RN #4, the previous Wound Care Nurse. There was no documentation regarding any skin or PUs to the resident's sacrum or buttocks.

A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 9/28/23 for "Weekly skin assessments ..." Review of the report revealed there were no Physician Orders that addressed any skin issues or PU treatments to the sacrum upon Resident #89's admission date of 9/28/23.

A record review of the "Wound/Skin Log", dated 10/8/23 (Sunday), which was 10 days after the Resident #89 was admitted to the facility, revealed he had a PU to the sacrum that measured 6.5 cm x 4.0 cm x UTD. The onset date was recorded as "9/28/23" which was the date of admission and conflicted with the "Nursing Random Skin Sweep" that was completed on 9/28/23 and the Physician's Orders. This was the first documentation that referred to the PU. The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log.

A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 10/10/23 and ended on 11/8/23, for "Sacrum Pressure Injury - Clean with NS, Pat dry apply Zinc Oxide and cover with bordered gauze daily and prn ..." This order was received two (2) days after the wound/skin log, dated 10/8/23, indicated

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Resident #89 had a PU that measured 6.5 cm x 4.0 cm x UTD.

A record review of the "Weekly Skin Sweep", dated 10/12/23, revealed Resident #89 had a PU to the sacrum that measured 2.0 cm length, 1.0 cm width, and UTD for the depth. The measurements conflicted with the measurements documented on the "Wound/Skin Log" that had been completed four (4) days prior. The documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. The document was signed by RN #3, the Admission Nurse.

A record review of the "Wound/Skin Log", dated 10/16/23, revealed Resident #89 had a PU to the sacrum that measured 6cm x 4 cm x UTD, which indicated an increase in the size of the wound from the "Weekly Skin Sweep" completed on 10/12/23, which was four (4) days prior. The onset date was recorded as "9/28/23". The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log.

A record review of the "Wound/Skin Log", dated 10/23/23, revealed Resident #89 had a PU to the sacrum that measured 6.25 cm x 4 cm x UTD. The onset date was recorded as "9/28/23". The measurements indicated the wound had increased in size since the log dated 10/16/23. The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of

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potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log.

A record review of the "Wound/Skin Log", dated 11/6/23, revealed Resident #89 had a PU to the sacrum that measured 6.5 cm x 4.2 cm x UTD. The measurements indicated the wound had increased in size from the documentation on the log dated 10/23/23. The onset date was recorded as "9/28". The "Wound /Skin Log documentation did not include a description of the PU characteristics, the progress toward healing, identification of potential complications, if infections were present, or the presence of pain. There was no indication of who had completed the wound/skin log. There was an additional "Wound/Skin Log', dated 11/6/23, which indicated Resident #89 had a PU to the sacrum that measured 6.5 cm x 4.5 cm x UTD and the onset date was "9/28/23."

A record review of the "Weekly Skin Sweep", dated 11/8/23, revealed Resident #89 had a PU to the sacrum that measured 3.0 cm length, 2.0 cm width, and UTD for the depth. These measurements were inconsistent with the measurements provided two (2) days prior on the wound/skin log dated 11/6/23.

A record review of the "Order Recap Report" with "Order Date: 09/28/2023 -11/30/2023" revealed Resident #89 had a Physician's Order, dated 11/8/23, for "Sacrum Pressure Injury - clean with NS, pat dry apply Santyl/Calcium Alginate and cover with bordered gauze daily and prn ...", and a Physician's Order, dated 11/9/23, for "Low air loss mattress for sacral wound". There was a Physician Order, dated 11/13/23, to "consult skilled wound care for evaluation of sacrum

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| M 615 | Continued From page 49<br>wound ..."<br><br>A record review of a "Surgical Note", dated 11/13/23, revealed Resident #89 was seen by the Wound Care Physician. The Physician visited the resident for management of wounds located on the sacrum. The "Wound Location" was listed as "Sacrum", and the "Etiology" was listed as "Pressure injury/ulcer - Wound Stage: 4 - Pressure Injury". The note also revealed that the wound measured 6.0 cm x 4.0 cm x UTD prior to his debridement, and 6.0 cm x 4.0 cm x 0.5 cm after the debridement procedure. The wound required the Physician to perform a muscle tissue debridement with the "Preoperative Indications" listed as "Biofilm, Devitalized tissue, and Slough. There were no signs of infection. The wound description indicated that the wound had no odor and had a moderate amount of serosanguineous exudate. The Peri wound area was unhealthy and unstable. The tissue of the wound was 80% slough and 20% granulation. This was the first wound assessment that included a complete wound description of the PU characteristics, for Resident # 89, which was 36 days after the PU was first documented on the Wound/Skin Log dated 10/8/23. A low air loss mattress is recommended ..."<br><br>At 3:00 PM on 11/28/23, during an interview with the DON, she explained Resident #89 was sent to the hospital on 11/16/23 because he was in respiratory distress.<br><br>A record review of the "Internal Medicine H & P (History and Physical), dated 11/16/23, revealed Resident #9's History or Present Illness (HPI) as " ... presents from his nursing facility with fever and tachycardia (increased heart rate) ... appears to have increased work of breathing ... heart rates | M 615 | | |

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were noted to be in the 120's to 130's ..." Date review of the recent labs revealed Resident #89 had an abnormal white blood cell count. The "Physical Exam" revealed, " ...Skin: Sacral ulcer covered with bandage ..." A review of the "Assessment/Plan" revealed ... Sepsis, suspected secondary to sacral decubitus ulcer ...Bone culture with moderate growth ..." Review of the "Indication for Surgery" was necrosis (death of body tissue) and the "Procedure: sharp excisional debridement sacral wound including bone 5 x 6.5 x 3 ..."

At 8:25 AM on 11/29/23, during an interview with RN #3/Admission Nurse she confirmed that she had completed the Weekly Skin Sweep for Resident #89 on 10/12/23 and that she did not stage the PU or provide descriptive characteristics of the PU. She explained that she had assumed the wound care team would follow Resident #89, but she did not follow up to ensure he was seen by the team. She explained that the wound care team at that time consisted of LPN #1 and the Wound Care Physician. She was unable to recall what the PU looked like when she had measured it. She confirmed that she only measured the PU and did not complete or document a full assessment of the wound. She said she was unaware that the Wound Care Physician was not seeing the resident when she completed the documentation on 10/12/23.

On 11/29/23 at 3:00 PM, during an interview with the DON, she explained she was not aware that RN #3 had not assessed or staged the PU to the sacrum for Resident #89 and that the Wound Care Physician had not assessed or staged the PU for more than four (4) weeks after the PU was first identified by facility staff on 10/8/23.

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| M 615 | Continued From page 51<br><br>At 3:10 PM on 11/29/23, during an interview with the Administrator and the DON, the Administrator explained that he could not determine who had completed the Wound/Skin logs that were provided. He explained that RN #4 was the previous wound care nurse and her last day at the facility was 10/04/23. The DON and the Administrator were unable to explain the PU measurement inconsistencies of the Wound/Skin logs and the Weekly Skin Sweeps for Resident #89.<br><br>On 11/30/23 at 10:35 AM, during an interview with LPN #1, he explained when Resident #89 was admitted to the facility, he did not have any PUs. He was unable to recall how he found out that Resident #89 had a PU, but he did recall asking RN #3 to measure the wound. LPN #1 described the PU when he first saw it as measuring approximately 2 cm x 3 cm, the area was discolored, but the skin was intact. He thought the wound was classified as "Moisture Associated Skin Damage" (MASD), because whenever he provided the treatments to the sacrum, Resident #89 was soiled with urine. He stated that he had instructed CNAs that the resident needed to be kept dry, changed in a timely manner, and turned more frequently, however he did not conduct and document a formal in-service. LPN #1 said that Resident #89's family would be with the resident daily and he would talk to them regarding resident's PU, but he never completed any documentation regarding the PU. LPN #1 said that when the wound was first found, the physician was notified, and new orders were received for zinc oxide, because the skin was intact. He stated that he continued to treat the PU with zinc oxide and did not notify the Wound Care Physician that the wound size was increasing. He confirmed he had no | M 615 | | |

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documentation of the wounds, including the progression or deterioration of the wound. When he noticed the PU to the sacrum had slough, he notified the Wound Care Physician and received orders to discontinue the zinc oxide and start a new treatment. He said that he felt like the PU measurements obtained on the Random and Weekly Skin Sweeps were accurate because he assisted RN #3/Admissions Nurse when she measured the wounds. He confirmed Resident #89's wound had deteriorated and increased in size from the time it was first identified on 9/28/23 until the time he was seen by the Wound Care Physician on 11/13/23. He confirmed that on 11/13/23, the PU to the sacrum was classified as a Stage IV. LPN #1 stated that he would not have done anything differently with the resident's wound. He confirmed that Resident #89 did not have a low air loss mattress to help with pressure reduction until 11/9/23.

At 11:10 AM on 11/30/23, during an interview with the Assistant Director of Nursing (ADON), she explained she was unaware that Resident #89 had a PU because she was not involved in his care. She stated that it appeared someone dropped the ball, but she didn't know who. She explained that for a resident to develop a Stage 4 PU in less than two (2) months of admission, the resident did not receive adequate care and should have been referred to the Wound Care Physician before a month had passed, especially since the resident had comorbidities, restricted mobility, and was at a high risk for skin breakdown.

At 12:00 PM on 11/30/23, during an interview with DON, she stated she was not aware that Resident #89's PU had increased in size before the Wound Care Physician had gotten involved

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with his care.

At 12:45 PM on 11/30/23, during a phone interview with the Nurse Practitioner NP), she explained that she had not observed Resident #89's PU, but she would have if she were asked to do so. The NP stated that she reviewed the Wound/Skin Logs, but not in detail.

At 1:25 PM on 11/30/23, during a phoneinterview with the Wound Care Physician, he confirmed that he saw Resident #89 on 11/13/23 for the first time. He stated the resident was not very alert or responsive and had comorbidities, restricted mobility, a tracheostomy, and had thinning skin. He said that when he observed the PU on 11/13/23, the sacrum was noted with devitalized tissue, consisting of slough and granulation, and was unstageable due to the slough. The wound was debrided and then staged as a Stage IV PU. He understood from the wound care nurse that the PU started out as MASD, but he felt the etiology of the wound was pressure due to his restricted mobility and the resident was completely dependent upon staff for offloading. He stated that all wounds should be assessed by the facility's protocol. He said that he rounded weekly at the facility and conducted complete assessments of the wounds for residents on his list. He stated that he was available via Tele-Med and could make visits as needed to the facility.

At 1:50 PM on 11/30/23, during a phone interview with the Medical Director, he explained that he never observed Resident #89's PU. He stated he was available to the facility staff for any questions or concerns about residents and wounds. The staff usually informed him when a resident's condition worsened, and he discussed any PU or wound issues with the Wound Care Physician

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through the electronic medical records portal. He stated that wounds should be assessed daily and if there were any changes, the facility should notify the physician and document accordingly.

On 12/02/23 at 10:05 AM, during an interview with LPN #6 /Weekend Wound Care Nurse, she stated that Resident #89's PU started out with redness and then had slough in the wound. She confirmed that she did not notify the Wound Care Physician or the Attending Physician regarding the change in the wound. She stated that Resident #89 was dependent upon staff for turning and repositioning.

Review of the facility's policy, "Skin Management Standard", revised April 2021, revealed " Approach to Skin Management: Purpose: The purpose of the skin management standards is to ...assist each facility with prevention and management of wounds ... The timely identification and documentation of potential risks, implementation of preventive measurements, consistent wound care and tracking of the progress of all wounds until healed are essential ... The goals ...are to prevent the formation of pressure ulcers, promote healing and to prevent the deterioration of existing pressure ulcers ...Pressure Ulcer Risk Assessment All residents will be assessed for risk using the Braden Skin assessment tool... with change of condition... Prevention/Body Audits All residents will be checked for skin condition changes and/or alterations on a daily basis or during routine care by the certified nursing assistant. Any change in skin condition will be reported to the licensed nurse. All residents will receive a head-to-toe body audit by a licensed nurse on admission ...weekly for four weeks, upon change in condition, after newly acquired

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pressure injury and quarterly. Any change in resident's skin condition will be documented and immediately reported to the supervising nurse ... The licensed nurse is responsible for notifying the Wound Care/Treatment Nurse and/or the Director of Nursing (DON) of changes in a resident's skin condition. The Wound Care/Treatment Nurse is responsible for reviewing Body Audits at least on a weekly basis and PRN (as needed) on residents and for implementing appropriate treatment interventions, per physician order ... Skin/Wound Alert Procedure ...The nurse that evaluates the resident, based on the findings of the staff, will document the assessment in the electronic medical record and will notify the Wound Care/Treatment Nurse, physician, and responsible party of the condition ... The Director of Nursing will be notified of any resident admitted with or developing, Stage II, III, IV +/- non-stageable wound, by the Wound Care/Treatment Nurse and/or licensed nurse ...b. the physician shall evaluate the resident's wound on his/her next visit ... c. the physician will assess residents with Stage III, Stage IV and non-stageable wound routinely and as needed ... g. The Director of Nursing will assess all residents with Stage II, Stage III, Stage IV and non-stageable wounds on at least a weekly basis. Wound rounds will be conducted weekly with the DON, Wound Nurse and other assigned staff on all resident wounds to evaluate status and treatment effectiveness ...Routine Preventative Care ...1. All individuals at risk should have a systematic skin inspection at least one a week ...recommends a minimum skin check of at least weekly by a licensed nurse. Findings will be documented in the medical record ...Routine preventive interventions include ...a. an approved pressure redistribution mattress ...b. Turning and repositioning as a clinical condition dictates ...g.

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| M 615 | Continued From page 56<br><br>Incontinence management for residents with incontinence ...h. Good skin care (clean, dry skin) ...Wound Documentation Tracking ...It is the standard of this facility to monitor the status of each individual wound and provide information to the interdisciplinary team to assist determining the most appropriate treatment modalities. Procedure 1. Complete documentation of the wound assessment in the medical record, numbering each wound. 2. Utilizing the information contained in the Weekly Wound Reports review and discuss each wound individually at the weekly High-Risk Meeting ..."<br><br>The facility provided an acceptable Removal Plan on 12/4/23, in which they alleged all corrective action to remove the IJ was completed on 12/4/23 and the IJ was removed on 12/5/23.<br><br>Removal Plan<br><br>On December 1st, 2023, at approximately 3:30pm Pine Forest Health and Rehabilitation received 5 Immediate Jeopardies during an Annual and Complaint Survey from the Mississippi Department of Health Licensure and Certification and provided the facility with the Immediate Jeopardy Templates.<br><br>Brief Summary of Events:<br><br>Pine Forest Health and Rehabilitation failed to put into place appropriate interventions to ensure proper assessment, staging, treatment and clinical care plans to treat and prevent the development and worsening of new and existing pressure ulcers.<br><br>Corrective Actions: | M 615 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 25CG | A. BUILDING: _____ B. WING _____ | C 12/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE FOREST HEALTH AND REHABILITATION | 1116 FOREST AVENUE JACKSON, MS 39206 |

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| M 615 | Continued From page 57<br><br>1. An Emergency QAPI Meeting was held at approximately 12/1/2023 at 5 PM to review the cited deficient practices and to determine a root cause analysis for the lack of appropriate interventions. This meeting included the Administrator, Director of Nursing/Infection Preventionist, Medical Director, Respiratory Director, & Business Office Manager. The following items were reviewed, coordinated, and corrected to allege compliance and remove the Immediate Jeopardy. The root cause analysis determined the cause of these occurrences was the facility's failure to be properly train staff on the policies for assessing, staging, preventing, and communicating wound and skin care issues for residents who could be at risk for skin breakdown or are already noted with skin/wound breakdown.<br><br>2. The facility did a complete policy review on Care Planning Standard, Skin Management Standard, and Employee Competency Standard. The facility conducted 100% in-services and education using outsourced, Qualified Trainers and Online Software as it pertains to each department and the correlated policies pertaining to the immediate jeopardies. The facility also did a 100% inservice on all staff on the Identification and Reporting of Resident Abuse and Neglect. No individual was allowed to work beginning at approximately 7PM on 12/1/2023 until they were able to successfully complete all prescribed In-services.<br><br>3. The facility outsourced a Qualified RN Trainer to properly train with return demonstration all individuals who are responsible for the assessment, staging, and provision of wound care for the Facility. Upon completion and approximately 7:30PM on 12/1/2023, the Facility began to conduct body audits on 100% of | M 615 | | |

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| M 615 | Continued From page 58<br><br>in-house residents to determine proper assessment, staging, and treatment of wounds and finished on 12/4/2023. All noted pressure areas were assessed, staged, and determined to have a proper assessment. The wound care physician was notified of all findings and coordinated a Telehealth Visit on all residents with pre-existing wounds to confirm appropriate assessment, staging, and treatment of all existing pressure ulcers. There were no changes noted after having concluded all consult Telehealth visits. The attending physician and facility Medical Director was then notified of all Wound Care Physician's Assessments and concurred with prescribed consultation on all noted patients. Resident #53 was determined to have a pressure ulcer in an optimal condition of healing. Resident #89 remains in the hospital.<br><br>4. Both MDS Nurses were immediately trained following the QAPI Meeting regarding the ability to properly develop and/or revise resident care plans interventions for residents with pressure ulcers, ensuring those who were admitted to the facility without pressure ulcers did not acquire pressure ulcers and that existing pressure ulcers did not get worse, or residents did not develop complications from pressure wounds. After completing each Telehealth visit from Wound Care Physician and receiving noted confirmation for Medical Director/Attending Physician on all residents with Pressure ulcers, the facility began assessing and updating all care plans on 12/1/2023 and completed 12/4/2023 on coordination with development and prevention of pressure ulcers according to the prescribed orders. Resident #53 was noted to have a proper care plan regarding his healing pressure ulcer. Resident #89 remains in the hospital. | M 615 | | |

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| M 615 | Continued From page 59<br><br>5. The facility determined to move forward by having the trained Unit RN Managers conduct weekly body audits on all residents as it pertains to their individual Units A & B and report the assessment of those daily audits to the Wound Care Team, consisting of the Wound Care Physician, Treatment Nurse, MDS Nurse, and Director of Nursing. All new admits/readmitting residents will their initial assessment conducted by the Unit Manager, who will be responsible for communicating the results of the audit to the Wound Care Team, Consisting of the Wound Care Physician, Treatment Nurse, MDS Nurse and Director of Nursing. The Director of Nursing has been delegated to report the reconciliation of this weekly review in High Risk and monitored monthly for no less than 1 year by the QAPI Committee.<br><br>6. The Facility alleges compliance on 12/5/2023. The facility alleges that all corrective actions to remove the Immediate Jeopardy were completed on 12/4/2023 and the Immediate Jeopardy was removed on 12/5/2023.<br><br>The SA validated the facility's Corrective Actions on 12/5/23:<br><br>The SA validated through interviews and record review that an Emergency QAPI meeting was held on 12/01/2023 with all members in attendance.<br><br>The SA validated through interviews and record reviews all policies on Care Planning Standards, Skin Management Standards, and Employee Competency Standards were reviewed with no corrections made. The facility conducted 100% in-services and education including Identification and Reporting of Resident Abuse and Neglect. | M 615 | | |

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| M 615 | Continued From page 60<br><br>The SA validated through interviews and record reviews the facility outsourced a Qualified RN Trainer to properly train and return demonstration all individuals who are responsible for the assessment, staging, and provision of wound care for the Facility. The facility completed 100% body audits of in-house residents to determine proper assessment, staging, and treatment of wounds and finished on 12/04/23. The Wound Care Physician was notified of all findings and coordinated a Telehealth Visit on all residents with pre-exiting wounds to confirm appropriate assessment, staging, and treatment of all exiting pressure ulcers. The Medical Director was notified of all findings. Resident #53 was determined to have a pressure ulcer in an optimal condition of healing. Resident #89 remains in the hospital.<br><br>The SA validated through interviews and record reviews both MDS Nurses were immediately trained following the QAPI meeting regarding the proper development and/or revise resident care plans interventions for residents with pressure ulcers, ensuring those who were admitted to the facility without pressure ulcers did not acquire pressure ulcers and that existing pressure ulcers did not get worse, or residents did not develop complications from pressure wounds. The facility assessed and updated all care plans and completed them on 12/04/23.<br><br>The SA validated through interviews and record reviews the facility trained Unit RN Managers conduct weekly body audits on all resident as it pertains to their individual Units A and B and report the assessment of those daily audits to the Wound Care Team, consisting of the Wound Care Physician, Treatment Nurse, MDS Nurse, | M 615 | | |

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| M 615 | Continued From page 61<br>and DON. The DON has been delegated to report the reconciliation of this weekly review in High Risk and monitored monthly for no less than one (1) year by the QAPI Committee.<br><br>The SA validated through interviews and record reviews and no associate can return to work until they have received this in-service training.<br><br>The SA validated that all corrective actions were completed on 12/04/2023 and the IJ was removed as of 12/05/2023. | M 615 | | |