STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL HEALTH AND REHABILITATION CENTER	1530 BROAD AVE GULFPORT, MS 39501

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F 000	INITIAL COMMENTS The State Agency (SA) conducted four (4) Complaint Investigations (CI MS #26146, CI MS #26246, CI MS #26268, and CI MS #26447), at the facility from 9/23/24 through 10/2/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #26246 was investigated for neglect and quality of care F684 was cited. CI MS #26268 was investigated for neglect, quality of care, and pressure sores and F686, F656, and F641 was cited. CI MS #26146 was investigated for dietary services and CI MS #26447 was investigated for quality of care and there were no deficiencies cited related to those investigations. The facility held a license for 180 beds and had a census of 131 at the time of the survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for a resident with an unhealed pressure ulcer for one (1) of three (3) residents sampled residents. (Resident #1) Findings Include: A review of the facility's policy titled "MDS," revised 9/25/2017, revealed: " ...The center	F 641	This Plan of Correction does not constitute admission or agreement by the Provider of the truth, of the facts alleged or conclusions set for in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of State and Federal Laws. 1. On October 21, 2024, Minimum Data Set (MDS) Licensed Practical Nurse (LPN) reviewed and modified Resident #1	10/29/24

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

Electronically Signed | 10/25/2024

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F 641	Continued From page 1 conducts initial and periodic standardized comprehensive and reproducible assessments no less than every three months for each resident ...using the federal and/or state-required RAI (Resident Assessment Instrument) .... Each person completing a section or portion of a section of the MDS signs ...indicating accuracy ..." A record review of the "Admission Record" revealed that the facility admitted Resident #1 on 09/07/24 with diagnoses including Osteomyelitis. A record review of the "Order Summary Report" revealed Resident #1 had a wound care order for his sacrum that was dated 07/03/24. A record review of the Comprehensive MDS for Resident #1, with an Assessment Reference Date (ARD) of 07/15/24, revealed Section M0210 indicated Resident #1 did not have a PU. A record review of the "Weekly Observation Tool" for Resident #1 revealed that on 07/03/24, a sacral pressure ulcer was present. There was no other weekly wound documentation until 8/9/24. On 10/01/24 at 1:13 PM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed that there had been a significant change in Resident #1's condition on 07/15/24 due to the resident receiving dialysis. She explained the wound had not been addressed on the comprehensive MDS because there was no weekly wound report in the medical record that corresponded with the lookback period. On 10/02/24 at 1:10 PM, during an interview, the Interim Director of Nursing (I-DON) stated that if	F 641	MDS for accuracy. 2. All residents that have wounds have the potential to be affected. 3. Beginning, October 7, 2024 and ending October 25, 2024, MDS Registered Nurse (RN) reviewed MDS of residents with pressure ulcers for accuracy of MDS. 6 MDS were modified beginning October 23, 2024 and ending October 25, 2024. MDS RN, MDS LPNs were educated on facility policy Minimum Data Set by Administrator on October 23, 2024. 4. Monitoring began on October 7, 2024 by Administrator and MDS RN. Findings will be brought to Quality Assurance Improvement Committee Meeting by MDS RN on October 29, 2024. MDS RN will monitor five MDS weekly for three (3) weeks then monthly times three (3) months and quarterly for two (2) quarters. Finding will be brought to the Quality Assurance Performance Committee Meeting quarterly by MDS RN to determine effectiveness and make necessary changes as indicated.	

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F 641	Continued From page 2 charting and wound assessment tools were not completed in the resident's chart, then the information could not be captured correctly on the MDS. She confirmed that the MDS with an ARD of 7/15/24 for Resident #1 did not accurately reflect that he had a PU.	F 641		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		10/29/24

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F 656	Continued From page 3 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement care plan approaches or interventions related to wound care for three (3) of four (4) sampled residents. Resident #1, Resident #3, and Resident #4. The failure to implement care plan interventions resulted in Resident #1 acquiring a wound infection with hospitalization. Resident #1, Resident #3, and Resident #4 Findings Include: A review of the facility's policy titled "Plans of Care," with a revision date of 09/25/2017, revealed: "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements." Resident #1:	F 656	1. Care Plan for Resident #1, Resident #3 and Resident #4 were reviewed and revised as necessary by Minimum Data Set (MDS) Licensed Practical Nurse (LPN) on October 4, 2024. 2. All residents with pressure ulcers have the potential to be affected. 3. MDS Registered Nurse(RN) and Director of Nursing educated nursing staff on facility policy "Plan of Care" beginning September 26, 2023 and ending October 25, 2024. Beginning October 7, 2024 and ending October 25, 2024 Care Plans were audited and twenty-four (24) pressure ulcer care plans were updated by MDS RN and MDS LPN for residents with pressure ulcers.	

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F 656	Continued From page 4 A record review of the "Admission Record" revealed that the facility initially admitted Resident #1 on 1/30/2017 and he had current diagnoses including Osteomyelitis. A record review of the "Order Summary Report" revealed Resident #1 had a physician's order, dated 07/03/24, to cleanse the sacrum with wound cleanser, pat dry, and gently apply Medihoney and secure with large foam dressing daily. A record review of Resident #1's "Comprehensive Care Plan" revealed a focus on impaired skin integrity. The interventions and tasks included: "Cleanse sacrum with wound cleanser, pat dry, gently apply Medihoney, and secure with large foam dressing daily." A record review of Resident #1's "Electronic Treatment Administration Record (E-TAR)" for July 2024 revealed that wound care was not documented as completed on ten (10) of 28 days: July 7, 8, 10, 11, 12, 15, 20, 26, 27, and 30. A record review of Resident #1's "E-TAR" for August 2024 revealed that wound care was not documented as completed on seven (7) of 21 days: August 2, 5, 6, 7, 8, 14, and 16. Resident #3: A record review of the "Admission Record" revealed that the facility admitted Resident #3 on 12/22/21 with diagnoses including Unspecified Injury to the Cervical Spine Cord and Paraplegia. Sacrum/Right Buttocks:	F 656	4. Monitoring began on October 7, 2024 by Administrator and MDS RN. Findings will be brought to Quality Assurance Improvement Committee Meeting by MDS RN on October 29, 2024. MDS RN and / or MDS LPN will monitor five (5) Care Plans weekly for three (3) weeks then monthly times three (3) months and quarterly times two (2) quarters. Finding will be brought to the Quality Assurance Performance Committee Meeting quarterly by MDS RN to determine effectiveness and make necessary changes as indicated.	

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F 656	Continued From page 5	F 656		

A record review of Resident #3's "Comprehensive Care Plan" revealed a focus on a high risk for impaired skin integrity, with interventions and tasks including wound care for the sacrum and right buttocks daily.

A record review of the "Order Summary Report" revealed a physician's order dated 06/26/24 to "Cleanse sacrum and right buttocks with wound cleanser, pat dry gently, apply Keesler cream to excoriated area, apply ABD (abdominal gauze) pads to cover areas, and secure with an adult diaper. No tape, daily."

A record review of the "E-TAR" for July 2024 revealed wound care was not documented for Resident #3's sacral wound as completed on nine (9) out 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for Resident #3's sacral wound as completed for nine (9) of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, and 19.

Left Heel:

A record review of Resident #3's "Comprehensive Care Plan" revealed a focus on impaired skin integrity, with interventions and tasks for the left heel wound: "Cleanse with wound cleanser, pat dry, cover with xeroform ABD pad, and secure with kerlix dressing daily ...."

A record review of the "Order Summary Report" dated 06/26/24 revealed orders for wound care for the left heel to be performed daily, as detailed

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F 656	Continued From page 6	F 656		

above.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on nine (9) out of 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for Resident #3's left heel as completed for ten (10) out of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, 25, and 26.

Right Heel:

A record review of the "Order Summary Report" revealed Resident #3 had a physician's order, dated 8/12/24, for wound care daily. Further review revealed the physician's treatment order for the right heel was changed on 8/21/24 and 8/26/24.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for Resident #3's right heel as completed for: August 14, 15, 16, 17, 18, 25, and 26.

Resident #4:

A record review of the "Admission Record" revealed that the facility admitted Resident #4 on 08/07/23 with diagnoses including Type 2 Diabetes Mellitus.

Right Heel:

Record review of the "Care Plan "with a date initiated of 10/12/2023, revealed "Focus: ...has actual impairment to skin integrity ...Interventions

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F 656	Continued From page 7	F 656		

..."Cleanse right heel with wound cleanser, pat dry, apply betadine-soaked 4x4, and cover with dry dressing."

A record review of the "Order Summary Report" dated 05/21/24 revealed orders for wound care to the right heel, to be completed every other day, as detailed above.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days: July 7, 13, 21, 27, and 31.

A record review of the "E-TAR" for August 2024 revealed that wound care was not documented as completed on three (3) out of 19 days: August 2, 14, and 25.

Sacrum:

A record review of the "Comprehensive Care Plan" revealed a focus on actual impairment to skin integrity, with interventions and tasks for the sacral wound: "Cleanse sacral wound with wound cleanser, pat dry, apply barrier cream, and cover with dry dressing every 12 hours."

A record review of the "Order Summary Report" dated 05/21/24 revealed a physician's order for wound care to the sacral wound, to be completed every 12 hours.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on eight (eight) days out of thirty-one (31) days, July 7, 13, 14, 21, 26, 27, 30, and 31.

A record review of the "E-TAR" August 2024

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F 656	Continued From page 8 revealed that wound care was not documented as completed on seven (7) out of nineteen (19), August 2, 5, 7, 9, 14, 17, and 25 On 09/25/24 at 12:30 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that care plans are developed to ensure individualized care and improve consistency in resident care. She added that as a manager of several halls in the facility, she expected all nursing staff to follow the care plans. On 09/25/24 at 1:00 PM, during an interview, the Interim Director of Nursing (I-DON) confirmed that wound care for Resident #1, Resident #3, and Resident #4 was not documented as completed on several occasion as per the care plan. She emphasized the importance of following the care plans for all residents, noting that the care plans provide a personalized and effective outline of care.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide care and treatment in accordance with professional	F 684	1. Resident #2 is not currently in the facility and unable to be assessed.	10/29/24

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F 684	Continued From page 9 standards of practice, by failing to follow a Physician's Order to obtain a urinalysis and to administer an antibiotic medication promptly for one (1) of four (4) sampled residents observed. Resident #2. Findings Include: A review of the facility's policy titled "Physician Orders," revised on 03/03/2021, revealed: " ...Policy: The center will ensure that physician orders are appropriately and timely documented in the medical record." A review of the facility's policy titled "Laboratory Diagnostic and X-Ray," revised on 06/21/2021, revealed: " ...Policy: To provide guidance on ordering, obtaining, documenting and reporting laboratory, diagnostic, and x-ray results ...Procedure ...Document notification of the practitioner and resident/resident representative of results ...Laboratory work, diagnostic testing ...to be filed in the electronic medical record ..." A record review of the "Admission Record" revealed the facility admitted Resident #2 on 08/07/2024 with diagnoses including Metabolic Encephalopathy. A record review of the facility's "Physician/Prescriber" document revealed Resident #1 had a telephone Physician's Order received on 08/15/2024 at 6:00 PM for a Urinalysis (UA) with Culture and Sensitivity (C&S), given by a medical provider to Registered Nurse (RN) #1. A record review of the "Order Summary Report" revealed that on 08/17/2024, an order was	F 684	2. Any resident that has an order for a Urinalysis and new onset antibiotic has the potential to be affected. 3. Minimum Data Set Registered Nurse and Director of Nursing educated Registered Nurses and Licensed Practical Nurses on facility policy "Laboratory, Diagnostic and X-Ray" and "Physician Orders" beginning September 26, 2024 and ending October 25, 2024. Beginning October 7, 2024 and ending October 25, 2024, Director of Nursing Service completed audit on physician orders for urinalysis and timely initiation of treatment. One resident required a urinalysis to be obtained. 4. Monitoring began on October 7, 2024 by Administrator and Interim Director of Nursing. Findings will be brought to Quality Assurance Improvement Committee Meeting by Director of Nursing on October 29, 2024. Director of Nursing, Unit Manager Registered Nurse and Unit Manager Licensed Practical Nurse will monitor five (5) residents lab orders for urinalysis and timely initiation of treatment weekly for three (3) weeks then monthly times three (3) months and quarterly times two (2) quarters. Finding will be brought to the Quality Assurance Performance Committee Meeting quarterly Director of Nursing to determine effectiveness and make necessary changes as indicated.	

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F 684	Continued From page 10	F 684		

received for Levaquin 750 milligrams (mg) daily for seven (7) days to treat a UTI (urinary tract infections).

A record review of the "Order Details" for Resident #2 revealed the Physician's Order for Levaquin was entered into the electronic medical record at 2:15 PM on 8/17/2024.

A record review of the medical record revealed there was no documentation indicating that a urine sample was collected and sent to the local laboratory on 8/15/24. Nor was there any documentation indicating laboratory results from a urinalysis in the medical record for Resident #2.

During a phone interview on 09/23/2024 at 10:00 AM, Resident #2's daughter revealed that on 08/13/2024, she informed staff that her mother was complaining of burning with urination and requested a urine test be performed since her mother had a history of frequent UTIs. The daughter stated that she thought the urine test was done on 08/16/2024. She said there were new orders for antibiotics prescribed on 08/17/2024, however, she complained that the antibiotics were not started until 08/18/2024.

On 09/25/2024 at 2:00 PM, Registered Nurse #1 confirmed that on 08/15/2024 at 6:00 PM, he received a phone order from the medical provider for Resident #2 to have a urine test with C&S late on 8/15/24. He stated that he informed his supervisor, who was responsible for obtaining the urine sample and taking it to the local hospital. However, RN #1 admitted that he did not follow up with the supervisor or other nursing staff to ensure the test was completed.

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During an interview on 09/26/2024 at 9:00 AM, the Interim Director of Nursing (I-DON) confirmed there was a delay in treatment for Resident #2 because the urine test, ordered on 08/15/2024, should have been collected and sent to the local hospital promptly. The I-DON also called the lab during the survey to request a copy of the U/A results, however, the lab did not have a record that the urine sample was received. She also confirmed that when the antibiotic order was received on 08/17/2024, the medication should have been administered from the facility's Omnicell (automated dispensing cabinet) the same day instead of being delayed until 08/18/2024.

On 09/26/2024 at 9:30 AM, during an interview, Licensed Practical Nurse (LPN) #1/Supervisor she confirmed RN #1 advised her of the order for Resident #2 on 08/15/2024, and she had instructed another nurse to collect the urine sample and take it to the local hospital. She explained the nurse no longer worked for the facility. She stated she did not follow up to ensure the urinalysis was collected or that the results were obtained. LPN #1 explained that when the antibiotic was prescribed for Resident #2 on 08/17/2024, it should have been administered that day because the medication was available at the facility. LPN #1 acknowledged that there was a delay in treatment, as the medication was not given until 08/18/2024.

On 09/26/2024 at 10:00 AM, during an interview, the Nurse Practitioner (NP) stated that although the urine test results were not available, she went ahead and prescribed a broad-spectrum antibiotic, Levaquin, on 08/17/2024 while awaiting

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F 684	Continued From page 12 the results of the culture and sensitivity, which can take several days to receive. The NP confirmed that she expected the facility to administer the antibiotic the day it was ordered. During an interview on 09/26/2024 at 11:00 AM, the Administrator confirmed that the urine test and the antibiotic medications should have been completed on the days they were ordered by the prescriber. On 09/26/2024 at 11:30 AM, during an interview with the Infection Preventionist (IP), she confirmed that she worked part-time at the facility and that all supervisors assist with the antibiotic stewardship program. The IP further confirmed that the urine test should have been collected on 08/15/2024 and sent to the local laboratory, and the antibiotic prescribed on 08/17/2024 should have been administered without delay. Not giving the antibiotic until 08/18/2024 constituted a delay in treatment for Resident #2.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		10/29/24

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record review, and facility policy review, the facility failed to ensure residents received consistent pressure ulcer (PU) care and treatment, for three (3) of three (3) residents reviewed for wounds, Resident #1, Resident #3, and Resident #4, and resulted in Resident #1 acquiring a wound infection with hospitalization.

Findings Include:

A review of the facility's policy titled "Skin and Wound", revised 01/24/2021, revealed, " ...To provide a system for identifying risk and implementing resident-centered interventions to promote skin health, prevention, and healing of pressure injuries ...Skin Impairment Identification: 1. Document presence of skin impairment(s)/new skin impairment(s) when observed ..."

Resident #1:

A record review of the "Order Summary Report" revealed Resident #1 had a physician's order, dated 07/03/24 for wound care to the sacrum daily.

A record review of Resident #1's "Electronic Treatment Administration Record (E-TAR)" for July 2024 revealed that wound care was not documented as completed on ten (10) of 28 days: July 7, 8, 10, 11, 12, 15, 20, 26, 27, and 30.

A record review of Resident #1's "E-TAR" for August 2024 revealed that wound care was not documented as completed on seven (7) of 21

1. On October 2, 2024, resident #1, #3, and #4 Pressure Ulcers evaluated and weekly skin assessment completed by Registered Nurse.

2. All residents have the potential to be affected.

3. Skin observations for all residents were completed beginning on October 7, 2024 and ending October 25, 2024. All identified Pressure Ulcers were evaluated and weekly wound assessment completed October 25, 2024. Seven (7) new pressure ulcers identified and addressed.

Educated Wound Care Registered Nurse on timely completion of weekly wound observation tool on October 4, 2024 by Administrator.

Interim Director of Nursing and Director of Nursing educated all nurses on facility policy "Skin and Wound to include documentation" beginning September 26, 2024 and ending October 25, 2024.

4. Monitoring began October 7, 2024 by Administrator and Interim Director of Nursing. Findings will be brought to Quality Assurance Improvement Committee Meeting by Director of Nursing on October 29, 2024. Director of Nursing, Registered Nurse Unit Manager and Licensed Practical Nurse Unit Manager will monitor five (5) residents Wound

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F 686	Continued From page 14 days: August 2, 5, 6, 7, 8, 14, and 16. A record review of the "Wound-Weekly Observation Tool" revealed the facility had documented Resident #1's PU to the sacrum on 07/03/24 and again on 08/09/24, which was a significant gap in weekly wound documentation. The facility failed to perform weekly wound assessments or documentation, including wound measurements, characteristics, and progression of the sacral wound for the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24. A record review of the "Progress Note Details", dated 7/3/24, indicated the Nurse Practitioner (NP) assessed Resident #1 for an "Initial Wound Evaluation" for the PU to the sacral region. The NP followed up with the sacral wound on 8/21/24 and determined the wound was deteriorating and recommended the resident be sent out for possible surgical debridement due to deterioration and odor. A record review of the "History and Physical" documentation from a local hospital, dated 08/21/24, revealed Resident #1 had a "History of Present Illness" listed as Sepsis, sacral wound infection ...Assessment/Plan Goals indicated Resident #1 had sepsis and the source was listed as "sacral wound infection, stercoral colitis, possible UTI (Urinary Tract Infection)...Status post excisional debridement on 8/26/24 by general surgery..." Further review revealed he was discharged from the local hospital on 09/04/24. A record review of the "Admission Record" revealed that the facility initially admitted Resident #1 on 1/30/2017 and he had current diagnoses	F 686	Documentation weekly for three (3) weeks then monthly times three (3) months and quarterly times two (2) quarters. Finding will be brought to the Quality Assurance Performance Committee Meeting quarterly by Director of Nursing to determine effectiveness and make necessary changes as indicated.	

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including Osteomyelitis.

Resident #3:

Sacrum/Right Buttocks:
A record review of the "Order Summary Report" revealed Resident #3 had a physician's order, dated 6/26/24, for wound care daily. Further review revealed the physician's treatment order for the right buttocks/sacrum was changed on 8/26/24 for continued wound care daily.

A record review of the "E-TAR" for July 2024 revealed wound care was not documented for Resident #3's sacral wound as completed on nine (9) out 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for Resident #3's sacral wound as completed for nine (9) of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, and 19.

A record review of the "Wound-Weekly Observation Tool" revealed the facility had documented on 7/4/24 that Resident #3 had Moisture Associated Skin Damage (MASD) to the right buttocks/sacrum. The facility's next weekly wound documentation occurred on 8/13/24 in which the area was identified as a diabetic/ischemic wound and created a significant gap in documentation. The facility failed to perform weekly assessments or document wound measurements and progression for the sacral/right buttocks wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, 08/04/24, and 08/18/24.

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Left Heel:
A record review of the "Order Summary Report" revealed Resident #3 had a physician's order, dated 6/26/24, for wound care daily. Further review revealed the physician's treatment order for the left heel was changed on 8/22/24 for wound care daily.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on nine (9) out of 31 days: July 1, 5, 7, 13, 14, 26, 27, 30, and 31.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for Resident #3's left heel as completed for ten (10) out of 31 days: August 2, 7, 9, 14, 15, 16, 17, 18, 25, and 26.

A review of Resident #3's medical record revealed there were no weekly wound reports documented for the wound to the left heel until 8/13/24, in which the area was classified as "Diabetic/Ischemic". The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24.

Right Heel:
A record review of the "Order Summary Report" revealed Resident #3 had a physician's order, dated 8/12/24, for wound care daily. Further review revealed the physician's treatment order for the right heel was changed on 8/21/24 and 8/26/24.

A record review of the "E-TAR" for August 2024 revealed wound care was not documented for

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Resident #3's right heel as completed for: August 14, 15, 16, 17, 18, 25, and 26.

A record review of the "Admission Record" revealed that the facility admitted Resident #3 on 12/22/21 with diagnoses including Unspecified Injury to the Cervical Spine Cord and Paraplegia.

Resident #4:

Right Heel:
A record review of the "Order Summary Report" revealed Resident #4 had a physician's order, dated 5/21/24, for wound care to the right heel daily. Further review revealed the order changed on 8/22/24.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days: July 7, 13, 21, 27, and 31.

A record review of the "E-TAR" for August 2024 revealed that wound care was not documented as completed on three (3) out of 19 days: August 2, 14, and 25.

A review of Resident #4's medical record revealed there were no weekly wound reports documented for the wound to the right heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24.

Sacral:
A record review of the "Order Summary Report" revealed Resident #4 had a physician's order,

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dated 5/21/24, for wound care to the sacrum daily.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on eight (eight) days out of thirty-one (31) days, July 7, 13, 14, 21, 26, 27, 30, and 31.

A record review of the "E-TAR" for August 2024 revealed that wound care was not documented as completed on seven (7) out of nineteen (19), August 2, 5, 7, 9, 14, 17, and 25

A review of Resident #4's medical record revealed there were no weekly wound reports documented for the wound to the sacrum heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24.

Left Heel:
A record review of the "Order Summary Report" revealed Resident #4 had a physician's order, dated 6/14/24, for wound care to the left heel every other day.

A record review of the "E-TAR" for July 2024 revealed that wound care was not documented as completed on five (5) out of eleven (11) days, July 7, 13, 21, 27, and 31.

A record review of the "E-TAR" for August 2024 revealed that wound care was not documented as completed on four (3) out of 18 days, August 2, 14, 16, and 25.

A review of Resident #4's medical record

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revealed there were no weekly wound reports documented for the wound to left heel until 8/13/24. The facility failed to perform weekly assessments or document wound measurements and progression for the left heel wound on the weeks of 07/07/24, 07/14/24, 07/21/24, 07/28/24, and 08/04/24.

A record review of the "Admission Record" revealed that the facility admitted Resident #4 on 08/07/23 with diagnoses including Type 2 Diabetes Mellitus.

On 09/24/24 at 1:00 PM, during an interview, the Physician confirmed that weekly wound reports are required for proper wound assessment and progression tracking. He noted that the facility experienced staff changes, including the resignation of the Director of Nursing (DON) and wound nurse, which impacted the consistency of wound documentation during July 2024.

On 10/02/24 at 12:58 PM, during an interview with the Wound Nurse, she confirmed that weekly wound assessments should be documented electronically for communication and care planning. She stated this was essential for staff communication regarding different approaches to wound care and/or changes.

During an interview on 10/2/24 at 1:10 PM, the Interim-DON revealed the weekly wound observation tool guide was a very important tool to monitor wounds and wound progress. The facility staff was performing wound care on the residents, but some may have been missed with documentation. She explained the facility used the "Wound-Weekly Observation Tool" to document measurements and characteristics of

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resident wounds and that they should be completed weekly. She confirmed that Residents #1, #3, and #4 did not have consistent weekly wound documentation completed for July and August.

On 10/02/24 at 2:00 PM, during an interview with the Administrator, she acknowledged the facility's staff turnover issues in July 2024, contributed to inconsistent wound documentation. The Administrator explained that the facility had since hired a full-time wound nurse and that a Nurse Practitioner (NP) visits weekly to assess deteriorating wounds and updates care plans.

On 10/4/24 at 10:00 AM, during a post survey interview with Wound Care NP, she confirmed that the facility assigned her a list of residents with wounds to be evaluated weekly, including the wounds that have deteriorated. She explained she normally evaluated five (5) or more residents weekly. She revealed she recommends measuring the wounds in the facility weekly to determine their characteristics and size, whether they have any drainage, and whether they have gotten better or worse.