STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	627 MIDDLETON ROAD WINONA, MS 38967

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI) at the facility for seven (7) complaints, CI MS #22045, CI MS #22062, CI MS #22065, CI MS #22066, CI MS #22089, CI MS #22090 and CI MS #22119 from 7/17/23 through 7/20/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #22062 for misappropriation of property, CI MS #22065 for call lights not answered timely, staffing, CI MS #22045 for residents left wet, misappropriation of property, residents with body odor, physical environment, CI MS #22089 for physical environment, CI MS #22119 for abuse and did not cite any deficiencies. The SA investigated CI MS #22090 for services not provided and Neglect and CI MS #22066 for staffing, physical environment and neglect and cited F600, F609, F656, F684, F686 and F726. At the time of survey, the facility had a census of 102 residents and was licensed for 113 beds.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		8/20/23

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

Electronically Signed | 08/08/2023

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy/procedure review, the facility failed to protect four (4) of ten (10) residents, Resident #1, Resident #2, Resident #3 and Resident #4, from neglect as evidenced by Resident #1 did not receive wound treatments on 7/8/23, 7/9/23, 7/10/23 and on 7/17/23 and Resident #2, Resident #3, Resident #4 did not receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for "Abuse, Neglect, Exploitation & Misappropriation", last revised 11/16/2022, revealed "Neglect is the failure of the center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Interview at 10:00 AM on 7/18/23, with the Director of Nurses (DON) and Administrator, the DON stated that Resident #1 is the resident that went to the wound care center on 7/11/23 and had a dressing on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing and that Resident #1 is being sent to the Emergency Room (ER) at the local hospital for evaluation. He stayed overnight and returned to the facility on 7/12/23. The DON stated the wound care clinic said something about Resident #1's antibiotic	F 600	On 7/18/23 the Director of Clinical Services interviewed interviewable residents with orders for wound treatments to determine if there were any other residents with allegations of neglect. Based on the allegations of neglect for resident #1, #2, # 3, and # 4, Registered Nurse # 2 was terminated on 7/18/23. Residents # 1, #2, # 3, and # 4 were assessed by Director of Clinical Services on 7/18/23 with no adverse findings. Current residents with wounds/treatment orders have the potential to be affected. Abuse and Neglect education was initiated by Executive Director (ED)/Director of Clinical Services (DCS) on 7/18/23 with current staff and will be completed by 8/15/23. Education with the Executive Director (ED) and Director of Clinical Services (DCS) on 8/4/23 by Regional Director of Clinical Services (RDCS) on Abuse and Neglect with emphasis on ensuring residents with wounds/treatment orders are completed as ordered. Newly hired staff will be educated by the Director of Clinical Services on the policies and procedures that govern resident abuse and neglect, specifically to include following physician orders, resident care plans and administering wound care.	

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F 600	Continued From page 2 therapy. They had called us with culture results and our Nurse Practitioner (NP) ordered Bactrim DS times 10 days. We were training a new treatment nurse, Registered Nurse (RN) #2 on those days. The DON stated RN#2 finally admitted during the investigation that she didn't do the wound care. During this interview, the DON stated that RN#2 was in the facility. The facility was about to suspend or terminate her employment due to the new allegation of wound care not being completed the day before. The Administrator revealed he went to visit Resident #1 this morning and Resident #1 stated his wound care was not done on 7/17/23. He stated he went and let the DON know what Resident #1 had said. He then went to talk to Licensed Practical Nurse (LPN) #1 who was doing treatments on 7/18/23. She told him that when she did wound care on Resident #1 this AM that the dressing was not dated and Resident #1 stated his wound care was not done on 7/17/23. Interview with LPN #1 on 7/18/23 at 10:30 AM, revealed there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. The SA obtained a list of residents that LPN #1 had performed the 7/18/23 wound care for and had on old dressings that were dated 7/16/23. That list revealed that Resident #1 and Resident #2's dressings were not dated. These residents have a Brief Interview for Mental status (BIMS) score above 10 and are interviewable. They told LPN #1 their wound care was not done on 7/17/23. Resident #3 and Resident #4's wound dressings were dated 7/16/23. Interview with RN #2 on 7/18/23 at 11:10 AM, revealed she began employment at this facility on	F 600	A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure the prevention of abuse and neglect by staff education and interviews with residents and staff. The Director of Clinical Services, Unit Managers, and Social Worker will conduct Quality Monitoring initiating on 7/24/2023, five (5) resident interviews per week for two (2) weeks, three (3) resident interviews per week for two (2) weeks, and then three (3) resident interviews per month for six (6) months to ensure the prevention of abuse and neglect. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern abuse and neglect. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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F 600	Continued From page 3	F 600		

7/7/23. She was to "shadow" the treatment nurse over the weekend of 7/8/23, 7/9/23, and 7/10/23. She stated she was hired as the RN treatment nurse. She would do measurements and assessments of wounds weekly. She was responsible for giving the weekly measurements to the DON for the weekly wound log. She stated she has done treatments in other facilities. She stated she was becoming familiar with the supplies used by this facility, getting familiar with their computer system and that she was "assisting" the weekend treatment nurse doing treatments. "On 7/9/23, I did treatments for ½ the day. On 7/10/23, Sunday, I came in around 5:00 PM that day. The treatment nurse here that day had to leave early. The DON was in the facility and did treatments until I could get here." She stated, "On 7/10/23, I did not do treatments on him (Resident #1). I was the treatment nurse the day. My initials are not on the Treatment Administration Record (TAR). I didn't chart any treatments for Monday due to a computer problem." She then stated, "It was a couple (of treatments) I didn't do that Monday. Yes, I was the treatment nurse yesterday (7/17/23). I came in at 10:15 AM on 7/17/23. I went in as lunch was being served. Resident #1 said to wait for him to eat. I missed the time when the Certified Nurse Aides (CNA) were doing rounds for incontinent care. They help with positioning for him and other residents. His treatment didn't get done yesterday. I did not let anyone know. It was a lack of communication on my part." Regarding Resident #4, she stated, " I did not do the treatment to his right hip because he said the last dressing fell off. There was a dressing on it. He said there was an extra dressing in his room, and they put it on his wound. He didn't say who "they" were so I didn't redo the treatment." Regarding

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Resident #2, she stated, "I did not do her treatment yesterday. I was going to get the CNA's to help me with positioning. I never did. I was going to wait to go with them on their incontinent rounds and I forgot." She then confirmed, "I didn't tell anyone I had not done the treatments. I did not ask for help from another nurse."

Resident #1

Interview with Resident #1 on 7/18/23 at 10:45 AM, revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before", his wound care was not done for four (4) days. He confirmed the dates were 7/8/23, 7/9/23, and 7/10/23. He stated he went to the wound care clinic on 7/11/23, got his wound care done while at the clinic then was sent to the ER and admitted to the hospital overnight.

Record review of the Admission Record revealed the facility admitted Resident #1 on 8/25/22 with diagnoses including Peripheral Vascular Disease, Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity and Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact.

Resident #2

Interview with Resident #2 on 7/18/23 at 10:40 AM, she revealed that the "new treatment nurse"

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F 600	Continued From page 5	F 600		

came into her room yesterday, told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday. She stated the new treatment nurse had performed her wound care before and has not had a problem with her until yesterday.

Record review of Resident #2's Admission Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4.

Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact.

Resident #4

Interview with Resident #4 on 7/18/23 at 2:00 PM, revealed that his wound care was not performed on 7/17/23. He stated that his wound care has been performed daily until "yesterday". He said he asked staff several times on 7/17/23 if the treatment nurse was in the facility and staff would tell him yes but he never saw her or spoke to her. "I waited up until 10:00 PM last night on RN #2 but I went on to bed and figured she'd wake me up to do the treatment. I never spoke to RN #2 yesterday. I never even saw her."

Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4.

Record review of Resident #4's Admission MDS

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F 600	Continued From page 6 with an ARD of 7/24/23, Section C revealed a BIMS score of 12, indicating moderately impaired cognition. Resident #3 Interview on 7/18/23 at 3:15 PM, with Resident #3, he stated that his treatment was not done yesterday. Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses including Pressure Ulcer of other site, Stage 3. Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		8/20/23

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F 609	Continued From page 7 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to report an incident of neglect to the appropriate licensing agencies for one (1) of three (3) reportable incidents reviewed. Resident #1. Findings include: Record review of the facility's Policies and Procedures: Subject: Reporting Reasonable Suspicion of a Crime with revision dated 10/24/2022 revealed " ...Procedure: 3. Where an alleged violation of abuse, neglect, misappropriation of resident property, exploitation or mistreatment, including injuries will be made to the executive director, to the State Survey Agency, and to local law enforcement ..." In an interview with the Administrator and Director of Nurses (DON) on 7/18/23 at 10:00 AM, the Administrator revealed that he had not reported the incident of Resident #1 not getting wound care on 7/8/23, 7/9/23 and 7/10/23 to any of the State licensing agencies. DON stated that Resident #1 is the resident that went to the wound care center on 7/11/23 and had a dressing	F 609	On 7/18/23 at 11:48 AM, facility reported an incident of neglect to the State Agency for 1 of 3 reportable incidents reviewed. Resident #1 was assessed by the Director of Clinical Services on 7/18/2023 with no adverse findings. The Registered Nurse that failed to provide wound treatments to resident #1 was terminated on 7/18/2023. The Executive Director initiated education on reporting incidents of neglect to the State Agency on 7/21/2023. All residents have the potential to be affected. Any issues deemed reportable will be reported to State agency. Quality review was completed on 7/24/2023 by the Executive Director and Director of Clinical Services on reportable incidents over the last 30 days. The Executive Director (ED) and Director of Clinical Services were educated on 8/4/23 by Regional Director of Clinical Services on the component of reporting to the appropriate agency. Education on reporting incidents to the State Agency	

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F 609	Continued From page 8 on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing and that Resident #1 is being sent to the Emergency Room (ER) at the local hospital for evaluation. He stayed overnight and returned to the facility on 7/12/23. The Administrator stated they began an investigation, inserviced staff and did a Quality Assurance emergency meeting but did not report the incident. We were training a new treatment nurse, RN #2 on those days. When questioned she said she did that wound care. She finally admitted during the investigation that she didn't do the wound care. An interview with RN #2 on 7/18/23 at 11:10 AM, she stated "On 7/10/23, I did not do treatments on him (Resident #1). She then stated "It was a couple (of treatments) I didn't do that Monday." In an interview with Resident #1 on 7/18/23 at 10:45 AM, revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before", his wound care was not done for four (4) days. He confirmed the dates were 7/8/23, 7/9/23, and 7/10/23. Record review of the Admission Record revealed the facility admitted Resident #1 on 8/25/22 with diagnoses including Peripheral Vascular Disease, Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity and Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1	F 609	was initiated on 7/21/2023 by the Executive Director and will be completed with all current employees by 8/14/2023. Newly hired staff will be educated by the Director of Human Resources on the policies and procedures that govern reporting incidents to the State Agency. A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure that incidents deemed as reportable will be reported to the appropriate agency by staff education and interviews with residents and staff. The Director of Clinical Services, Unit Managers, and Social Worker will conduct Quality Monitoring initiating on 7/24/2023, five (5) resident interviews per week for two (2) weeks, three (3) resident interviews per week for two (2) weeks, and then three (3) resident interviews per month for six (6) months to ensure that incidents deemed as reportable will be reported to the appropriate agency. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern reporting incidents to appropriate agencies. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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F 609	Continued From page 9 was cognitively intact.	F 609		
F 656 SS=D	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 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	F 656		8/20/23

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F 656	Continued From page 10 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 interview, observations, record review and policy/procedure review, the facility failed to implement the comprehensive care plan for four (4) of ten (10) residents, Resident #1, Resident #2, Resident #3, and Resident #4, as evidenced by Resident #1 did not receive wound treatments on 7/8/23, 7/9/23, 7/10/23,and 7/17/23, and Resident #2, Resident #3, Resident #4 did not receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for "Plans of Care", last revised 9/25/2017, revealed "Procedure: Develop and implement an individualized person-centered comprehensive plan of care by the Interdisciplinary Team that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident and to the extent practicable, the participation of the resident and the resident's representative(s)	F 656	Residents # 1, # 2, #3, and # 4 Physician/Nurse Practitioner were notified that their residents care plans were not followed and treatments were not carried out as ordered on 7/18/23. Based on the allegations of the care plans were not followed and treatments were not carried out as ordered for resident #1, #2, # 3, and # 4, Registered Nurse # 2 was terminated on 7/18/23. The Director of Clinical Services re-assessed all pressure sores and updated treatment orders and care plans as needed on 7/18/23. All residents have the potential to be affected by this deficient practice. A Root Cause Analysis (RCA) was completed on 7/21/2023 by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring all resident care plans are followed. We identified one Registered Nurse did not follow the care plans and she was terminated on 7/18/2023. The Minimum Data Set (MDS) nurse and Licensed Nurses were educated on the	

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F 656	Continued From page 11 within seven (7) days after completion of the comprehensive assessment (MDS)." An interview at 10:00 AM on 7/18/23, with the Director of Nurses (DON) and Administrator, revealed the DON stated that Resident #1 is the resident that went to the wound care center on 7/11/23 and had a dressing on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing. "We were training a new treatment nurse, RN #2 on those days. She finally admitted during the investigation that she didn't do the wound care." The DON stated that care plans are supposed to be followed by all staff. An interview with Licensed Practical Nurse (LPN) #1 on 7/18/23 at 10:30 AM, revealed there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. She stated Resident #1 and Resident #2's dressings were not dated and they told LPN #1 their wound care was not done on 7/17/23. Resident #3 and Resident #4's wound dressings were dated 7/16/23. An interview with RN #2 on 7/18/23 at 11:10 AM, revealed "It was a couple (of treatments) I didn't do that Monday. I didn't tell anyone I had not done the treatments. I did not ask for help from another nurse." Resident #1 Record review of Resident #1's care plan revealed, "Focus: I have arterial ulcer to my Lateral Inferior RLE (right lower extremity), I have Arterial ulcer to my Posterior LLE (left lower	F 656	components of this regulation with emphasis on developing and implementing a care plan for residents with wounds/treatment orders by the Director of Clinical Services on 7/24/23. Newly hired licensed nurses will be educated by the Director of Clinical Services on the policies and procedures that govern care plans, following physician orders, and wound care. A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure care plans are being followed with an emphasis on resident with pressure ulcers and/or wounds. On 7/24/2023 the facility Director of Clinical Services (DCS), Minimum Data Set nurse will conduct ongoing quality monitoring of residents with wounds/treatment orders to ensure the plan of care is developed and implemented, two (2) times weekly for four (4) weeks, then one (1) time a week for four (4) weeks, then monthly for six (6) months to ensure the wounds/treatment care plans are being developed and implemented. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern care plans, following physician orders, and wound care. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions	

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F 656	Continued From page 12 extremity)...Interventions: WOUND CARE: Arterial ulcer to Lateral RLE - Cleanse with Dakins, pat dry with 4x4 gauze, cover with silvercel, Cover with ABD pad, wrap with kerlix and secure with tape daily and PRN (as needed) soiled/dislodged dressing every day shift..." and "WOUND CARE: Arterial Ulcer to Lateral LLE - Cleanse with Dakins, pat dry with 4x4 gauze, cover with silvercel wound bed followed by Maxsorb AG, Cover with ABD pad, wrap with kerlix and secure with tape daily and PRN soiled/dislodged dressing every day shift..." An interview with the Administrator on 7/18/23 at 10:00 AM revealed he went to visit Resident #1 this morning and Resident #1 stated his wound care was not done on 7/17/23. He then went to talk to Licensed Practical Nurse (LPN) #1 that was doing treatments on 7/18/23. She told him that when she did wound care on Resident #1 this AM that the dressing was not dated and he stated his wound care was not done on 7/17/23. Interview with RN #2 on 7/18/23 at 11:10 AM, She stated "On 7/10/23, I did not do treatments on him (Resident #1). I was the treatment nurse that day. Yes, I was the treatment nurse yesterday (7/17/23). His treatment didn't get done yesterday. I did not let anyone know. It was a lack of communication on my part." An interview with Resident #1 on 7/18/23 at 10:45 AM, revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before", his wound care was not done for four (4) days. He confirmed the dates were 7/8/23, 7/9/23, and 7/10/23. Record review of the Admission Record revealed	F 656	are sustained.	

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F 656	Continued From page 13	F 656		

the facility admitted Resident #1 on 8/25/22 with diagnoses including Peripheral Vascular Disease, Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity and Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact.

Resident #2

Record review of Resident #2's care plans revealed each Pressure Ulcer is care planned to "administer treatments as ordered and monitor for effectiveness."

An interview with Resident #2 on 7/18/23 at 10:40 AM, she revealed that the "new treatment nurse" came into her room yesterday, told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday.

Interview with RN #2 on 7/18/23 at 11:10 AM, regarding Resident #2, she stated, "I did not do her treatment yesterday.

Record review of Resident #2's Admission Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4.

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Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact.

Resident #3

Record review of the care plan revealed, "Focus: I have a Stage 3 pressure ulcer to my left lateral distal foot...Interventions...Administer treatments as ordered and monitor for effectiveness...WOUND CARE: Cleanse stage 3 to Left lateral distal foot with wound cleanser or NS (normal saline), pat dry with 4x4 gauze, apply calcium alg AG, and bordered dressing daily and prn soiled/dislodged dressing every day shift..."

An interview on 7/18/23 at 3:15 PM with Resident #3 he stated that his treatment was not done yesterday.

Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses including Pressure Ulcer of other site, Stage 3.

Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.

Resident #4

Record review of Resident #4's care plan revealed, "Focus: I was admitted with a stage 4 pressure ulcer to my right trochanter...Interventions:... administer treatments as ordered and monitor for effectiveness."

An interview with RN #2 on 7/18/23 at 11:10 AM,

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F 656	Continued From page 15 regarding Resident #4, she stated, "I did not do the treatment to his right hip." An interview with Resident #4 on 7/18/23 at 2:00 PM, revealed that his wound care was not performed on 7/17/23." Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4. Record review of Resident #4's Admission MDS with an ARD of 7/24/23, Section C revealed a BIMS score of 12, indicating moderately impaired cognition.	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 interview, record review, observation and policy/procedure review, the facility failed to provide needed care and services in accordance with professional standards of practice for one (1) of ten (10) sampled residents, Resident #1, as evidenced by Resident #1 did not receive wound treatments on 7/8/23, 7/9/23, 7/10/23, and 7/17/23.	F 684	Residents #1 Physician was notified on 7/18/2023 that his wound care/treatment orders were not carried out as ordered on the following days 7/8/2023, 7/9/2023, 7/10/23. and 7/17/2023. Based on the allegations the wound care/treatment orders were not followed and treatments were not carried out as ordered for	8/20/23

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F 684	Continued From page 16 Findings include: Record review of a statement on facility letterhead and signed by the Administrator revealed, "We do not have a specific policy on "Following Physician Orders"." This was undated. Record review of the facility's policy/procedure for "Plans of Care", last revised 9/25/2017, revealed "Procedure: Develop and implement an individualized person-centered comprehensive plan of care by the Interdisciplinary Team..." On 7/18/23 at 10:00 AM, in an interview with the Director of Nurses (DON) and Administrator, the DON revealed that Resident #1 went to the wound care center on 7/11/23 with a dressing on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing and that Resident #1 is being sent to the Emergency Room (ER) of the local hospital for evaluation. He stayed overnight and returned to the facility on 7/12/23. We were training a new treatment nurse, RN #2 on those days. She admitted during the investigation that she didn't do the wound care. The facility was about to suspend or terminate her employment due to the new allegation of wound care not being completed the day before. The Administrator went to visit Resident #1 this morning and Resident #1 stated his wound care was not done on 7/17/23. He then went to talk to Licensed Practical Nurse (LPN) #1 that was doing treatments on 7/18/23. She told him that when she did wound care on Resident #1 this AM that the dressing was not dated and he stated his wound care was not done on 7/17/23.	F 684	resident #1, Registered Nurse #2 was terminated on 7/18/23. The Director of Clinical Services re-assessed all pressure sores and updated treatment orders and care plans as needed on 7/18/23. All residents have the potential to be affected by this deficient practice. A Quality Review of current residents with pressure ulcers was conducted by the Director of Clinical Services/Unit Manager on 7/18/23 and 7/19/23 to ensure treatment and services are provided to prevent the development or worsening of pressure ulcers and to promote wound healing. A Root Cause Analysis (RCA) was completed on 7/21/2023 by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring all residents with pressure ulcers/wound treatment orders are being carried out per physician order. We identified one Registered Nurse did not follow physician orders and/or carry out ordered treatments to resident #1. She was terminated on 7/18/2023. On 7/18/23, the Director of Clinical Services and Treatment nurse began education with nursing staff on the components of this regulation with emphasis on providing necessary treatment for prevention and healing of pressure ulcers. Newly hired licensed nurses will be educated by the Director of Clinical Services on the policies and procedures that govern care plans, following physician orders, and wound care.	

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F 684	Continued From page 17 On 7/18/23 at 10:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that Resident #1's dressing was not dated and he said his wound care had not been done on 7/17/23. On 7/18/23 at 11:10 AM, in an interview with RN #2 she stated "On 7/10/23, I did not do treatments on him (Resident #1). I was the treatment nurse the day. Yes, I was the treatment nurse yesterday (7/17/23). His treatment didn't get done yesterday. I did not let anyone know. It was a lack of communication on my part." On 7/18/23 at 10:45 AM, during an interview with Resident #1 he revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before", his wound care was not done for four (4) days. He confirmed the dates were 7/8/23, 7/9/23, 7/10/23. Record review of the Admission Record revealed the facility admitted Resident #1 on 8/25/22 with diagnoses including Peripheral Vascular Disease, Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity and Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity. Record review of the Treatment Administration Record for July 2023 revealed wound care as "Arterial ulcer to Lateral RLE cleanse with Dakins, pat dry with 4x4 gauze, cover with silvercel, Cover with ABD pad, wrap with kerlix and secure with tape daily and PRN..." and "Arterial Ulcer to Lateral LLE - Cleanse with Dakins, pat dry with 4x4 gauze, apply sivercel wound bed followed by Maxsorb AG, Cover with ABD pad, wrap with kerlix and secure with tape daily and PRN...."	F 684	A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure pressure ulcer/wound care is being provided for per physician orders. On 7/24/2023 the facility Director of Clinical Services (DCS), and Unit Managers will conduct ongoing quality monitoring of residents with wounds/treatment orders to ensure the treatments are being carried out per physician orders, two (2) times weekly for four (4) weeks, then one (1) time a week for four (4) weeks, then monthly for six (6) months to ensure the wounds/treatment are being carried out per physician orders. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern care plans, following physician orders, and wound care. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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F 684	Continued From page 18 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact.	F 684		
F 686 SS=D	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 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, observations, record reviews and policy/procedure review, the facility failed to ensure that three (3) of 10 sampled residents received the necessary treatment and services, consistent with professional standards of practice for pressure ulcers, as evidence by Resident #2, Resident #3, Resident #4 did not receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for	F 686	Residents #2, #3, and #4 Physician/Nurse Practitioner were notified that their residents wound care/treatment orders were not carried out as ordered on 7/18/23. Based on the allegations the wound care/treatment orders were not followed and treatments were not carried out as ordered for resident #2, # 3, and # 4, Registered Nurse # 2 was terminated on 7/18/23. The Director of Clinical Services re-assessed all pressure sores and updated treatment orders and care plans as needed on 7/18/23.	8/20/23

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F 686	Continued From page 19 "Skin and Wound", with a revision date of 1/24/2022 revealed "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure ulcers..." Licensed Practical Nurse (LPN) #1 reported during an interview on 7/18/23 at 10:30 AM, there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. The SA obtained a list of residents that LPN #1 had performed the 7/18/23 wound care for and had on old dressings that were dated 7/16/23. The list indicated that Resident #2's wound dressings were not dated current. Resident # 2 told LPN #1 wound care was not done on 7/17/23. Resident #3 and Resident #4's wound care dressings were dated 7/16/23. Resident #2 During an observation and interview with Resident #2 on 7/18/23 at 10:40 AM, revealed that the "new treatment nurse" came into her room yesterday, told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday. She stated the new treatment nurse had performed her wound care before and has not had a problem with her until yesterday. Observations of wound care with RN #1 on 7/19/23 at 10:45 AM, revealed multiple wounds. There are treatments for 4 wounds on her sacral, coccyx and bilateral buttocks but upon observation, there are 3 wounds noted. This was	F 686	All residents have the potential to be affected by this deficient practice. A Quality Review of current residents with pressure ulcers was conducted by the Director of Clinical Services/Unit Manager on 7/18/23 and 7/19/23 to ensure treatment and services are provided to prevent the development or worsening of pressure ulcers and to promote wound healing. A Root Cause Analysis (RCA) was completed on 7/21/2023 by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring all residents with pressure ulcers/wound treatment orders are being carried out per physician order. We identified one Registered Nurse did not follow physician orders and/or carry out ordered treatments to resident #2, #3, and #4. She was terminated on 7/18/2023. On 7/18/23, the Director of Clinical Services and Treatment nurse began education with nursing staff on the components of this regulation with emphasis on providing necessary treatment for prevention and healing of pressure ulcers. Newly hired licensed nurses will be educated by the Director of Clinical Services on the policies and procedures that govern care plans, following physician orders, and wound care. A Quality Assurance Improvement (QAPI) meeting was held on 7/21/2023 to ensure pressure ulcer/wound care is being provided for per physician orders. On	

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F 686	Continued From page 20 confirmed by RN #1. The wound on the coccyx is a Stage 4. It measures 5.0 cm L (centimeters/length) x (by) 6.0 cm W (width) x 7.4 cm D (depth). The wound bed is beefy in color. The right buttock inferior is a Stage 2 and measures 14.0 cm L x 8.7 cm W x 0.0 cm D. The left buttock wound is a Stage 2 and measures 4.2 cm L x 3.4 cm W x 0.0 cm D. She stated she is not going to do the treatment to the left heel due to that area is healed. She stated she is going to talk to the Medical Doctor (MD) or Nurse Practitioner (NP) to get the order discontinued due to it being healed at this time. She stated it was a Deep Tissue Injury that had a treatment begin on 7/4/23. Interview with RN #2 on 7/18/23 at 11:10 AM, stated, "I did not do her treatment yesterday. She gets Betadine on her foot, I believe. I was going to heal her wound today. I was going to get the CNA's to help me with positioning. I never did. I was going to wait to go with them on their incontinent rounds and I forgot." Record review of the wound care orders were to "Clean Stage 4 to coccyx with wound cleanser or NS (normal saline), pat dry with 4x4 gauze, pack wound with wet-dry dakins kerlix, cover with dry dressing daily and PRN (as needed). Cleanse Stage 4 to left buttock/sacrum with wound cleanser or NS (Normal Saline), pat dry with 4x4 gauze, apply CA+ alg AG (Calcium Alginate), cover with dry dressing daily and PRN (as needed). Cleanse Stage 2 to right buttock (inferior) with wound cleanser or NS, pat dry with 4x4 gauze, apply CA+ alg AG, cover with dry dressing daily and PRN. Record review of Resident #2's Admission	F 686	7/24/2023 the facility Director of Clinical Services (DCS), and Unit Managers will conduct ongoing quality monitoring of residents with wounds/treatment orders to ensure the treatments are being carried out per physician orders, two (2) times weekly for four (4) weeks, then one (1) time a week for four (4) weeks, then monthly for six (6) months to ensure the wounds/treatment are being carried out per physician orders. Staff education will be completed monthly beginning on 8/10/2023 to the policies and procedures that govern care plans, following physician orders, and wound care. On 8/15/2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4.

Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact.

Resident #3

Observation and interview on 7/18/23 at 3:15 PM, with Resident #3 stated that his treatment was not done yesterday. Wound care observation revealed the wound is a Stage 3 on his left lateral foot. The measurements observed by the SA were 0.5 cm L x 0.3 cm W x 0.0 cm D.

Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses that included Stage 3 pressure ulcer to left lateral distal foot.

Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.

Record review of the Order Summary Report with active orders as of 7/20/23 revealed "Wound Care: Cleanse stage 3 to left lateral distal foot with wound cleanser or NS, Pat dry with 4x4 gauze, apply calcium alg AG, and bordered dressing daily and PRN every day shift."

Resident #4

RN #2 stated in an interview on 7/18/23 at 11:10 AM, regarding Resident #4, "I did the wound care

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on his toe on the left foot. The wound under his arm is healed and I don't think there is a treatment ordered. I did not do the treatment to his right hip because he said the last dressing fell off. There was a dressing on it. He said there was an extra dressing in his room, and they put it on his wound. He didn't say who 'they' were. So, I didn't redo the treatment."

Observations and interview on 7/18/23 at 2:00 PM, of Resident #4's wound care performed by RN#1 being assisted by RN #3 revealed Resident #4 has multiple wounds. The right hip Stage 4 pressure ulcer measured 5.0 cm L x 5.7 cm W with tunneling between 2:00-3:00 o'clock measured 1.4 cm D. The wound on his left medial foot is below his great toe measured 3.8 cm L x 2.4 cm W x 0.0 cm D. Hyper granulation is noted. Resident #4 revealed that his wound care was not performed on 7/17/23. He said he asked staff several times on 7/17/23 if the treatment nurse was in the facility and staff would tell him yes but he never saw her or spoke to her. "I waited up until 10:00 PM last night on RN #2 but I went on to bed and figured she'd wake me up to do the treatment. I never spoke to RN #2 yesterday. I never even saw her."

Record review of the Order Summary Report with active orders as of 07/20/23 revealed "Wound Care: Clean Stage IV (4) abrasion to Right Trochanter with wound cleanser or normal saline and gauze daily: dry the peri-wound skin and place skin proctetant...Place santyl on slough of wound base;Dampen non-stretch gauze with 1/4 strength Dakin's solution and fan to cover wound bed ONLY;fill the volume of the wound with FLUFFED (not stuffed) with the least amount of gauge. Cover with ABD pad and secure. Wound

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F 686	Continued From page 23 Care: Cleanse abrasion to left medial foot below great toe with wound cleanser or normal saline daily and PRN;cover with meplix dressing every day shift..." Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4. Record review of the MDS with an ARD of 7/24/23 revealed a BIMS score of 12 which indicated Resident #4 had moderate cognitive impairment.	F 686		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		8/20/23

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F 726	Continued From page 24 implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy/procedure review the facility failed to ensure staff provided competent care as ordered by the physician for four (4) of ten (10) residents. Resident #1 did not receive wound treatments on 7/8/23, 7/9/23, 7/10/23 and on 7/17/23 and Resident #2, Resident #3, and Resident #4 did not receive their pressure sore treatments on 7/17/23. Findings include: Record review of the facility's policy/procedure for "Skin and Wound", last revised 1/24/2022 revealed "...To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries..." During an interview on 7/18/23 at 10:00 AM, with the Director of Nurses (DON) and Administrator, the DON stated that Resident #1 went to the wound care center on 7/11/23 and had a dressing on his wound dated 7/7/23. She stated that the wound care clinic contacted her letting her know the date on the dressing and that Resident #1 was being sent to the Emergency Room (ER) at (Name of local hospital) for evaluation. He stayed	F 726	Root Cause Analysis (RCA) was completed by the Quality Assurance Improvement (QAPI) Committee on 7/18/23. Based on findings, the facility failed to ensure facility had sufficient nursing staff with the appropriate competencies and skill sets to care for residents' needs as identified through resident assessments, and described in the plan of care for Resident #1, #2, #3, and #4. Registered Nurse # 2 was terminated on 7/18/23. The Director of Clinical Services re-assessed all pressure sores and updated treatment orders and care plans as needed on 7/18/23. Wound care was provided on 7/18/23 to residents #1, #2, #3, and #4 by Treatment nurse with no adverse findings. All residents have the potential to be affected by this alleged deficient practice. On 7/24/23, Executive Director and Director of Clinical Services conducted Quality Review of facility process to determine competencies needed. Education for all licensed nurses was initiated on 7/18/2023 on skin and wound	

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F 726	Continued From page 25 overnight and returned to the facility on 7/12/23. When the State Agency (SA) questioned the DON about RN #2, she said she did that wound care. She finally admitted during the investigation that she didn't do the wound care. During this interview, the DON stated that the facility was about to suspend or terminate her employment due to the new allegation of wound care not being completed the day before. The Administrator stated he went to visit Resident #1 this morning and Resident #1 stated his wound care was not done on 7/17/23. He then went to talk to Licensed Practical Nurse (LPN) #1 that was doing treatments on 7/18/23. She told him that when she did wound care on Resident #1 this morning that the dressing was not dated and Resident #1 stated his wound care was not done on 7/17/23. During an interview on 7/18/23 at 10:30 AM, LPN #1 reported there were other residents that had dressings dated for 7/16/23 and not 7/17/23 as she anticipated she would see on the morning of 7/18/23. The SA obtained a list of residents that LPN #1 had performed the 7/18/23 wound care for and had on old dressings that were dated 7/16/23. The list indicated that Resident #1 and Resident #2's wound dressings were not dated current. In an interview with RN #2 on 7/18/23 at 11:10 AM, revealed she began employment at this facility on 7/7/23. She was to "shadow" the treatment nurse over the weekend of 7/8/23, 7/9/23, and 7/10/23. She stated she was hired as the RN treatment nurse. She would do measurements and assessments of wounds weekly. She was responsible for giving the weekly measurements to the DON for the weekly wound log. She stated she was "assisting" the	F 726	guidelines on with pre/post testing, with score of 80% deemed as passing. Education was initiated on 7/24/23 by the Regional Director of Clinical Services to provide education to Director of Clinical Services (DCS) and Unit Managers to ensure competent staff is adequate to provide necessary care for residents' needs. Newly hired licensed nurses will complete skills training during orientation. Beginning on 7/24/23, Director of Clinical Services and Unit Managers will conduct quality improvement monitoring of four (4) licensed nurses for competency skills a week for 4 weeks, then three (3) licensed nurses a week for 4 weeks, then two (2) licensed nurses a week for (four (4) weeks, then one (1) licensed nurse a month for six (6) months. On 8-15-2023 we will conduct a QAPI meeting to review our findings from our Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the third Thursday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six (6) months to ensure our solutions are sustained.	

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weekend treatment nurse doing treatments. "On 7/9/23 I did treatments for ½ the day. On 7/10/23, Sunday, I came in around 5:00 PM that day. The treatment nurse here that day had to leave early. She stated, "On 7/10/23, I did not do treatments on him (Resident #1). I was the treatment nurse that day. My initials are not on the Treatment Administration Record (TAR). I didn't chart any treatments for Monday due to a computer problem. It was a couple of treatments I didn't do that Monday. I was the treatment nurse yesterday (7/17/23). His treatment didn't get done yesterday. I did not let anyone know. It was a lack of communication on my part. I did look at his legs and both dressings were on. I didn't check the dates on the dressings but they were not soiled through."

Resident #1
During an interview with Resident #1 on 7/18/23 at 10:45 AM, revealed that he did not have wound care performed on 7/17/23. He also confirmed that on the "weekend before" his wound care was not done. He confirmed the dates his wound care was not completed were 7/8/23, 7/9/23 and 7/10/23.

Record review of the Admission Record revealed Resident #1 was admitted to the facility on 8/25/22 with diagnoses the included Peripheral Vascular Disease and Unspecified atherosclerosis of native arteries of extremities, bilateral legs.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was cognitively intact.

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Resident #2

On 7/18/23 at 10:40 AM, during an interview with Resident #2 revealed that the "new treatment nurse" came into her room yesterday and told Resident #2 she'd be back to do her wound care and never returned. Resident #2 confirmed that her wound care did not get done yesterday. She stated the new treatment nurse had performed her wound care before and has not had a problem with her until yesterday.

In an interview with RN #2 on 7/18/23 at 11:10 AM, RN #2 revealed "I did not do her treatment yesterday. She gets Betadine on her foot, I believe. I was going to heal her wound today. I was going to get the CNA's to help me with positioning. I never did. I was going to wait to go with them on their incontinent rounds and I forgot." She then confirmed, "I can't remember anyone else's treatment I didn't do. I didn't tell anyone I had not done the treatments. I did not ask for help from another nurse."

Record review of Resident #2's Admission Record revealed an admit date of 3/13/23. She admitted with diagnoses including Pressure Ulcer of Sacral Region, Stage 4, Pressure Ulcer of Right Buttock, Stage 2 and Pressure Ulcer of Left Buttock, Stage 4.

Record review of the MDS with an ARD of 6/12/23 revealed a BIMS score of 15 which indicated Resident #2 was cognitively intact.

Resident #3

Interview on 7/18/23 at 3:15 PM, with Resident #3

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revealed that his treatment was not done yesterday.

Record review of the Admission Record revealed Resident #3 was admitted to the facility on 8/5/21 with diagnoses that included Stage 3 pressure ulcer to left lateral distal foot.

Record review of the MDS with an ARD of 6/22/23 revealed a BIMS score of 15 which indicated Resident #3 was cognitively intact.

Resident #4

During an interview with RN #2 on 7/18/23 at 11:10 AM, regarding Resident #4, she stated, "I did not do the treatment to his right hip because he said the last dressing fell off. There was a dressing on it. He said there was an extra dressing in his room, and they put it on his wound, He didn't say who 'they' were. So I didn't redo the treatment."

During an interview with Resident #4 on 7/18/23 at 2:00 PM, revealed that his wound care was not performed on 7/17/23. He said he asked staff several times on 7/17/23 if the treatment nurse was in the facility and staff would tell him yes but he never saw her or spoke to her. "I waited up until 10:00 PM last night on RN #2 but I went on to bed and figured she'd wake me up to do the treatment. I never spoke to RN #2 yesterday. I never even saw her."

Record review of the Admission Record revealed Resident #4 was admitted to the facility on 7/13/23 with diagnoses that included Pressure ulcer of right hip, Stage 4.

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F 726	Continued From page 29 Record review of the MDS with an ARD of 7/24/23 revealed a BIMS score of 12 which indicated Resident #4 had moderate cognitive impairment.	F 726		