| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0018954 | A. BUILDING: _____ B. WING _____ | C 07/19/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **AASHIYANA FAMILY CARE LLC UNIT A** | **2900 RUSSET STREET UNIT A RACINE, WI 53405** |

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| M 000 | INITIAL COMMENTS<br><br>On 07/19/2023, Surveyor concluded a complaint investigation at Aashiyana Family Care LLC Unit A.<br>One complaint was substantiated.<br>One deficiency was identified.<br><br>Census: 4 | M 000 | | |
| M 448 | 88.07(2)(b)5 MONITORING HEALTH<br><br>Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review the provider did not ensure health monitoring for 1 of 1 resident by observing and documenting changes in Resident 1's health. Resident 1 was discharged on 05/24/2023 from the Adult Family Home (AFH) following a 05/23/2023 readmission to an area hospital due to deterioration in his/her physical health and increased disorientation. The provider did not document Resident 1's status during his/her deterioration.<br><br>Findings include:<br><br>On 05/24/2023, the department received a complaint alleging the provider did not monitor the change in condition of a resident.<br><br>On 06/22/2023 at 12:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was initially admitted to the AFH on 01/05/2023. The admission Face Sheet listed diagnoses including | M 448 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| M 448 | Continued From page 1 | M 448 | | |

acute renal failure on dialysis, end stage chronic renal failure, anemia of renal disease, chronic kidney disease (stage 1), colon injury unspecified site, with open wound into cavity, left ischial pressure sore, open fracture of lumbar spine with spinal cord injury (l3-4 with paraplegia), pancreatic injury, right ischial pressure sore, duodenal injury, and vascular injury. Resident 1's admission orders from a 07/06/2022-01/05/2023 hospitalization leading to the initial AFH admission included a hospital bed, kidney dialysis, and home health care to provide wound care.

Resident 1's record contained a discharge summary from Resident 1's 03/03/2023-04/03/2023 hospitalization that included the diagnoses: decubitus ulcer of the sacral region, pressure injury of the buttock (stage 4), pressure injury of deep tissue of left foot, pressure injury of left foot (stage 3), pressure injury of left heel (stage 3), pressure injury of right foot (stage 3), pressure injury of right heel (stage 4), and right ischial pressure sore, unspecified pressure ulcer stage. In the section describing Resident 1's skin, the summary stated, "Looks to be non stageable [sic] sacral pressure wound with some serosanguineous (yellowish with some blood present) type drainage present does smell foul necrotizing fasciitis or cellulitis present."

On 06/22/2023 at 12:30 PM, Surveyor interviewed Licensee A. Licensee A stated that much of the reason Resident 1's pressure wounds became so severe was due to his/her noncompliance. Licensee A stated at times Resident 1 was rude to staff at the AFH, including Licensee A. At times Resident 1 would call staff names and refuse cares. Licensee A added that

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|---|---|---|---|---|
| M 448 | Continued From page 2 | M 448 | | |

there were occasions when Resident 1 was told by Wound Care (WC) Registered Nurse (RN) L to not to get the freshly bandaged wounds wet, but after RN L left, Resident 1 showered. Licensee A stated that part of Resident 1's wound care was time on a "wound vac," but, at times, when it was supposed to be functioning, staff would find it unplugged or turned off. Licensee A thought it was Resident 1 who turned the machine off or unplugged it. Licensee A believed Resident 1 exacerbated the wounds by using his/her slide board for self-transfers despite being advised to stop using it because of the added pressure it caused on the wounds.

Licensee A stated Resident 1's skin assessments were in the Initial Assessment, and RN L was responsible for ongoing assessments and monitoring of Resident 1's wounds. Surveyor asked if any wound care records were kept onsite, and Licensee A reported RN K was responsible for completion of ongoing skin assessments and did not leave any at the home for Resident 1's record. Licensee A stated that other outside providers left documentation for care coordination, but RN L had not. Licensee A stated s/he should have insisted RN L leave copies of documentation of cares provided and Resident 1's status at the AFH.

Licensee A stated Resident 1 was served with a 30 day notice twice while living at the AFH due to his/her noncompliance, disrespectful interactions with staff, and illegal drug use at the AFH. The first notice was rescinded after Licensee A's business partner convinced Licensee A to give Resident 1 another chance to improve his/her behavior. Licensee A added the second notice was served to Resident 1 on 06/22/2023 and agreed to provide a copy of the notice to

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|---|---|---|---|---|
| M 448 | Continued From page 3<br>Surveyor.<br><br>"A wound vac is a device that drains seeping liquid from a wound such as bed sores by forming an airtight cover and pumping the liquid out. Wound vacs can reduce the incidence of infection and aid in the healing process." (Source: Nursing Home Law Center Website, General Articles About Bedsores: https://www.nursinghomelawcenter.org/what-is-a-wound-vac-and-how-does-it-work.html (Retrieval date - 07/20/2023).)<br><br>On 06/22/2023 at 4:30 PM, Surveyor reviewed the 30-day notice given to Resident 1. The notice consisted of an email sent from Licensee A to Case Manager (CM) M on 04/20/2023 at 11:50 AM. The notice stated in part: "So As [sic] of 04/20/2023 [s/he] gets 30 days notice to move out. If [s/he] does have hospitalization in between, I will not take [him/her] back."<br><br>On 06/22/2023 at 3:58 PM, Surveyor interviewed RN L. RN L disagreed with Licensee A's assessment of Resident 1 and added Resident 1 was generally cooperative during wound care visits. RN L stated the wound care visits were once or twice daily when Resident 1 was initially admitted to wound care services. Eventually the wounds improved enough the physician reduced the frequency of visits prior to Resident 1's deterioration and hospitalization. RN L stated s/he believed Resident 1's noncompliance with cares was only partially responsible for his/her deterioration and a lack of cleanliness in Resident 1's room contributed to the infection in the wounds. RN L described an incident when s/he walked into Resident 1's room and observed Resident 1's colostomy without a bag to catch the feces as it dripped out onto uncovered wounds. | M 448 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| M 448 | Continued From page 4 | M 448 | | |

RN L observed feces on Resident 1's body, clothing, possessions, and the floor of the room. S/He stated Licensee A claimed no responsibility for obtaining ostomy bags. Licensee A informed RN L it was CM M's responsibility to order the colostomy supplies and Resident 1's responsibility to perform the colostomy cares. RN L added s/he believed there may have been a personality conflict between Resident 1 and Licensee A which contributed to Resident 1's disrespectful behavior toward Licensee A. RN L informed Surveyor the 30-day notice Resident 1 received included the warning if Resident 1 was hospitalized prior to moving out, Resident 1 would not be readmitted. RN L believed this led to Resident 1's resistance to seeking medical care as his/her condition deteriorated.

On 06/23/2023 at 11:00 AM, Surveyor reviewed Resident 1's Admission Assessment, dated 01/10/2023. The section titled "Chronic Illnesses" stated, "Resident's Needs/Preferences: Has chronic illness(es) that require proper treatment and management. [S/He] has few pressures sore injuries that require attention from the nurse. [S/He] will be having home health nurse come to the facility for dressing change. [S/He] is also on dialysis three times a week (M,W,F). [S/He] also does Stright [sic] Cath twice a day on [his/her] own. Resident's Desired Goals & Outcomes: Continue and enjoy desired activities and daily functions as conditions allow. Service Provider Responsibilities: Outside agency RN Measurable Goals, Outcomes and Review: Maintain or improve [his/her] current health." The section titled "Nursing Procedures" stated, "Resident's Needs/Preferences: Wound care to [his/her] bottom, legs and feet. Resident's Desired Goals & Outcomes: To get rid off [sic]them and live with pain free life. Service Provider Responsibilities:

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|---|---|---|---|---|
| M 448 | Continued From page 5<br>RN from the home health agency. Measurable Goals, Outcomes and Review: (This was blank)."<br><br>On 06/23/2023 at 11:05 AM, Surveyor reviewed Resident 1's Individual Service Plan (ISP.) The section's titled "Chronic Illnesses" and "Nursing Procedures" repeated what was stated in the Initial Assessment and added that both subjects were the responsibility of an "Outside agency RN (Registered Nurse)." There was no specific section covering Resident 1's wound care or monitoring his/her skin condition. There were no ISP updates provided to Surveyor.<br><br>On 06/23/2023 at 11:10 AM, Surveyor reviewed Resident 1's 'Observation Notes' completed by multiple caregivers at the AFH. They included the following:<br><br>05/13/23 at 1:00 AM Caregiver B wrote: "Upon my arrival [Resident 1] was in [his/her] room trying to find something on tv i [sic] asked if [s/he] needed anything [s/he] did not. i [sic] folded [his/her] clothes and swepted [sic] out [his/her] room.<br>05/13/23 at 6:30 PM Caregiver C wrote: "upon [sic] my arrival [Resident 1] was in room watching tv [s/he] did not feel good all day [s/he] kept throwing up [s/her] kept falling to sleep in random places"<br>05/14/23 at 8:00 AM Caregiver B: "upon [sic] my arrival [Resident 1] was laying down in [his/her] bed sleep"<br>05/14/23 at 3:45 PM Caregiver D wrote: "upon [sic] my arrival [Resident 1] was sleeping [his/her] [family member] came to visit i [sic] washed [his/her] bedding [s/he]'s outside with the other residents and co workers [sic]"<br>05/15/23 at 9:15 AM Caregiver E wrote: "[Resident 1] ran out of bags, woke up in a panic | M 448 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| M 448 | Continued From page 6 | M 448 | | |

due to having no more bags and trying to figure out what we were going to do, called [Licensee A] and [s/he] said to call [his/her] case manager because [s/he] is [his/her] own person and there is nothing [s/he] can do about that. I blew [his/her] case manager's phone up, left 3 voicemails, [s/he] went out for a smoke, declined [his/her] meals, declined [his/her] medication due to having no bag in order to use the bathroom correctly. [His/Her] wound care nurse came in and noticed that [s/he] did not look normal and that [s/he] needs to go the hospital, but [s/he] refused and argued up and down not to get sent out, even ran the report with [Licensee A] about everything, and after that it was said that's why [s/he] has a 30 day notice because [s/he] requires to [sic] much care. I begged [him/her] all last week to please go to the hospital because I felt it in my spirit something was not right with him by noticing [his/her] legs and feet were swollen really bad but [s/he] just kept saying,"i'll [sic] be fine after I take my pain medication"
05/15/23 at 10:30 PM Caregiver D wrote: "was [sic] out when I arrived didn't eat dinner took 8 p m [sic] meds just went outside to smoke mopped bedroom floor"
05/15/23 at 11:00 PM Caregiver F wrote: "Upon arrival [Resident 1] was in [his/her] room watching tv"
05/16/23 at 2:00 PM Caregiver E wrote: "[Resident 1] went outside for a smoke, had [his/her] medication, refused lunch, went out to smoke, changed [his/her] pants, washed [his/her] sheets, nurse came to see [him/her] but will be back later, and [his/her] friend (family member) is here to visit [him/her]"
05/16/23 at 7:45 PM Caregiver D wrote: "was [sic] sleepng [sic] when I handed out 8 p,m, [sic] meds I tried looking for [his/her] blue blanket when I did [s/he] got upset about me looking through

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|---|---|---|---|---|
| M 448 | Continued From page 7<br>[his/her] things I was only try to find [his/her] blanket"<br>05/17/23 at 6:30 AM Caregiver G wrote: "[Resident 1] was in [his/her] room [his/her] chair when i [sic] arrived no problems no concerns"<br>05/17/23 at 6:30 AM Caregiver G wrote: "Upon arrival [Resident 1] was in [his/her] room asleep no problems no concerns"<br>05/17/23 at 10:30 PM Caregiver H wrote: "Upon [his/her] arrival dinner was served [sic] and medication passed [s/he] did go outside a few times to smoke and did some pacing around currently [s/he] is in [his/her] bed half sleep no issues or concerns."<br>05/18/23 at 9:15 PM Caregiver C wrote: "upon [sic] my arrival [Resident 1] was in [his/her] room just sitting in [his/her] chair [s/he] seemed off today so all [s/he] did was stay in [his/her] room all day. [S/He] eat [sic] and took [his/her] medications in [his/her] room.<br>05/18/23 at 10:45 PM Caregiver I wrote: "[Resident 1] spent the day in [his/her] room he had dinner and fluids no concerns"<br>05/19/23 at 6:00 AM Caregiver J wrote: "upon [sic] my arrival the previous staff was getting [Resident 1] washed up and into bed"<br>05/19/23 10:45 PM Caregiver I wrote: "[Resident 1] spent the day in his room [s/he] had dinner fluids no concerns"<br>05/19/23 at 11:30 PM Caregiver J wrote: "upon [sic] my arrival [Resident 1] was in [his/her] room falling asleep in [his/her] wheelchair. I woke [him/her] up helped [him/her] into bed and noticed blood on [his/her] floor. [S/He] said it was from a toe injury from earlier. I got [him/her] into bed and cleaned up [his/her] room."<br>05/20/23 at 6:00 PM Caregiver C wrote: "upon [sic] my arrival [Resident 1] was in [his/her] room sleep when [s/he] got up [s/he] took [his/her] medication got [him/her] ready for the day | M 448 | | |

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|---|---|---|---|---|
| M 448 | Continued From page 8 | M 448 | | |

changed [his/her] clothes [s/he] ate dinner [s/he] was back and fourth [sic] from A side to B side and outside"
05/21/23 at 6:00 AM Caregiver J wrote: "upon [sic] my arrival [Resident 1] was in [his/her] room in the bed asleep, [s/he] slept the rest of the night."
05/21/23 at 2:45 PM Caregiver D wrote: "was [sic] sleep until 2;30 [sic] this afternoon"
05/21/23 at 4:00 PM Licensee A wrote: "This writer was told to check on this resident as [s/he] was sleeping all day. This writer went to check on this resident and found [him/her] sleeping. This resident woke up to this writer's voice and stated [s/he] is fine. this writer offered [him/her] to go to the ER (emergency room) but [s/he] Refused and stated 'I am fine. I don't need to go to the ER.' This writer suggested to keep close eyes on [him/her] with any decline."
05/21/23 at 6:45 PM Caregiver C wrote: "upon my arrival [Resident 1] was in the bed sleep [s/he] didnt [sic] wake up until two forty five when [s/he] woke up i [sic] got [him/her] in [his/her] chair then [s/he] fell back to sleep in the chair. [S/He] had a [sic] accident where the bag where [his/her] poop gets collected was open and got on to [his/her] chair and [his/her] clothes. Cleaned [his/her] chair, changed [him/her]. Called Licensee A to take a look at him as [s/he] was sleeping all day, since Licensee A was at the facility. [S/He] took [his/her] five o clock medication [s/he] didnt [sic] eat at all today [s/he] only drunk a glass of water [s/he] was off today like somethings [sic] wrong with [him/her] but [s/he] is currently in [his/her] room sleeping in his chair because [s/he] cant [sic] function enough to move around in [his/her] chair"
05/21/23 at 8:30 PM Caregiver D: "upon [sic] my arrival [Resident 1] was in room watching TV [s/he] took [his/her] 8 p.m [sic] meds. [Resident 1]

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|---|---|---|---|---|
| M 448 | Continued From page 9 | M 448 | | |

sat in living room for awhile [sic] we watched TV and talked for awhile. [sic] [S/He] asked for [his/her] garbage can so [s/he] can changed [his/her] bag everything was fine."
05/22/23 at 4:15 AM Caregiver D wrote: "around 11 p,m [sic] [Resident 1] asked me to help [him/her] get [him/her] into bed it took [him/her] 20 minutes to get [his/her] wheelchair close to [his/her] bed [s/he] did't [sic] seem like [him/her]elf [sic] it seemed like [s/he] didn"t [sic] know how to use [his/her] wheelchair [s/he]"s [sic] sleeping good right now"
05/22/23 at 6:45 AM Caregiver B wrote: "[S/He] was up through the night. in bed awake rubbing [his/her] leg everything is fine"
05/22/23 at 11:30 AM Caregiver K wrote: "did [sic] a check on [Resident 1] at 9:05 am [s/he] was in bed [s/he] ask me to get [him/her] a cigarette and [s/he] could not hold it in [his/her] hand at all [his/her] [family member] also came to visit with [him/her] and to check on [him/her] as well to tell [him/her] that [s/he] needed to go in to the hospital as well and even got a lil [sic] argumentative with [him/her] as well. did [sic] another check on [him/her] around 11:20 am [s/he] was sleep i [sic] asked [him/her] was [s/he] ok [s/he] responded "Im [sic] good" I preceded from the door way [sic] to go in [his/her] room to further look at [him/her] and made sure [s/he] was clean i [sic] walked out [his/her] room. did [sic] a check on [Resident 1] [s/he] seemed very delirious fatigued and [s/he] couldn't hold anything in [his/her] hands [his/her] wound care nurse came and said [s/he] is very sick at this point gave Licensee A a call [s/he] has been taken to the hospital by ambulance [his/her] wound care nurse came to see [him/her] and [s/he] just seemed so fatigued, [s/he] could not get [him/her] self [sic] out of bed into [his/her] chair so we where [sic] told when reported to Licensee A so

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| M 448 | Continued From page 10 | M 448 | | |

told me to call 911 to have [him/her] go to the hospital."
05/22/23 at 12:00 PM Licensee A wrote: "This writer got a phone call regarding this resident not looking good. This writer suggested to call 911."
05/22/23 at 12:15 PM Licensee A wrote: "Ambulance is called to take this resident to the ER as [s/he] is not looking like [him/her] self [sic]."
05/22/23 at 1:30 PM Caregiver K wrote: "[Resident 1] is in the hospital"

On 06/23/2023 at 11:30 AM Surveyor reviewed Resident 1's 'Resident Status Log' completed by Licensee A. The following was identified:
01/23/2023 6:30 PM: "Went to the hospital on January 23rd and got admitted to the hospital on the same day.; Hospital Readmission within 30 days: No."
02/02/2023 6:32 PM: "Came back from the hospital on 02/02/2023."
03/03/2023 9:15 AM: "[Resident 1] went to the hospital on 03/03/2023 at 8:30 am for the appointment but then they admitted [him/her] to do IV antibiotics.; [sic] Hospital Readmission within 30 days: No."
04/03/2023 1:57 PM: "Resident came back to the facility on 04/02/2023 at 1:00 PM."
05/23/2023 8:55 AM: " Sent [him/her] to the ER (emergency room) on 05/22/2023 at 12:20 pm. [S/He] got admitted to the hospital; Hospital Readmission within 30 days: No."
05/24/2023 11:16 AM: "Discharging Resident."

On 06/28/2023 at 5:00 PM, Surveyor interviewed Licensee A to discuss the documentation received. Licensee A confirmed both 30 day notices contained the condition Resident 1 would not be readmitted if hospitalized following receipt of the 30 day notice regardless of whether or not 30 days had passed. Licensee A added s/he

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|---|---|---|---|---|
| M 448 | Continued From page 11 | M 448 | | |

thought RN L and some former AFH caregivers believed this contributed to Resident 1's resistance to seeking outside medical attention when his/her condition deteriorated. Licensee A stated CM M was responsible for ordering ostomy supplies, and there was nothing s/he could do when Resident 1 ran out of them.

On 07/13/2023 at 3:00 PM, Surveyor reviewed RN L's clinical notes with wounds labeled, which identified the following: 1) left heel; 2) Right heel; 3) Left lateral foot, and 4) Right ischium (The ischium is a paired bone of the pelvis.) /sacrum (The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis.):
05/01/2023: " ...[Resident 1] has remained compliant with home health services. Wounds at all sites are stable ..."
05/04/2023: "Writer [RN L] spoke wound care clinic 5/3 for update on wound location orders received. Provider satisfied with direction of wounds, stated writer could reduce daily visits to 3 times weekly/PRN (as needed) per my discretion ..."
05/05/2023: " ...1) ...no drainage present 2: Optifoam dressing changed. Site improving, drainage minimal 3): Site continues to be unchanged. Slight increase in depth 4): Moderate drainage present. No odor present. Will continue to monitor"
05/10/2023: " ...1): Continue to monitor, site intact, no open areas, no drainage; 2): Location stable. No changes, continue to monitor; 3): Site unchanged. Bilateral edema present. Moderate drainage. [Resident 1] advised to elevate feet and reduce sodium intake; 4): Ischium unchanged, persistent drainage. Sacrum continues to present with ecchymosis (discoloration) secondary to persistent pressure. Moderate drainage present,

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|---|---|---|---|---|
| M 448 | Continued From page 12 | M 448 | | |

mild odor."
05/14/2023: " ...1) Unchanged, stable ... 2) Site remains improving. No drainage present; 3) Bilateral edema present, moderate drainage present. Site stable but not improving; 4) Sacrum has new areas of tiny openings, moderate drainage from area. Needs further monitoring. Writer [RN L] will come back to perform daily dressing changes to prevent prolonged drainage to area ..."
05/15/2023: "Upon writer's [RN L] arrival at facility, [Resident 1] stated that [s/he] was unable to cover ostomy site because [s/he] was out of supplies. [Resident 1] had feces on clothes and in living environment. Staff was requested to assist writer to clean area .... Case Team notified by writer's staff. [Licensee A] updated by staff and was stated to reply, "[Resident 1] was responsible for ordering [his/her] own supplies via [his/her] case management team. Once environment was cleaned to the best of the ability of staff, wound care was performed ...No identifiable changes to wound locations 1, 2, 3, or 4. Will continue to monitor for new changes from exposure to stool."
05/16/2023: "[Resident 1] still having continuous stool secondary to ostomy open to air. Writer advocated that [s/he] be sent out via non-emergency to staff and [Resident 1]. [Resident 1] refuses to seek outside medical treatment in fear of being unable to return to facility because of existing 30-day notice issued. Strongly advised [Resident 1] and staff that [s/he] needed to be seen in emergency room due to inflammation & bleeding of ostomy site, along with continued stool exposure to wounds. Staff stated they would report to owner, [Licensee A]. [Resident 1] continued to refuse recommendations. Wound care performed as ordered by provider ..."
05/17/2023: "[Resident 1] received supplies for

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|---|---|---|---|---|
| M 448 | Continued From page 13 | M 448 | | |

ostomy care, Resumed normal w/c (wound care) measures. 1 unchanged, preventative, dressing changed; 2 Remains stable, unchanged; 3 but reoccurrence of weeping present possibly from increased edema; Location 3 Swelling present with increased drainage secondary to edema; 4 Increased breakdown present. Additional findings: [Resident 1] increasingly fatigued and had difficulty transferring. Refused dialysis. Writer advised staff to closely monitor for changes. [Resident 1] afebrile (body temperature not elevated), however presented with new onset of lethargy."
05/18/2023: " ... Present dressing saturated with fluid prior to dressing. Additional findings: [Resident 1] states legs are heavy & rating bilateral leg pain at 6 out of 10 which will not resolve despite [him/her] taking scheduled pain medication. Writer [RN L] made recommendation for further evaluation; [Resident 1] refused."
05/19/2023: "[Resident 1] refused WC (wound care). Stated that [s/he] was exhausted and did not want to use extra energy before dialysis. Staff educated to contact [Licensee A] if this change continues. [Resident 1] presented differently from baseline. Remained A & O x 4 ( alert and oriented to person, place, time, and event) but still not typical presentation."
05/20/2023: "[Resident 1] in bed upon arrival. Stated [s/he] slept the majority of the day. States that [s/he] was extremely thirsty and persistently requested soda & juice from staff. Writer advised to consume H2O (water) and expressed concern about the probability of infection. [Resident 1] stated [s/he] would wait until the weekend was over because 'the regular doctors were not there over the weekend.' Staff updated of writer's firm recommendations and asked if they would update [Licensee A] of findings. Staff stated all parties were aware of presentation, and suggested

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|---|---|---|---|---|
| M 448 | Continued From page 14 | M 448 | | |

[Resident 1] was 'high' and that was the reason for [his/her] fatigue ..."
05/21/2023: "[Resident 1] stated that [s/he] remains in bed throughout shift. Writer [RN L] enquired if [s/he] was up to smoke today. FC E stated that [s/he] slept the majority of shift and has not requested to smoke. Findings extremely ARN (meaning unknown) for [Resident 1]. [S/He] presented A & O x 4 however extreme fatigue was present. [S/He] also continued stating that pain was rating 7 of 10 in bilateral lower extremities ...Had extreme difficulty lifting legs or turning to access posterior sacral wounds. All wound sites saturated from weeping secondary from edema. Writer [RN L] advised for urgent medical attention, [Resident 1] refused and stated that dialysis would assist with edema. WC clinic will be contacted re (regarding): findings of deterioration of wounds from edema & suspected infection on Monday AM."
05/22/2023: "Writer [RN L] contacted [Resident 1] at 9:00 AM to confirm arrival for WC appt. (appointment) [Resident 1] never answered cell phone or returned phone call. Writer [RN L] attempted to call phone 3 x (times). Writer [RN L] went to facility to find [Resident 1] in bed. When approached patient, [Resident 1] disoriented and presented with dehydration as evidenced by dry mouth and pale complexion. When asked how [s/he] was feeling, [s/he] said [s/he] just wanted to sleep and could barely open eyes. Writer instructed to call 911 immediately. Writer contacted [Resident 1]'s [family member] to advise [Resident 1] to accept emergency care for evaluation. [CM M] updated."

On 07/19/2023 at 10:00 AM, Surveyor interviewed CM M. CM M confirmed Resident 1's noncompliance with the AFH was a pattern of behavior shown at previous placements but

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|---|---|---|---|---|
| M 448 | Continued From page 15<br>added s/he also thought there was a personality conflict between Resident 1 and Licensee A which may have worsened the situation. CM M stated s/he had reservations about placing Resident 1 at the AFH as Resident 1 was previously a resident at another AFH operated by Licensee A. CM M stated Resident 1 was given a 30 day notice at the previous facility with the same no readmission if hospitalized during the 30 days condition as the 2 notices s/he received at this AFH. Resident 1 was hospitalized after 4 days when placed there and was not allowed to return. After Resident 1's hospitalization on April 22, 2023, RN K informed CM M that s/he had been stressing the need for Resident 1 to go to the hospital due to his/her worsening condition. Licensee A informed CM M that s/he had offered to call "911" for Resident 1, but s/he refused it. CM M asked Licensee A when Resident 1 was deteriorating so much why they had not just called for an ambulance despite Resident 1's refusal to see if s/he would accept care once it arrived. Licensee A informed CM M that since Resident 1 continually declined outside help, the provider didn't call.<br><br>SUMMARY:<br>Licensee A admitted Resident 1 knowing there were multiple comorbidities requiring care but did not document them upon admission or when advised by the wound care nurse that changes were occurring in Resident 1's status. Caregiver Observation Notes and Resident Status Logs did not record changes in fatigue, alertness, edema, or pain level as they worsened. No documentation was onsite regarding daily wound care procedures despite RN L documenting incidences of training staff. | M 448 | | |