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N 000	Initial Comments On 09/17/2024 with additional information gathered through 10/01/2024, Surveyor conducted a complaint investigation at Wyndemere Cedar House in Green Bay. As a result, 1 of 2 complaints was substantiated and 2 deficiencies were identified. One was a recite (see SOD EEK212, dated 03/06/2020). Census: 12	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure individual service plans (ISP) reviewed were updated when there was a change in Resident 1 and Resident 2's needs. Resident 1 was at risk for pressure injuries due to his/her diagnoses, skin integrity, immobility and incontinence. Resident 1 also tended to refuse care. Resident 1's individual service plan (ISP)	N 389		

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

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was not updated to identify the needs or potential interventions to include frequent repositioning, frequent incontinence care, or strategies to manage refusals.

Resident 2 was incontinent of bowel and dependent on caregivers for incontinence care. S/he also had a history of refusing medication and exhibiting behaviors. Resident 2's ISP did not include information about his/her incontinence care needs or interventions to prevent and/or manage behaviors.

Findings include:

On 09/16/2024 and 09/17/2024, the Department received complaints alleging care concerns specific to wounds, medications and incontinence.

According to Mayo Clinic, "Bedsores are injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time. Bedsores most often arise on skin that covers bony areas of the body, such as the heels, ankles, hips and tailbone. Bedsores also are called pressure ulcers, pressure injuries and decubitus ulcers. The people who are most at risk of bedsores have medical conditions that keep them from changing positions or moving. Or they spend most of their time in a bed or a chair. Bedsores can arise over hours or days ...

Pressure against the skin that limits blood flow to the skin causes bedsores. Limited movement can make skin prone to damage and cause bedsores ...things that lead to bedsores are: Pressure. Constant pressure on any part of the body can lessen the blood flow to tissues. Blood flow is essential to deliver oxygen and other nutrients to

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tissues. Without these key nutrients, skin and nearby tissues are damaged and might die over time. Limited movement can make skin prone to the damage that the pressure causes. For people with limited mobility, pressure tends to happen in areas that aren't well padded with muscle or fat and that lie over a bone ...Friction. Friction occurs when the skin rubs against clothing or bedding. It can make fragile skin more vulnerable to injury, especially if the skin also is moist.

Your risk of getting bedsores is higher if you have a hard time moving and can't change position easily while seated or in bed. Risk factors include: Immobility. This might be due to poor health, spinal cord injury or another cause. Incontinence. Skin becomes more vulnerable with extended exposure to urine and stool ...Medical conditions affecting blood flow. Health problems that can affect blood flow can raise the risk of tissue damage such as bedsores. Examples of these types of medical conditions are ...vascular disease.

Complications of pressure ulcers include ...Bone and joint infections. An infection from a bedsore can burrow into joints and bones. Joint infections, such as septic arthritis, can damage cartilage and tissue. Bone infections, also known as osteomyelitis, can reduce the function of joints and limbs ...Some complications can be life-threatening ...

Prevention - You can help stop bedsores with these steps: Frequently change your position to avoid stress on the skin ... Shift your weight frequently. Ask for help with changing your position every two hours ...Keep skin clean and dry. Wash the skin with a gentle cleanser and pat dry. Do this ...regularly to limit the skin's exposure

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to moisture, urine and stool ...Look closely at your skin daily for warning signs of a bedsore ..."

Source: https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893; retrieval date 10/08/2024.

RESIDENT 1

On 09/17/2024 at 10:21 AM, Surveyor observed Resident 1 laying in bed. S/he had limited mobility on the left side of his/her body and his/her left hand was constricted. Surveyor also observed the room smelled strongly of urine. Resident 1 told Surveyor s/he is incontinent, uses a wheelchair, needs staff assistance with activities of daily living and requires a Hoyer lift for transfers. Resident 1 explained s/he spends most of the day in bed due to his/her physical limitations. Resident 1 stated, "I have trouble with the left side of my body..."

On 09/17/2024 at 12:05 PM, Surveyor returned to Resident 1's room while accompanied by Nurse Practitioner (NP) A and NP B. Resident 1 remained in the same position as s/he was at 10:21 AM. Surveyor observed NP A pull back Resident 1's sheets. Resident 1 had wounds to the left lower extremity; one to the back of the heel and another on the top of his/her foot. Surveyor observed Resident 1's jeans were unzipped and unbuttoned, and his/her incontinence brief was saturated with urine. Surveyor again noted the odor of urine. At 12:07 PM, Surveyor asked Caregiver Q when the last time Resident 1's brief was changed, s/he stated s/he did not know.

On 09/17/2024 at 4:10 PM, Surveyor interviewed Caregiver G who said sometimes Resident 1

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refuses cares. Caregiver G reported Resident 1 does not like to get out of bed and doesn't like staff moving his/her legs. Caregiver G stated, "[S/he] may say [s/he] doesn't want us in [his/her] room. [S/he] likes to be left alone and in the dark." Caregiver G confirmed Resident 1 is incontinent and requires brief changes in bed.

During an interview with Resident Care Coordinator (RCC) J on 09/25/2024 at 9:42 AM, RCC J confirmed Resident 1 is non-ambulatory, incontinent and staff change his/her brief while s/he is laying in bed. RCC J stated, "[S/he] is a check and change ...every 4 hours." RCC J acknowledged Resident 1's left side is paralyzed but claimed s/he can reposition him/herself independently. RCC J acknowledged Resident 1 is not able to do a complete turn from one side to the other due to his/her left side paralysis. RCC J confirmed the ISP does not reflect a need for repositioning. Surveyor inquired when Resident 1 signed his/her ISPs and after reviewing the record, RCC J confirmed they were signed on 01/21/2024 and 02/27/2024. Surveyor requested both signed versions of Resident 1's ISPs from RCC J to be provided by 4:00 PM on 09/25/2024. RCC J did not provide documentation as requested by Surveyor.

On 09/17/2024 at approximately 12:30 PM, Surveyor requested and reviewed Resident 1's record including his/her ISP, face sheet and observation notes from Administrator (ADM) C. On 09/19/2024 and 09/20/2024, Surveyor received additional documentation from ADM C via email including care history, active cares, additional observation notes, shower history and body charts. Additionally, on 09/27/2024, Surveyor sent a follow up email to ADM C requesting Resident 1's signed ISPs as originally

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requested from RCC J on 09/25/2024. Surveyor note: ADM C did not provide the signed February 2024 ISP as requested by Surveyor.

On 09/28/2024 at 9:00 AM, Surveyor reviewed the records and noted the following:

Resident 1 was admitted on 01/24/2024 with diagnoses to include burns of 10-19% of body surface with third degree burn of 10-19%, depression, anxiety, stroke, peripheral vascular disease (reduces blood flow to extremities), spastic hemiparesis (weakness) of left dominant side and atherosclerosis (chronic inflammatory disease) of the extremities. Resident 1 is non-ambulatory and relies on staff assistance with transfers and activities of daily living.

"Care History" between 08/13/2024 to 08/30/2024, 9 out of 18 entries were marked, "Refused by Resident."

Surveyor was provided 2 versions of ISPs for Resident 1. Surveyor reviewed the ISPs for needs and individualized interventions related to incontinence care, mobility, transferring, repositioning needs and pressure injuries.

The first ISP was signed and dated 01/23/2024. Surveyor note: This date was different than what was reported by RCC J on 09/25/2024. The ISP identified the need for "full walking assistance ...full assistance with pivot transfer on the strong side, left side weak due to HX of stroke ...staff to assist with a wheelchair ...monitor and document bowel movements ...Daily (at) 5:45 AM, 1:45 PM, 9:45 PM, As needed ...Urine ...offer and assist with toileting every four hours ..."

The second ISP provided was the current ISP in

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place as of 09/17/2024. The ISP was not signed by Resident 1. An "Active Cares" document identified dates associated with the ISP categories.

-- "Requires full assistance including physical and verbal assistance with mobility. Requires hands-on assistance with helping get up and helping sit down/lay down. Resident is two person assist with use of hoyer [sic]."
-- "Monitor and document resident's bowel movement at the end of each shift and as needed ...Staff to assist in toileting ..."
-- "Follow their toileting schedule and assist in monitoring and assisting. Daily @ 11:00 PM, 3:00 AM, 7:00 AM, 11:00 AM, 3:00 PM, 7:00 PM. To have staff initiate and assist with toileting schedule on an ongoing basis. Staff will cue as needed and assist when required. To maintain continence and receive assistance with toileting schedule."

The "Active Cares" document included cares dating back to 01/21/2024. The document did not identify risks/needs related to pressure injuries prior to 08/29/2024.

Surveyor noted:
-- The ISP information about bowel movements and a toileting schedule contradicted interviews with staff which indicated Resident 1 was not continent and did not use the toilet. Interviews indicated s/he relied entirely on staff to provide incontinence checks and care.
-- The ISP was silent to needs for frequent repositioning either by staff or by cues and/or monitoring to ensure Resident 1 was repositioning him/herself.
-- The ISP was silent to needs or interventions related to refusals of cares.

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N 389	Continued From page 7 -- On 08/29/2024, a care titled "Wound Monitoring" was added. It was specific to the wounds on Resident 1's lower left extremity (LLE) and did not address to the overall risk for development of pressure injuries. -- On 09/17/2024 (the day of Surveyor's onsite visit), two more cares were added titled, "Chronic Skin Conditions" and "Wound Care - Home Health." Both cares were also specific to the active wounds on the LLE. -- As of 09/17/2024, The ISP remained silent to Resident 1's overall risk for pressure injuries, the need for frequent repositioning or the needs for frequent incontinence checks and cares to ensure Resident 1's skin remained clean and dry. RESIDENT 2 On 09/17/2024 at 11:07 AM, Surveyor interviewed Resident 2 who was laying upright in bed. Resident 2 reported s/he is paralyzed, requires full assistance with activities of daily living, transfers with a Hoyer lift and ambulates using an electric wheelchair. Resident 2 explained s/he is incontinent of bowel, has a catheter and requires care after a bowel movement. On 09/17/2024 at approximately 12:30 PM, Surveyor interviewed ADM C and RCC D who confirmed Resident 2 refuses cares often. ADM C reported Resident 2 refused a call light, so s/he was offered a baby monitor, but refused that. RCC D stated, "[S/he] refuses staff every other day. We talk to [him/her] about the importance of getting [him/her] changed and [s/he] still refuses." On 09/23/2024 at 8:51 AM, Surveyor interviewed Caregiver F who stated, "You never know with [Resident 2]. You ask if [s/he] is ready to get up or be changed, it depends on how [s/he]'s feeling	N 389		

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that day. [S/he] refuses especially with medications. [S/he] denies them often." Caregiver F reported staff are supposed to document when Resident 2 refuses his/her medications.

During an interview with RCC J on 09/25/2024 at 9:42 AM, s/he confirmed Resident 2 is incontinent of bowel, utilizes a catheter and does not like to wear incontinence briefs. RCC J explained Resident 2 does not wear undergarments and has bowel movements on a disposable incontinence pad while in bed. RCC J said staff rely on Resident 2 to inform when s/he is incontinent so they provide care in bed. RCC J also confirmed Resident 2 often refuses medication and cares and stated, "It's been ongoing since [s/he] moved in." RCC J acknowledged there are no identified interventions for when Resident 2 refuses medications or cares and stated, "All encounters are supposed to be documented." During the interview, Surveyor inquired when Resident 2 signed his/her ISPs. After reviewing the record, RCC J said it was last signed on 11/06/2023. Surveyor asked RCC J for all signed versions of Resident 2's ISPs and asked they be provided by 4:00 PM on 09/25/2024. RCC J did not provide documentation as requested by Surveyor.

On 09/17/2024 at approximately 12:30 PM, ADM C provided Resident 2's record including his/her ISP and observation notes. On 09/17/2024 and 09/20/2024, Surveyor received additional documentation from ADM C via email to include Resident 2's medication administration record (MAR) for September 2024 and care history. Additionally, on 09/27/2024, Surveyor sent a follow up email to ADM C requesting Resident 2's signed ISPs as originally requested from RCC J on 09/25/2024. Surveyor note: ADM C only

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provided the ISP signed "10/2023" and did not provide the signed November 2023 ISP as requested by Surveyor.

On 09/29/2024 at 1:00 PM, Surveyor reviewed the records and noted the following:

Resident 2 was admitted to the facility on 10/09/2023 with diagnoses to include quadriplegia (paralysis of limbs), neuromuscular dysfunction of bladder, unspecified injury at unspecified level of cervical spinal cord, other incomplete lesion at C5, C6, C7 level of cervical spinal cord, infection and inflammatory reaction due to indwelling urethral catheter, asthma, anxiety, fracture of unspecified part of scapula - right shoulder - subsequent encounter for fracture with routine healing, muscle weakness, post-traumatic stress disorder (PTSD) and Ankylosing spondylitis (chronic, inflammatory autoimmune disease) of multiple sites in spine. Resident 2 is non-ambulatory and relies on staff assistance with transfers and all activities of daily living.

Observation notes from 09/01/2024 to 09/17/2024 documented refusals and behaviors by Resident 2. The notes read in part:

-- 09/09/2024, Observation Note, 7:30 PM, "staff went in room to administer meds. resident denied meds, and said that [s/he] was going to have another member of staff administer [his/her] meds." Author: Caregiver H.
-- 09/13/2024, Observation Note, 12:00 PM, "resident has been refusing meds and cares..." Author: Caregiver F.
-- 09/13/2024, Observation Note, 1:30 PM, "resident refused to take afternoon and morning meds from staff that work in building, resident

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N 389	Continued From page 10 keeps calling staff out of name and started swearing at staff and telling them to get out of room." Author: Caregiver F. -- 09/13/2024, Observation Note, 1:45 PM, "resident refused medication again. Resident also ignored writer when asked if [s/he] was going to take them [s/he] ignored me and two other staff taking [his/her] medication another employee was present when resident refused and had writer leave [his/her] room Resident refused multiple times from multiple staff today." Author: Caregiver F. -- 09/14/2024, Observation Note, 10:45 AM, "staff asked writer to get napkins for them as they were feeding resident and resident does not like writer so when writer brought napkins [s/he] told writer to get out of [his/her] room and to shut the [expletive] up, all writer did was walk a few steps into room to hand off napkins. Writer is no longer comfortable being in residents [sic] room with how verbally abusive [s/he] has been the past few weeks." Author: Caregiver G. Surveyor reviewed the ISPs that were provided for needs and individualized interventions related to incontinence care, medication administration, refusals and behavior management. Surveyor noted the following: The first ISP was signed and dated "10/2023." It identified the need for "full assistance with mobility needs...resident uses a power wheelchair...staff to ensure resident is sitting all the way back in [his/her] wheelchair to help prevent falls or tipping forward...complete transfer...full assist with use of Hoyer for all transfers..." Surveyor note: The ISP was silent to incontinence care, refusals of cares/medications or behaviors.	N 389		

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N 389	Continued From page 11 The second ISP provided was the current ISP in place as of 09/17/2024. The ISP was unsigned and read in part: -- "Transferring - Complete transfer. Risk due to transfer difficulty due to risk and other person or Hoyer lift. Requires full assistance with use of Hoyer for all transfers. To be safely transported with use of Hoyer. Staff to provide two person assist with use of Hoyer for all transfers..." -- "Bowel Movement Monitoring - Monitor and document resident's bowel movement at the end of each shift and as needed ... daily @ 1:45 PM, 9:45 PM, as needed. Staff to assist in toileting. Staff to monitor and document bowel movements." -- "Medication Management - Needs assistance administering medications." -- "Behavior Monitoring - Monitor and document any abnormal behavioral patterns each shift. Include any verbal reports made by the resident. Immediately report any disruptive, abusive or destructive behaviors or incidents. Daily @ 5:30 AM, 1:30 PM, 9:30 PM, As needed. Resident has history of threatening, refusing cares, falsifying information for attention, screaming and being inappropriate." -- "Monitoring Behaviors - Monitor for behaviors such as: physical/verbal aggression, anxiousness, increased tiredness, decreased responsiveness, increased confusion, delusions/hallucinations, any other behaviors outside of the residents' normal behaviors. Document behaviors and report behaviors to PCP immediately. Daily @ 5:45 AM, 1:45 PM, 9:45 PM, As needed. Resident had a history of compulsive lying, fabricating stories to get staff in trouble and refusing cares then stating staff are refusing to help [him/her], resident has a history of agitation when not getting [his/her] way and will	N 389		

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N 389	Continued From page 12 take it out on staff. Staff to monitor and report behaviors to management." Surveyor noted: -- The ISP noted Resident 2 needed assistance with "toileting," however caregiver interviews described Resident 2 as fully incontinent of bowel and s/he did not use the toilet. The ISP prompted for 2 scheduled checks daily at the end of first and 2nd shift, however it was reported during interview staff relied entirely on Resident 2 to report when s/he was incontinent and scheduled checks were not provided. Surveyor also noted due to Resident 2's immobility and time spent in bed, s/he was at increased risk for pressure injuries with a need to maintain clean, dry skin. -- The ISP was silent to the history of medication refusals or interventions caregivers could utilize to encourage acceptance of medications. -- The ISP identified history of behaviors but did not include interventions based on assessment to manage Resident 2's behaviors. Cross Reference: Y3244 CH 50.09(1)(L) Care	N 389		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility.	Y3244		

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This Rule is not met as evidenced by:
Based on observations, interviews and record review, the provider did not ensure Resident 1 received adequate care to prevent or manage wounds on his/her left lower extremity (LLE). The provider did ensure adequate care or services to meet Resident 1's needs for pressure injury prevention, management or treatment. Resident 1 was admitted to the facility on 01/24/2024 and was at risk of pressure injuries due to diagnoses and immobility. The provider did not develop a plan to prevent the development of pressure injuries. On 08/12/2024, Resident 1 developed small, reddened areas on top of his/her left foot and the back of the heel. The pressure wounds worsened resulting in an emergency room visit on 08/28/2024 when both wounds were open with tendon and underlying structure visible.

Resident 1 was discharged back to the facility the same day with orders to be seen in the wound care clinic and by a vascular surgeon within 2 days. The provider did not arrange for either appointment within 2 days. On 09/12/2024 (2 weeks after ER orders), Resident 1 was seen by home health and his/her sock was embedded in the wound. Home health assessed the wound again on 09/13/2024 and it was unstageable. The ER orders for wound care clinic were not satisfied until 09/20/2024 (3 weeks after the ER orders) and Resident 1's wounds were diagnosed as stage 3. As of the exit date of the survey

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Y3244	Continued From page 14 10/01/2024, the ER orders for the vascular surgery appointment had not been satisfied. Between 08/12/2024 when the wounds were first identified and 09/12/2024 the provider did not provide timely updates to Resident 1's primary care provider about the wounds, their progression or Resident 1's associated pain. This is a repeat deficiency. See SOD EEK212, dated 03/06/2020. Findings include: On 09/16/2024, the Department received a complaint alleging residents were not receiving adequate care for wounds. The facility is licensed to serve up to 14 residents from the following client groups: irreversible dementia/Alzheimer's, developmentally disabled, physically disabled and/or advanced age. On 09/17/2024, Surveyor made an onsite visit and interviewed Resident 1 at 10:21 AM. Surveyor observed Resident 1 who was laying in his/her bed with a pillow behind his/her back and had a wrapped left foot. Resident 1's left foot was elevated and resting on a pillow. His/her right foot was hanging slightly off the side of the bed. Surveyor observed Resident 1's left side was immobile and his/her left hand was contracted. Resident 1 confirmed s/he had wounds on the top of his/her foot and on the backside of [his/her] heel. Resident 1 was not able to recall when the wounds first started but reported s/he was previously burned in a house fire and had skin grafts to those areas on his/her legs and feet. Resident 1 explained s/he crosses his/her feet when s/he is sleeping and that "didn't allow it to	Y3244		

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heal." S/he stated his/her wounds are "getting better now."

According to Cleveland Clinic, "A pressure injury (also called a bedsore, pressure ulcer, pressure sore, or decubitus ulcer) is an area of injured skin. A pressure injury happens when force is applied on the surface of the skin. This force can be a constant pressure on an area of skin or a dragging (shearing) force between the skin and another surface. These injuries usually happen over bony parts of the body (hips, heels, tailbone, elbows, head and ankles). A pressure injury can become life-threatening if it advances to a deep wound or becomes infected. There are four stages that describe the severity of the wound...:

Stage 1: This stage is discolored skin. The skin appears red in those with lighter skin tones and blue/purple in those with darker skin tones...

Stage 2: This stage involves superficial damage of the skin. The top layer of skin is lost. It may also look like a blister. At this stage, the top layer of skin can repair itself.

Stage 3: This stage is a deeper wound. The wound is open, extending to the fatty layer of the skin, though muscles and bone are not showing.

Stage 4: This stage is the most severe. The wound extends down to the bone. The muscles and bone are prone to infection, which can be life-threatening.

Who is at risk for developing pressure injuries? People with a limited amount of mobility or a total inability to move. Those in wheelchairs or bedridden are at particular risk and need to be moved or turned regularly...Those with

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malnutrition. Wound healing is slowed when nutritional needs are not met ...As people age, the skin naturally becomes thinner and more easily damaged...

Pressure injuries are caused when a force is applied to the skin, causing damage to the tissue. Several types of force include: Pressure: Constant pressure on the skin results from remaining in the same position for a prolonged period of time. Shear: Shear damage or a dragging force can occur when the head of the bed is raised and the body slides down ...Moisture: Fluids (sweat, urine, fecal matter) that remains on the skin can cause the skin to become overly wet, which increases the risk for pressure injury development..."

Source: https://my.clevelandclinic.org/health/diseases/17823-pressure-injuries-bedsores; retrieval date 10/01/2024.

On 09/17, 09/18 and 09/20/2024, Surveyor received and reviewed portions of Resident 1's record to include the individual service plan (ISP), care history 08/13-09/16/2024, observation notes, body charts, shower history, emergency room records, medication administration record (MAR) and medical records.

Resident 1 was admitted on 01/24/2024, was non-ambulatory and had diagnoses to include burns of 10-19% of body surface with third degree burn of 10-19%, depression, anxiety, stroke, peripheral vascular disease (reduces blood flow to extremities), spastic hemiparesis (weakness) of left dominant side and atherosclerosis (chronic inflammatory disease) of the extremities. Resident 1's ISP (current as of

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09/17/2024) identified his/her needs for staff assistance with medication management, scheduling of medical appointments, bathing, grooming and transfers using a Hoyer lift. Resident 1 established services with Nurse Practitioner (NP) A.

Surveyor noted Resident 1 was at risk for pressure injuries due to his/her diagnoses, immobility and skin integrity concerns.

TIMELINE BASED ON RECORD REVIEW - 08/12/2024 to 08/28/2024 (date of ER visit)

The following timeline is based on observation notes, individual service plans (ISPs), medication administration records (MARs), care history 08/13-09/16/2024, body charts, shower history, emergency room (ER) records, home health records, medical records (from Nurse Practitioner - NP A's Office E) and an investigation authored by Administrator (ADM) C initiated on 09/17/2024.

Surveyor noted the following timeline starting from when the wound was first notified and up until the ER visit on 08/28/2024:

-- Prior to 08/12/2024: The ISP did not include interventions to prevent the development of pressure injures on Resident 1's LLE which were known to be susceptible to pressure injuries due to a history of burns and skin graft.

-- 08/12/2024: Observation note, "Staff reported over the weekend seeing a possible small area on top of resident's foot and back of ankle due to the resident consistently wanting to stay in bed, added treatment to care plan to monitor wounds and report changes and concerns to writer or RCCs (Resident Care Coordinators) Upon

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assessment of foot, areas are reddened no opening as of yet staff will continue to monitor." Author: ADM C. Surveyor note: There was no documentation to show NP A was notified of Resident 1's wounds.

-- 08/12/2024: The ISP was not updated to reflect the change in condition.

-- 08/13/2024: A shower form documented a laceration on the back of the left ankle and the top of the right foot. (Surveyor note: the wound was actually on the top of the left foot.)

-- 08/16/2024: Observation note, "pt [sic] was seen by [NP A's Office E] for rounding ... advised to continue to monitor foot and encourage PT to reposition and try to keep booties on feet." Author: RCC D. Surveyor note: Records from NP A's Office E documented a visit for psychiatric purposes, but it did not reference wounds or related interventions. Surveyor note: Surveyor did not observe booties on Resident 1's feet during 2 observations on 09/17/2024 and this intervention was not documented in the ISP.

-- 08/16/2024: Psych Initial Visit Note electronically signed by NP A. Surveyor note: NP A's visit reflects a cognitive evaluation and there is no reference to being notified of or assessing the wound.

-- 08/20/2024: Observation note, "Reached out to [NP A's Office E] ... regarding small wound forming on resident foot advised [NP A] would be rounding end of the month if any changes or concerns arise let them know, staff to continue to monitor for changes and concerns and let RCC or Admin know." [sic - all] Author: RCC D. Surveyor note: The medical records from NP A's Office E

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did not document this notification.

-- 08/22/2024: Observation note, " ...noticed small wound forming on back of the ankle and small one on top of skin grapht [sic] on top of foot wrapped foot, and advised the Coordinator so we can let Dr know." [sic - all] Author: Caregiver F. Surveyor note: Medical records from NP A's Office E did not document this notification was made.

-- 08/22/2024: A shower form documented a laceration on the back of the left ankle and the top of the right foot, and a note that read: "small red area back of ankle and top of foot where scar tissue is."

-- 08/24/2024: Observation note, "Resident dressing changed on foot ...minor draining ...cleaned and wrapped tried to tell [Resident 1] to not be crossing legs all day on top of left foot as it is rubbing, I think resident old skin grapht is not working." [sic - all] Author: Caregiver F

-- 08/13/2024 - 08/28/2024: "Care History" prompted for, "Open Areas (Pressure)." The exact care was not identified in the prompt, but there were references to cleaning and wrapping the wounds. Refusals were charted on 7 out of 16 days (08/14/2024, 08/15/2024, 08/18/2024, 08/23/2024, 08/24/2024, 08/25/2024 and 8/27/2024) and included the following responses, "would not let me," "did not want," "did not want foot to be touched," "refused to let me do anything, "refused advised RCC" and "re wrapped foot did not want me to clean." Surveyor note: The provider did not give Surveyor documentation to show the root cause of the refusals was assessed or interventions were implemented to ensure Resident 1 received the necessary care

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and monitoring.

Surveyor note: The care history entries included dates and times. Eleven (11) of 16 entries were entered on 09/17/2024 after Surveyor arrived onsite; approximately 1 month after the care was reportedly provided or refused.

TIMELINE BASED ON RECORD REVIEW
AFTER ER VISIT 08/28/2024

-- 08/28/2024: Facility incident report for hospitalization, "staff entered room and noticed drainage coming from [his/her] left foot. Staff called management in to take a look at it. Staff discovered resident had open areas on top of old scar tissue. [NP A] requested resident to be sent out." Author: Caregiver H.

-- 08/28/2024: ER records, "Patient ... presenting to the ed [sic] for left leg pain ... [s/he] has a history of bypass graft in left leg vasculature. [S/he] states that over the past month [s/he] has developed a wound to the top of the left foot near the ankle, as well as the left heel. [S/he] states that the facility first saw these wounds today and sent to ed (emergency department) [sic]. [S/he] denies fevers chills sweats." The report documented a "wound, with visible tendon" and another "Wound on the back [sic] of the (left) heel, some underlying structures visible." An antibiotic was prescribed and discharge orders were: (1) schedule an appointment as soon as possible for a visit in 2 days at [Hospital K] Health Wound Healing Clinic and (2) schedule an appointment as soon as possible for a visit in 2 days with vascular surgery. The medical records also documented an ER nurse attempted to call the facility three times on 08/28/2024 and was only able to get voicemail.

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Y3244	Continued From page 21 Surveyor note: "Underlying structures" could include nerves, tendons, vessels, joints, or bones. In addition, the wounds progressed significantly since first identified 16 days prior; both wounds were open with tendons and underlying structure visible. -- 08/29/2024: ISP update, "Wound Monitoring ...Monitor Skin concern weekly until resolved. If current treatment shows no improvement for 2 weeks, modify the current treatment and notify PCP (primary care physician). Notify PCP of any worsening or signs or symptoms of infection. Status: Resident has open areas on top of feet and back of ankles." The update did not identify the severity of the wounds or the need for Resident 1 to have appointments within 2 days with the vascular surgeon and at the wound care clinic. -- 08/29/2024: Fax from provider to NP A asking, "Can we have an order for PRN Home Health?" NP A approved the order and faxed back the same document with a question, "Is there an appointment setup with [Hospital K] wound healing center or vascular surgery?" Medical records from NP A's Office E did not document a response from the provider. -- 08/29/2024: Triage Note electronically signed by NP A "...Facility updated that the patient had a wound on left lower extremity which is black. Facility updated requesting for wound care referral ..." The assessment identified on the triage note reflects Resident 1 had an unspecified open wound, left lower leg, initial encounter. The plan indicated an order for wound care evaluation and treatment.	Y3244		

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Y3244	Continued From page 22 -- 08/30/2024: Memo, written by Licensed Practical Nurse (LPN) N with NP A's Office E, "Received an update from [facility] requesting orders for PT/OT. Patient also noted yesterday to have wound so verbal orders obtained from [NP A] for PT/OT/RN eval & treat. Will be seen 9/3 for f2f (face to face) visit ... AVS (After Visit Summary) 8/28/24 Attached to request. Seen in [Hospital K] ER for leg pain. DX: Wound of left lower extremity, open wound of left heel ... Referral placed for wound care. Schedule an appointment with [Hospital K] wound healing center and vascular survey. Requested update from facility on appointments." -- 08/30/2024: Facility observation note, "received email from [Home Health Agency I] intake coordinator ... stated they got [Resident 1] paperwork and will be coming out for eval and sign pt [sic] on to services." Author: RCC D. -- 08/30/2024: Facility observation note, "received call from wound clinic asking to set up follow up appointment that ER recommended, told wound clinic PCP said pt [sic] was okay to be seen in house, got order for home health Eval and treat from PCP and cancelled follow up wound clinic appointments." Author: RCC D. Surveyor note: Between 08/31/2024 - 09/12/2024 there was no documentation the provider contacted home health wound care to follow on the status of the referral. -- 09/03/2024: NP A visit note, "Face to face is being completed today as patient requires HHC (home health care) to receive wound care services ...d/t (due to) homebound status." The assessment read: "Infected ulcer of skin ... local infection of the skin and subcutaneous tissue, unsp [sic] ..."	Y3244		

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Y3244	Continued From page 23 -- 09/03/2024: "Seen by [NP A] Castor Oil to lower extremities BID ..." Author: RCC J. -- 09/05/2024: A shower form/body audit documented open areas on left ankle and top of left foot. There was also a note of "other" noted on the right foot. Surveyor note: This was the last documented shower/body audit as of Surveyor's onsite visit on 09/17/2024 in spite of the need for twice weekly showers identified in the ISP. -- 09/12/2024: Home Health Note, "Wound Clinic appointment scheduled for 9/20/2024 at 1050 - informed/confirmed with [facility] staff [RCC J], today to arrange ride. Vascular Surgery referral had been placed at ER visit end of August; they need imaging and are going to fax orders to [Hospital K]. Writer requested they coordinate for 9/20 when [Resident 1] will be there for wound clinic. They have left multiple msg's [sic] with [facility] looking to schedule this. provided Medicare # that is on facility face sheet, which is active and current ... [NP A] was updated to condition of wounds ..." Author: RN L. -- 09/12/2024: Home Health Note, "Pre Vascular appointment for imaging scheduled for: September 25th 1145am arrival; ultra sound and cat scan. Needs to be NPO [sic] after 0830 ([NP A' office] to fax orders for NPO) ...Vascular surgeon appointment scheduled for: October 1st 930am ...RN case manager was updated to these visits, and call was placed to facility to arrange rides." -- 09/12/2024: Memo, written by LPN O with NP A's Office E - "[Home Health Agency I][RN L] sent a picture of patient's wound on his right upper part of [his/her] foot. [RN L] states [s/he] sees	Y3244		

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tendon being visual but the wound does not look infected. [RN L] used a couple bottles of saline to be able to remove the sock. As it was embedded into the wound bed ... Per patient's last ER discharge patient was to be scheduled with wound care as well as a consult with a vascular surgeon. [RN L] ... contacted [Hospital K] wound clinic and was advised that the wound clinic tried to schedule and was told by the facility they were not scheduling it. Also, the vascular surgeon advised [RN L] they have been calling the facility to schedule and the facility will not return call to schedule ...."

-- 09/12/2024: "[Home health] aide in to assist with wound dressing on left foot, myself and other staff were told that resident who lays in bed most of the day by choice and continuously placing foot on top of other foot could be causing a lot of friction to skin graph/scar tissue and told resident to stop doing it so much as it is adding more pressure, [home health] advised us to no longer touch wound." Author: ADM C.

-- 09/12/2024: Facility observation note, "Appointment set for September 20th at 1050am ...wound clinic...September 25th 1145am cat scan...October 1st 930am ...vascular surgeon." Author: RCC J.

-- 09/13/2024: Home health note, "Patient seen today for start of care home health admission visit. Patient was referred to home health following a ED (Emergency Department) visit on 08/28/24 resulting in patient being referred to wound clinic due to significant wounds to the LLE. Due to insurance concerns home health nursing was not able to see patient until 9/12/24 ... Dressing was removed to foot and this was painful for [him/her]. Wound care nurse consulted

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during visit and [s/he] was able to assist with dressing change. Wounds were cleansed with saline. There is a [sic] unstageable pressure injury to the top of the foot and an unstageable pressure injury to the Achilles heel area. There is a large amount of drainage from both wounds. There is a tendon visible to the top of the foot and when the foot is flexed the tendon does move. It is white at this time ... Wound clinic consult needed immediately due to severity of wounds ..." Author: RN M.

-- 09/13/2024: Addendum to memo on 09/12/2024, written by LPN O - "[RN L] updated that patient is scheduled with wound care on 09/20/2024 and a pre-vascular appointment on 09/25/2024..."

-- 09/13/2024: "pt has new orders as follows: PT to be NPO (nothing to eat or drink) after 0830am on 09/25 for vascular imaging appointment." Author: RCC D

-- Between 08/30/2024 to 09/16/2024 the facility's "Care History" was updated to include a prompt for "Wound Monitoring." This documented wound measurements, odor, open areas, improvement, signs of infection and pain. According to caregiver charting, Resident 1's wound (unclear which wound) tripled in size over the course of 3 days; on 09/06 0.5 inches and on 09/09 it was 1.5 inches. There was no charting of wound monitoring on 09/07/2024 and 09/08/2024. Additionally, 10 out of 18 entries document Resident 1 was having pain. Surveyor note: The medical records from NP A's Office E did not document they were informed of the increased wound size or there was persistent pain.

-- 09/17/2024: There were 2 updates to Resident

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1's ISP. This was the day of Surveyor's onsite visit. The updates included "Wound Care-Home Health" and "Skin-Chronic Skin Conditions." These updates did not provide clear information about the history or severity of the wounds, current status of the wounds, or the facility's role in monitoring or caring for the wounds.

-- 09/20/2024: After Visit Summary from Hospital K reflects Resident 1 attended the initial wound care clinic appointment to address a "pressure ulcer of left heel, stage 3" and a "pressure ulcer of dorsum of left foot, stage 3." Resident 1 was provided wound care, a dressing change and his/her next appointment was scheduled for 10/11/2024. In addition, another referral was made to the vascular surgeon.

-- 09/25/2024: Resident 1 had an appointment for imaging in advance of the appointment with the vascular surgeon on 10/01/2024. On 09/27/2024, Surveyors requested the After Visit Summary from the 09/25/2024 appointment from ADM C. S/he replied via email and stated the 09/25 appointment was rescheduled. ADM C did not provide information about the reason it was rescheduled or when the new appointment was.

INTERVIEW WITH NP A AND OBSERVATIONS

On 09/17/2024 at 11:36 AM, Surveyor interviewed NP A. NP A confirmed Resident 1 had a wound to his/her left ankle and heel, and his/her tendon was visible. NP A stated Resident 1's wound was "pretty gnarly." S/he reported Resident 1 has a history of crossing his/her feet which creates friction in that area. NP A explained Resident 1 has skin grafts in the past after s/he was burned and described how it made the skin more fragile. NP A stated Resident 1's skin started breaking

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down in mid-August and by late August there was a significant opening. NP A reported Resident 1 went to the ER on 08/28/2024 and was released with orders to follow up with wound care and vascular surgery. NP A reported s/he referred Resident 1 for home health wound care and was initially unaware it took 2 weeks for Resident 1 to be seen.

On 09/17/2024 at 12:05 PM, Surveyor observed Resident 1's wounds accompanied by NP A and NP B. NP B removed the dressing from Resident 1's foot. Surveyor observed the top of his/her foot an open area with a visible white structure. NP A stated the white structure was his/her tendon. Surveyor observed a piece of skin hanging from Resident 1's heel. NP A said the wound currently was healing well.

INTERVIEWS WITH CAREGIVERS

On 09/18/2024 at 4:10 PM, Surveyor interviewed Caregiver G. S/he reported s/he was not sure when Resident 1's left foot wounds started, but s/he would care for them by unwrapping, cleaning and rewrapping. Caregiver G said their process was to chart both cares provided and refusals. Caregiver G recalled wounds got worse because s/he would rub his/her feet together. Caregiver G did not describe any interventions such as pillows or reminders to remind Resident 1 not to cross or rub his/her feet. S/he recalled Resident 1 getting booties but was not sure if s/he received them yet or not.

On 09/23/2024 at 8:51 AM, Surveyor interviewed Caregiver F who stated Resident 1 has always had issues with [his/her] skin. S/he said, "We need to make sure [his/her] feet are not rubbing together and there is a pillow between [his/her]

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legs." Caregiver F stated Resident 1 has never really refused care or complained of pain until after the ER visit on 08/28. Caregiver F reported, "The facility LPN is supposed to do the wound care. The most we would do for [his/her] wound is clean it and wrap it." S/he acknowledged "I did not feel comfortable doing that." S/he stated s/he was told Resident 1's tendon was showing in his/her foot and not to touch it.

INTERVIEW WITH HOME HEALTH

On 09/18/2024 at 4:35 PM, Surveyor interviewed RN L who recalled Resident 1 was initially seen and assessed on 09/12/2024 by a different RN in their agency. RN L recalled that nurse called him/her out of concern because the wounds were severe. RN L subsequently assessed Resident 1 and said the wound on the top of the foot was "pretty significant" and tendons were visible. RN L described Resident 1's care at the facility after the ER visit as, "really poor healthcare." RN L said s/he reviewed the ER discharge instructions and Resident 1 was supposed to have follow up with [Hospital K] wound care clinic and vascular surgery within 2 days. RN L said s/he had knowledge both the wound care clinic and vascular surgery tried to call the facility to schedule and the facility told the wound clinic home health would be coming out, but "we didn't even have the referral yet." RN L reported vascular surgery was waiting on a call from the facility for insurance verification. S/he stated, "I provided [his/her] Medicaid number to the vascular surgery center from the facility face sheet and it went through." RN L confirmed their agency had a delay before the initial visit due to the insurance issue as well. RN L said once they assessed the wound his/her impression was the wound was too complex for home health to

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manage and added, "We need doctor oversight." RN L said s/he was aware NP A saw Resident 1 on 09/03 but was unsure if s/he assessed the wound. RN L recalled s/he contacted NP A's Office E on 09/12/2024 and sent a picture of the wound to LPN O who then showed NP A. RN L stated, "They were all surprised" by what they saw. RN L reported, "A wound like this needs immediate action. That is not our standard of care." RN L confirmed they did not receive any follow up calls from the facility after their intake coordinator contacted the facility on 08/30/2024.

INTERVIEWS WITH NP A's OFFICE E

On 09/19/2024 at 12:00 PM, Surveyor interviewed RN P who stated on 09/12/2024 they received a picture of Resident 1's wounds from RN L. S/he reported, "When we got the picture, we did not know [his/her] wounds were that bad. It blew our socks off." RN P reported, "The facility struggles bad with wounds and Resident 1 is not the only one." RN P discussed a referral was approved by NP A for wound care and treatment on 08/29/2024. S/he stated NP A completed a face-to-face visit with Resident 1 on 09/03/2024, but stated the documentation did not specifically document if the wound was assessed.

On 09/25/2024 at 12:15 PM, Surveyor conducted a follow up interview with NP A. NP A recalled s/he made a visit to Resident 1 on 08/15/2024 (Surveyor note: Facility notes indicate a visit on 08/16, but NP A records indicate this visit was a psychiatry visit. NP A records note a medication review visit on 08/15.) NP A said s/he did not receive reports from staff regarding Resident 1's wounds. Surveyor asked about the 08/20 observation note which noted NP A's Office E was informed. NP A said while it is possible the

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call was made, s/he was not informed and the call was not documented in their records. NP A stated s/he first became aware of Resident 1's wound when s/he received the after-hours phone call on 08/28/2024 and Resident 1 was sent out to the ER. NP A confirmed the ER orders were for follow up with the vascular surgeon and wound clinic. NP A recalled on 08/29 the facility requested an order for home health and s/he approved it. NP A explained s/he thought the request for home health was in addition to treatment at the hospital wound clinic. NP A stated s/he never intended to discontinue the ER orders for the wound clinic and s/he intended home health to be in addition to the clinic.

INTERVIEWS WITH MANAGEMENT

On 09/17/2024 at 12:30 PM, Surveyor interviewed ADM C who stated a referral to wound care was placed on 08/30/2024, but there was a delay for treatment because they were waiting on insurance approval. Surveyor asked for documentation to show their communication efforts with the home health agency after Resident 1's ER visit on 08/28/2024. ADM C stated it was RCC D who communicated with them, so s/he would have him/her gather the information and provide it to Surveyor.

On 09/18/2024 at 7:34 AM, Surveyor sent a follow up email to ADM C regarding RCC D's communication with the home health agency. At 9:28 AM, Surveyor received an email from ADM C who stated, "[RCC D] and [RCC J] share responsibility in following up with providers, the last note from [RCC D] was on 08.30.24 that [s/he] followed up with [Intake Coordinator P] to find out when they would be starting services. [RCC J] ... said [s/he] called between 9/5-and 9/6

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to follow up again and left a message for a call back. It is not required for them to follow up however I do say best practice is to follow up with all providers if we do not receive a response."

On 09/18/2024 at 3:41 PM, Surveyor emailed ADM C requesting documentation to include Resident 1's active care history, additional observation notes, documentation of all in person visits and other communication with NP A between 08/13 - 08/20 related to his/her wound or skin integrity, body charts and medication administration records (MAR) for August and September.

On 09/18/2024 at 3:47 PM, Surveyor received a follow up email from ADM C indicating s/he is out the remainder of the day and s/he would send the documentation on 09/18. In addition, ADM C stated, "...Please note that we do not document every single phone call, which can occur up to ten times a day at times..."

On 09/19/2024 at 8:49 AM, Surveyor received an additional follow up email from ADM C with the requested documentation. ADM C stated, "...We do not maintain records of such communications or their clinical notes. Our daily communication with [NP A's Office E] does not necessitate the recording of every call placed or received from their team..."

On 09/25/2024 at 9:42 AM, Surveyors interviewed RCC J. S/he explained ADM C "makes all the decisions, but s/he and RCC D serve in a leadership role which include responsibility for physician communication and coordination of outside services. RCC J said those contacts are typically documented in the observation notes. RCC J said 08/13/2024 "sounds approximately

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right" for the date Resident 1 first developed wounds on his/her LLE and staff were responsible for cleaning and wrapping the wounds. RCC J stated the facility LPN did not look at or assess the wound from 08/13/2024 to 09/12/2024 (home health start date) and verified s/he did not personally follow up with home health between 08/28 and 09/12/2024. RCC J also confirmed there was no documentation in the observation notes that anyone else followed up.

On 09/27/2024 at 8:27 AM, Surveyor sent an email to ADM C and offered an opportunity for an exit conference to review the preliminary findings of the survey. ADM C initially agreed and the conference was scheduled on 10/01/2024 at 10:00 AM.

On 09/29/2024 at 6:51 PM, ADM C sent Surveyor a notice s/he was declining the exit conference. ADM C wrote, "I have a call during this time I was unaware of, if you can email me your exit survey that would be great. I have multiple things on my schedule due to me being out, if I have questions or concerns I will reach out thank you!"

On 09/30/2024, Surveyor replied and stated the findings would be sent via email no later than 10/01/2024.

On 10/01/2024 at 11:53 AM, Surveyor sent an email with the preliminary findings to ADM C and wrote, "If you have questions please let us know. Likewise, if you have additional documentation or information to provide in response to the preliminary findings we encourage you to send that to us. We will accept additional documentation/information until 5:00 PM today." ADM C did not respond to the email or provide additional documentation.

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Y3244	Continued From page 33 IN SUMMARY: Resident 1 had diagnoses and skin integrity concerns on his/her LLE that placed him/her at risk for pressure injuries. The provider did not develop an ISP to identify the risk or interventions to prevent pressure injuries. On 08/12/2024, Resident 1 developed pressure wounds on the top of his/her left foot and back of heel. Between 08/12/2024 and 08/27/2024, the provider did not consistently document changes in condition, notify the physician when needed, promptly respond with interventions or monitor to verify caregivers were providing adequate care. On 08/28/2024, Resident 1 was sent to the ER when his/her wounds worsened. The wound on the foot was open with a "visible tendon"and the heel wound had "underlying structures visible." The ER discharge instructions were to schedule an appointment as soon as possible for a visit in 2 days with both the wound care clinic and vascular surgeon. On 08/29/2024, facility staff faxed [NP A's Office E] requesting an order for home health wound care instead of wound care at the clinic, as instructed by the ER. Between 08/31/2024 and 09/12/2024, home health services for wound care were not started and the provider did not document efforts to follow up on the necessary services. During this time, caregivers were prompted to monitor the wound daily. At times, Resident 1 would state s/he didn't want staff to touch or unwrap the wound and s/he frequently reported pain. Over the course of 3 days between 09/06/2024 -09/09/2024, caregivers charted one of the wounds tripled in size.	Y3244		

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Y3244	Continued From page 34 Between 09/04/2024 and 09/12/2024, NP A was not notified of Resident 1's pain or increased wound size and the wounds were not medically assessed. On 09/12/2024, home health services assessed the wound and found Resident 1's sock was embedded in the wound bed. The nurse described Resident 1's care as poor and was very concerned the ER instructions for wound care at the clinic were not satisfied. Home health sent photos of the wounds to NP A who was surprised at the seriousness of the wounds. On 09/20/2024 (3 weeks after the ER visit) the initial wound care clinic appointment took place and the wounds were diagnosed as stage 3. As of 09/25/2024, the vascular surgery appointment still had not occurred. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	Y3244		