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	535043	A. BUILDING _____ B. WING _____	C 03/14/2023

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COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/8/23 to 3/14/23. The survey was prompted by complaint intakes WY00003546 and WY00003554. The following common abbreviations are used throughout this document: ADL- Activities of Daily Living cm- Centimeters CNA- Certified Nurse Aide DO- Doctor of Osteopathic Medicine DON- Director of Nursing DPT- Doctor of Physical Therapy DTPI- Deep Tissue Pressure Injury ED- Emergency Department MDS- Minimum Data Set RN- Registered Nurse WNL- Within Normal Limits Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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	F 656		4/17/23

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

Electronically Signed | 04/07/2023

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F 656	Continued From page 1 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 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 medical record review, staff interview, hospital record review, hospital staff interview, and policy and procedure review, the facility failed to ensure a care plan was developed for 1 of 6 residents (#1) identified as being at risk for	F 656	F656: Corrective Action: Resident #1 no loner resides at the community. Identification: DON/Designee will review	

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F 656	Continued From page 2 developing pressure ulcers. The findings were: Review of the 12/6/22 admission MDS assessment showed resident #1 was admitted to the facility on 11/29/22 with diagnoses which included diabetes mellitus II, osteoporosis, and non-Alzheimer's dementia. The review showed the resident was rarely or never understood. Further review showed the resident required the extensive assistance of 1 staff member for bed mobility and personal hygiene. Review of the 12/13/22 Braden Scale For Predicting Pressure Sore Risk assessment showed a score of 8, which indicated the resident was at very high risk of developing pressure ulcers. Review of the resident's care plan showed the facility failed to ensure a plan was in place to address this risk. Review of the activities of daily living plan showed the resident required extensive assistance from staff with bed mobility, locomotion, and transfers. However, the plan failed to address the need for repositioning and off-loading. The following concerns were identified: a. Review of the 1/2/23 hospital wound assessment note by DPT #1 after wound assessment was performed from 9:52 AM to 10:39 AM showed the following: " Assessment: "Wounds evaluated, photographed, and treated with focus on comfort. Purple foot wounds are consistent with deep tissue injury from prolonged pressure over bony prominence." b. Interview with hospital RN #1 on 3/14/23 at 9:50 AM revealed she was present for the resident's visit to the ED on 1/1/23. She stated the resident's appearance on 1/1/23 indicated s/he had not received ADL care since being seen in the ED on 12/29/22. She also stated it was her	F 656	current residents Braden Scale scores to ensure a care plan is developed for residents who are at risk for developing pressure ulcers. This will include re-positioning and offloading heals if needed. Residents missing an appropriate care plan IDT will complete at time of identification. Systemic Changes: Each resident is reviewed on admission, re-admission and with significant changes to ensure the care plan is comprehensive, person centered and include measurable objectives and time frames that meet the residents medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment. IDT will be educated by the NHA/Designee on the policy Care Plans, Comprehensive Person-Centered All licensed nursing staff will be educated on or before date of compliance by DON/designee on reporting, documenting changes of conditions according to policy and procedures and the required action when pressure injury is identified. Monitoring: IDT to review 24hour report daily during the business week for any significant changes and make the necessary care plan changes. Saturday and Sunday 24-hour reports will be reviewed by IDT on Mondays. Issues identified will be corrected at that time with on-the-spot reeducation. Audits will be brought to QAPI team recommendations will be addressed as needed to ensure continued compliance.	

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F 656	Continued From page 3 professional opinion the resident was not repositioned adequately between 12/29/22 and 1/1/23 at the facility to prevent pressure ulcers. c. Interview with the assistant director of nursing on 3/13/23 at 4:20 PM confirmed the facility failed to develop a plan to address the resident's very high risk of developing pressure ulcers. d. According to the facility policy titled, "Care Plans, Comprehensive Person-Centered" last revised March 2022, the Policy Statement shows, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Under Policy Interpretation and Implementation" the following was included, "... The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes..."	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, hospital record review, hospital staff interview, and policy and procedure review, the facility failed to ensure residents received received necessary services to maintain good grooming, and personal and oral hygiene for 1 of 6 sample residents (#1) reviewed who required staff assistance with ADLs. The findings were:	F 677	F677 Corrective Action: Resident no longer resides at the community. Identification: MDS/Designee will audit all residents care plans and MDS to identify residents who require extensive assistance from one or more staff members for bed mobility, dressing, eating, locomotion, personal hygiene,	4/17/23

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F 677	Continued From page 4 Review of the 12/6/22 admission MDS assessment showed the resident was admitted to the facility on 11/29/22 with diagnoses which included diabetes mellitus II, osteoporosis, and non-Alzheimer's dementia. The review showed the resident was rarely or never understood. Further review showed the resident required the extensive assistance for one staff member for bed mobility and personal hygiene. Review of the care plan showed a 12/11/22 plan with a focus as follows: "I have increased risks for actual/potential limitations in my ability to perform my ADLs." The interventions included an extensive assistance requirement from staff with bed mobility, dressing, eating, locomotion, personal hygiene, toileting, and transfers. Review of the 1/1/23 progress note timed 12:21 PM showed the family requested the resident be transferred to the local hospital, and the resident was sent to the ED by non-emergent transfer at 11:40 AM. The following concerns were identified: a. Review of the hospital record showed the resident was admitted to the local ED on 1/1/23 at 12:07 PM and was then admitted to the hospital on 1/1/23 at 4:04 PM with a diagnosis of sepsis. Review of a 1/1/23 nursing note timed 12:15 PM by hospital RN #1 showed the following, "On arrival...[Resident #1] has dry mucous membranes with severe halitosis, dirty teeth, and dry lips. [Resident #1's] perineal area is malodorous and [s/he] has crusting in [his/her] groin and [genitalia]. There is dried crusted bowel movement between [his/her] buttocks." Further review showed pictures of the resident's right and left hand. The right hand picture showed a dried brownish substance under the resident's thumbnail. The left hand picture showed the same dried brownish substance under the fingernail of the fourth and fifth fingers, and the	F 677	toileting, and transfers to ensure a care plan is complete and implemented. Systemic Changes: License nursing staff will be educated by the DON/Designee on performing, ADL care to maintain good nutrition, grooming, and personal and oral hygiene. Staff members on leave will be educated before they return to work. Monitoring: Quality of Care Rounds will be completed by the DON/ADON/Designee weekly for 3 months and then prn to ensure cares are being provided and documented for residents who are unable to carry out activities of daily living independently. Audits will be brought to QAPI team, recommendations will be addressed as needed to ensure continued compliance.	

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F 677	Continued From page 5	F 677		

brownish substance was around the nailbed and down to the first digit of the fourth finger. The middle finger could also be observed in the picture, and the appearance of both pictures showed the resident's fingers were dirty, and the resident's fingernails had not been cared for. The resident's right middle fingernail was jagged on the left hand.

b. Review of the Intervention/Task documentation by CNAs for the resident from 12/17/22 through 12/31/22 showed that documentation failed to include an area for oral care or fingernail care.

c. Interview with CNA #1 on 3/13/23 at 11:05 AM revealed the resident was resistant to cares, especially from male staff. The CNA had taken care of the resident in the last few days at the facility and was unsure when the resident had any fingernail care from anyone. The CNA further stated that residents sometimes received fingernail care during showers, but there was no specific timeframe or plan for care of fingernails. The CNA could not remember the condition of the resident's fingernails at the time of transfer to the ED on 1/1/23. Interview with CNA #2 on 3/13/23 at 1:20 PM revealed that either nurses or an outside provider that came to the facility normally provided care for fingernails, and added that CNAs sometimes provide fingernail care for non-diabetics when providing showers. The CNA was unsure how often the outside provider completed fingernail care for residents. Interview with CNA #3 on 3/13/23 at 1:27 PM revealed residents routinely received nail care with showers. The CNA stated the resident was resistant to cares, and further stated it took 3 staff members to try and do anything for the resident's fingernails. The CNA could not remember the condition of the resident's fingernails prior to

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F 677	Continued From page 6	F 677		

being transferred to the local ED on 1/1/23.

d. Interview with hospital RN #1 on 3/14/23 at 9:50 AM revealed she was present for the resident's visits to the ED on both 12/29/22 and 1/1/23. She stated the resident's appearance was unkempt on arrival to the ED on 12/29/22. She stated staff provided a bedbath and care at that time, which included oral care because she was concerned that baths and oral care had not been provided in a timely manner for the resident as shown by the resident's mouth odor, unclean teeth, and unkempt appearance. She stated when the resident was brought back to the ED on 1/1/23, there was an odor about the resident so strong that staff thought the odor came from the resident's entire body due to sepsis. She stated staff realized at some point the odor was coming from the resident's mouth, and a respiratory therapist assisted in oral care which included utilizing normal saline and swabbing. At one point the respiratory therapist removed what appeared to be a "nasty" mucous plug. She further stated the resident's mouth, lips, and teeth were all dry and dirty. She also stated the resident's fingernails had dry bowel movement on them and under them, and the resident's perineal area had dried bowel movement that was noticeable and appeared to have been there for an extended period of time. She further stated the resident's appearance indicated s/he had not received ADL care since being in the ED on 12/29/23.

e. Interview with the director of nursing on 3/9/23 at 12:05 PM revealed her primary concern for the resident on 1/1/23 was starting intravenous fluids and transferring the resident to the local ED per family request. She confirmed that a head to toe skin assessment was not performed at that time.

f. According to the facility policy title,

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F 677	Continued From page 7 "Activities of Daily Living (ADLs), Supporting" last revised March 2018, the Policy Statement was as follows, "Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene."	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, hospital record review, hospital staff interview, and policy and procedure review, the facility failed to ensure residents received care and services necessary to prevent pressure ulcers from developing for 1 of 6 sample residents (#1) reviewed for pressure ulcer risk. This failure resulted in harm to resident #1, who was discovered to have multiple pressure injuries	F 686	Resident #1 no longer resides in the community. CORRECTION: Residents will receive the care and services necessary to prevent the development of additional pressure injuries and/ or worsening pressure	4/17/23

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F 686	Continued From page 8 upon transfer to the ED. The findings were: Review of the 12/6/22 admission MDS assessment showed the resident was admitted to the facility on 11/29/22 with diagnoses which included diabetes mellitus II, osteoporosis, and non-Alzheimer's dementia. The review showed the resident was rarely or never understood. Further review showed the resident required the extensive assistance of 1 staff member for bed mobility and personal hygiene. Review of the resident's 12/13/22 Braden Scale For Predicting Pressure Sore Risk assessment showed a score of 8, which indicated the resident was at very high risk of developing pressure ulcers. Review of all progress notes from admission through 1/1/23 showed no evidence the resident had pressure ulcers. Review of the 12/27/22 Skin and Wound-Total Body Skin Assessment showed the resident had no new pressure ulcers or wounds. Review of the 12/29/22 SBAR (Situation, Background, Assessment, Recommendation) Communication Form showed there were no changes to the resident's skin. Review of the 12/29/22 note timed at 4:12 PM showed the resident was unresponsive after several days of decline, and the family requested the resident be sent to the local ED. The assessment at that time showed no changes to the resident's skin. Review of the 12/29/22 progress note timed 10:43 PM showed the resident returned to the facility from the local ED with orders to start procedures for comfort care per family request. Review of the 1/1/23 progress note timed 12:21 PM showed the family requested the resident again be transferred to the local hospital, and the resident was sent to the ED by non-emergent transfer at 11:40 AM. Review of the related 1/1/23 SBAR Summary for Providers note timed 3:34 PM showed the	F 686	injuries. The Facility will ensure the tracking of pressure injuries is accurate, consistent, and complete. In addition, the facility will ensure residents with risk for skin breakdown are identified and will provide treatment interventions associated with those risks and monitoring of pressure injuries to prevent pressure injuries from declining. IDENTIFICATION On or before date of compliance the DON/Designee will conduct a head-to-toe Skin Assessment on Residents currently residing here at Cottonwood Care Center. On or before date of compliance the DON/Designee will review records of those residents residing at the facility, specifically the most recent Braden Risk Score, to identify those residents at low, medium, and high risk for development of pressure injuries. Then those care plans will be reviewed/revised/updated as indicated to ensure interventions are in place to address identified risks at that time and identify any resident whose care plan may not appropriately address resident's risk. The DON/Designee will meet along with IDT to evaluate all residents currently with pressure injuries to review current care plan interventions (including mattress and cushion) to evaluate effectiveness. Care plan will be revised if indicated. SYSTEMIC CHANGES Residents will be reviewed for their risk of	

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F 686	Continued From page 9 assessment area for skin was left blank. Interview with the director of nursing on 3/9/23 at 12:05 PM revealed her primary concern on 1/1/23 was starting intravenous fluids and transferring the resident to the local ED per family request. The DON further stated she did not observe any pressure ulcers or skin issues on the resident at that time, but she confirmed she did not perform a head to toe skin assessment. Review of the resident's care plan showed the facility failed to ensure a plan to address the resident's very high risk of developing pressure ulcers. Review of the activities of daily living plan showed the resident required extensive assistance from staff for bed mobility, locomotion, and transfers. Further review of the care plan showed it failed to address the need for repositioning and off-loading. The following concerns were identified: 1. Review of the hospital record showed the resident was admitted to the local ED on 1/1/23 at 12:07 PM and was admitted to the hospital on 1/1/23 at 4:04 PM with a diagnosis of sepsis and a consult for the wound team to examine the resident on 1/2/23. Review of a 1/1/23 nursing note timed 12:15 PM by hospital RN #1 showed the following, "On arrival, the patient has new wounds that were not present during [resident #1's] previous stay in the ED, days before. There is a skin tear to [resident #1's] medial knee area and what appear to be blisters from pressure to [his/her] sacral area with boggy centers. [Resident #1] has dry mucous membranes with severe halitosis, dirty teeth, and dry lips. [Resident #1's] perineal area is malodorous and [s/he] has crusting in [his/her] groin and [genitalia]. There is dried crusted bowel	F 686	skin breakdown on admission, weekly times 4 weeks after admission, quarterly, annually, and with significant changes in status, which includes development of new pressure injuries. Licensed nurses communicate any newly identified pressure injuries to the IDT via the 24 hour communication report. Residents with pressure injury will be reviewed daily and pressure injury progress will be evaluated weekly with corresponding documentation. All the residents residing at facility will have a total skin evaluation completed weekly by a licensed nurse, which is documented in the treatment administration record on PCC. Immediate action to include treatment orders and notification of MD/Family will be provided for any issues noted. The care plans will be reviewed/revised/updated as indicated at that time. Prior to Date of compliance all licensed nursing staff will be in-service on the system above as well as prevention of pressure injury according to policy and procedure and required actions when a pressure injury is identified. An attendance sheet will be kept and reconciled with and active roster of licensed Nursing staff and those unable to attend will be provided with 1:1 reeducation. Prior to date of compliance all C.N.A's will be in-serviced on prevention of pressure injuries. An attendance sheet will be kept and reconciled with and active roster of C.N.A's and those unable to attend will be provided with 1:1 reeducation.	

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F 686	Continued From page 10 movement between [his/her] buttocks." Review of an ED note on 1/1/23 at 12:51 PM written by hospital physician's assistant #1 showed, "Spoke with [resident's long-term care physician], states patient has been obtunded [having diminished arousal and awareness] since 12/31..." 2. Review of the hospital record showed the following notes written on 1/1/23 by RN #2 at 4 PM, "...Wound #2 Pressure Injury Buttocks Placed....Present on Hospital Admission: Yes. Primary Wound #2 Primary Wound Type: Pressure Injury. Wound Assessment: Purple; Fluid Blister; Nonblanchable erythema, Drainage: Scant, Drainage Description: Serosanguinous, Peri-wound Assessment: Non-blanchable erythema; Draining; Blister (Blister open) Wound Covering: Open to air." 3. Review of a General Admission H&P (history and physical) dated 1/1/23 and timed 3:44 PM by hospital DO #1 included the following, "...Pressure ulcer Chronic, present on admission. Present over sacral area. Per review of records and discussion with emergency room staff, not present on 12/29/22 when seen that day..." 4. Review of a hospital record Daily Progress Note dated 1/2/23 at 11:10 AM written by FNP #1 included the following, "...Pressure ulcer Assessment: Chronic, present on admission. Present over sacral area, left heel, left knee, right foot, and right elbow. Per review of records and discussion with emergency room staff, not present on 12/29/2022 when seen that day. Small skin tear on medial left leg as well. Plan: Wound care to evaluate. End of life/Comfort Care." 5. Review of hospital In-Patient Physical Therapy	F 686	MONITORING: The Nurse Managers will review the resident's Treatment Records for competition of the weekly skin assessments as well as ordered treatment documentation 3 times a week for 1 month, and then weekly for one month, then monthly and prn until a pattern of compliance has been met. PCC Telephone orders will be reviewed in the morning meeting (stand-up) to review new orders and follow up as needed. Director of Nursing and/or designee will facilitate. Quality of Care Rounds will be completed by the DON/ADON/Designee weekly for 3 months and then prn to ensure care planned interventions for residents with pressure injuries are in place. Issues identified will be corrected at that time with on the spot reeducation. The Completed Quality of Care rounds will be reviewed by the QAPI team Recommendations will be addressed as needed to ensure continued compliance. Results of Treatment Sheet reviews will be reviewed by the QAPI committee. Recommendations will be addressed as needed to ensure continued compliance. Identified issues will be reported to the monthly QAPI committee to ensure the plan has been implemented, achieved, sustained and evaluated for its effectiveness.	

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	535043	A. BUILDING _____ B. WING _____	C 03/14/2023

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Wound Care Evaluation notes and pictures documented on 1/2/23 by DPT #1 with a time in of 9:52 AM and an out time of 10:39 AM showed the following assessment information for each wound:

a. On 1/2/23 at 10:17 AM, "Wound 01/01/23 #2 Pressure Injury Buttock (Active), Wound Assessment: Boggy; Draining; Blister; Purple, Peri-wound Assessment; Non-blanchable erythema; Intact, Peri-Wound Skin Temp: WNL, Dressing Status: Dressing applied, Drainage: Small, Drainage Description: Serosanguinous, Periwound Treatment: Barrier-skin barrier wipe, Wound Treatment: Cleansed, Wound Covering: Foam Dressing, Pressure Injury Stage: DTPI, Wound length (cm): 9 cm, Wound Width (cm): 10 cm, Wound Surface Area (cm^2): 90 cm^2, Pressure Injury Stage: Deep Tissue."

b. On 1/2/23 at 10:12 AM, "Wound 01/01/23 Pressure Injury Elbow Right (Active), Wound Assessment: Nonblanchable erythema, Peri-wound Assessment: Intact, Peri-Wound Skin Temp: WNL, Dressing Status: Dressing discontinued, Drainage: None, Wound Covering: Open to air, Pressure Injury Stage: 1, Wound Length (cm): 1.1 cm, Wound Width: 1.5 cm, Wound Surface Area (cm^2): 1.65 cm^2, Pressure Injury Stage: Stage I."

c. On 1/2/23 at 9:59 AM: "Wound 01/01/23 #4 Pressure Injury Foot Right; Lateral (Active), Wound Assessment: Purple; Nonblanchable erythema, Peri-wound Assessment: Non-blanchable erythema, Peri-Wound Skin Temp: Cool, Drainage: None, Wound Treatment: Other (Comment), Wound Covering: Open to air, Pressure Injury Stage: DTPI, Wound Length (cm): 1.1 cm, Wound Width (cm): 1.2 cm, Wound Surface Area (cm^2): 1.32 cm^2, Pressure Injury Stage: Deep Tissue."

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d. On 1/2/23 at 10:01 AM: "Wound 01/02/23 Pressure Injury Foot Right; Lateral; Plantar (Active), Wound Assessment: Purple, Peri-wound Assessment: Non-blanchable erythema, Peri-wound Skin Temp: Cool, Drainage: None, Wound Treatment: Other (Comment), Pressure Injury Stage: DTPI, Wound Length (cm): 2 cm, Wound Width (cm): 1.7 cm, Wound Surface Area (cm^2): 3.4 cm^2, Pressure Injury Stage: Deep Tissue."

e. On 1/2/23 at 10:03 AM: "Wound 01/02/23 Pressure Injury Heel* Left (Active), Wound Assessment: Boggy; Purple, Peri-wound Assessment: Non-blanchable erythema, Callus, Peri-Wound Skin Temp: Cool, Drainage: None, Wound Treatment: Other (comment), Pressure Injury Stage: DTPI, Wound length (cm): 6.8 cm, Wound Width (cm): 5.5 cm, Wound Surface Area (cm^2): 37.4 cm^2, Pressure Injury Stage: Deep Tissue."

f. Review of the 1/2/23 In-Patient Physical Therapy Wound Care Evaluation showed: Assessment: "Wounds evaluated, photographed, and treated with focus on comfort. Purple foot wounds are consistent with deep tissue injury from prolonged pressure over bony prominence... Applied foam sacral dressing to wound #2 as this will decrease painful shearing on the bedding. Dressing on [left] knee as well due to drainage. Otherwise wounds were left open to air and offloaded using pillows...."

6. Interview with CNA #1 on 3/13/23 at 4:05 PM revealed the aide had cared for the resident during the last few days at the facility and "tried" to reposition the resident every 2 hours, but there were times it may have been longer than every two hours between repositioning, and the aide could not recall observing any skin issues on the

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resident.

7. Interview on 3/9/23 at 12:20 PM with the long-term care family nurse practitioner (FNP) #1 for the resident at the facility confirmed the facility staff had not made her aware of the resident's wounds. She was unaware of the wounds until the 1/1/23 hospital admission when hospital staff at the facility notified her. She confirmed some of the resident's wounds were pressure wounds. She stated the hospital wound team were the ones who assessed the wounds, and she stated there was documentation in the hospital record. She would not provide an opinion on the severity of the wounds or the timeframe for when they occurred.

8. Interview with hospital DO #1 on 3/13/23 at 11:27 AM confirmed he assessed the resident in the local ED on 1/1/23 after concerns about the resident's wounds were brought to his attention by hospital RN #1. He stated that he was not present in the ED on 12/29/22 and did not observe the resident at that time. He stated the ED staff who were present on 12/29/22 were unaware of any wounds on the resident during that ED visit. He further stated he put in a consult for the wound team to assess the resident's wounds for 1/2/23. He was aware of the resident's sacral wound, and confirmed it was a pressure wound. He was unsure as to the timeframe of the sacral wound and was unaware of the left heel wound until the wound team assessed the resident on 1/2/23. He was non-committal when asked if the pressure ulcers were preventable, but he stated it was best practice to ensure a repositioning schedule for the resident to lessen the likelihood of pressure ulcer development.

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9. Interview with hospital RN #1 on 3/14/23 at 9:50 AM showed she cared for the resident at the local ED on 12/29/22 and 1/1/23. She stated no wounds were identified on the resident on 12/29/22, but further confirmed the wound on the left heel could have been overlooked. She stated that the resident's multiple skin issues, which included a pressure wound to the sacral area, were concerning enough that she brought them to the attention of hospital DO #1. She confirmed she did not observe the pressure ulcer on the resident's left heel. She further stated it was her professional opinion the resident was not repositioned adequately between 12/29/22 and 1/1/23 at the facility to prevent pressure ulcers.

10. Interview with the assistant director of nursing on 3/13/23 at 4:20 PM confirmed the facility failed to develop a care plan to address the resident's very high risk of developing pressure ulcers.

11. According to the policy titled, "Prevention of Pressure Injuries" last revised April 2020, "Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors...Skin Assessment: ...3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs...e. Reposition resident as indicated on the care plan...Mobility/Repositioning: 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of

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F 686	Continued From page 15 repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions...Monitoring: 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis."	F 686		