STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 3/18/25 to 3/20/25. The survey was prompted by complaint intakes WY000004077, WY000004135, WY000004147, WY000004200, WY000004276, WY000004278, WY000004281, WY000004282, WY000004286, WY000004322, and WY000004326. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing CNA: Certified Nursing Assistant LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		4/4/25

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

Electronically Signed | 04/14/2025

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, medical record review, and policy review, the facility failed to notify residents' physicians with changes of condition or treatment	F 580	1. Residents #9, and #10 are currently discharged from the facility. 2. Facility wide audit done by Executive Director/ADNS or designee to validate	

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F 580	Continued From page 2 for 2 of 10 sample residents reviewed (#9, #10). This failure resulted in actual harm to resident #9 who required additional surgical intervention. The findings were: 1. Review of the admission MDS assessment dated 10/7/24 showed resident #9 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included wound infection, displaced simple supracondylar fracture without intercondylar fracture of the right humerus, unspecified open wound of the right elbow, and methicillin resistant staphylococcus aureus. Further review showed the resident had a surgical wound. Review of the care plan, initiated on 10/22/24 showed " ...I admitted with a right elbow surgical wound that has an infection" and interventions included dressing changes as ordered. The following concerns were identified: a. Review of the medication administration record (MAR) for October 2024 showed the resident was to receive a wound vac change on Monday, Wednesday, and Friday which was ordered on 10/2/24. Further review showed the order was discontinued on 10/7/24. b. Review of a physician notification to the facility physician dated 10/7/24 showed the wound nurse requested to discontinue the wound vac and the reason showed "Per wound nurse not applied." The order was signed by the PA-C on 10/7/24. There was no evidence the orthopedic surgeon was notified. c. Review of the "Operative Note Final Report" dated 10/11/24 showed "...postop approximately 6 weeks status post Open Reduction and Internal Fixation (ORIF) right distal humerus extra-articular fracture and 2 weeks status post right elbow wound dehiscence	F 580	residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and responsible party. 3. Director of Nursing or designee educated wound care nurse regarding timely physician notification for any treatment changes. Director of Nursing or designee educated Nursing staff to validate they are notifying physicians and responsible parties of change in conditions, changes in antibiotic therapy, wound care changes and wound treatment orders. Director of Nursing or designee educated Nurse Management to validate they are reviewing all new wound care orders received to validate they are entered into the TAR and orders are followed. 4. Executive Director or Designee will audit weekly for 90 days to validate residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and responsible party.	

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F 580	Continued From page 3 Incision and Drainage (I & D) with placement of A stem cell therapy (A cell) and wound vac. Patient presented to clinic yesterday and has been staying at a skilled nursing facility. [S/he] is present with [his/her] wound Vac not in place and states that the facility decided to discontinue the wound vac. In clinic, the triceps tendon was obviously exposed and began developing eschar overlying it. Given the concern for possible contamination and the need to have a wound vac in place to provide a healthy soft tissue bed for potential plastic surgery coverage, we recommend returning to the OR [operating room] for irrigation debridement of wound and placement of wound vac." d. Review of a progress note dated 10/13/24 and timed 10:54 PM showed "Daily Skilled Evaluation for Fracture/Orthopedic Surgery/Spinal Surgery: Pt with hx [history] of falls, fracture of right elbow with post-surgical infection of deep tissue. NWB [non weight bearing] RUE [right upper extremity]. Pt had debridement of wound yesterday at [hospital] per [clinic] with a wound vac placed ..." e. Review of progress note dated 10/14/2024 and timed 3:36 PM showed " ...Pt had surgical debridement 10-11-24 on [his/her] right elbow wound making this the 4th surgical intervention. Pt returned with a wound vac in place and no new orders for a F/U or future wound care. This nurse did add wound vac orders on 10-12-24 to change every MWF [Monday, Wednesday, Friday] as that is standard for a wound vac. On this date this nurse went in to change wound vac per [clinic name], [clinic staff member name]. Wound vac canister was found with minimal clear drainage (75% of dry pack still dry). Wound vac dressing removed in which black foam was used and directly on Tendon that was thought to be fascia	F 580	The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 580	Continued From page 4	F 580		

in prior assessment. Wound is completely dry at this time and foam stuck to parts of wound. Tendon is dry and frayed in areas. Facility PA-C in room during the entire assessment. PA-C agrees to not put wound vac back on as it is causing more damage. PA-C called [clinic name] whom stated both the surgeon and PA, [name] are out of the office this date, but they will have their nurse call back. This nurse placed hydrogel impregnated gauze over entire wound to help add moisture then secured it in place. Approximately 1 hour later [clinic name] nurse called PA-C with this nurse present. This nurse explained what wound looked like and that this nurse will not be able to replace the wound vac as it is contraindicated. [Clinic name] nurse states one of her providers will call back. A phone call was received from [clinic name's] PA, [name]. Both our facility PA-C and this nurse informed [PA] of what the wound looked like and that the black foam was placed directly on the tendon the PA, [name] stated at that time that she did not place the wound vac and that this nurse should place adaptic over tendon before placing the black foam, this nurse informed [name], PA that she will not be able to place the wound vac as it is not appropriate [name], PA became very mad and stated she did not want to talk to this nurse, so this nurse left the room. Per transportation [name], PA called to have appt set up for 10-15-24 with [clinic name] for wound vac placement. Transportation also states [clinic name] has now requested a consult with [alternate clinic name] on this date 10-14-24 for a skin graft. That appt is 10-17-24."

f. Interview with the Orthopedic Surgeon on 3/20/25 at 1:15 PM revealed the resident required additional surgeries due to the facility's failure to apply the wound vac per the surgeon's orders.

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F 580	Continued From page 5	F 580		

g. Interview with the DON on 3/20/25 at 11:46 AM revealed the wound care nurse should have called the surgeon, and she did not.

2. Review of an admission MDS assessment dated 1/29/25 showed resident #10 had a BIMS score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing and history of falling. Further review showed the resident had a surgical wound. The following concerns were identified:

a. Review of physician communication dated 2/10/25 showed "Orders paint surgical incisions [with] betadine 2 x [times] daily begin keflex 500 mg Qlb [sic] until follow up. FU [follow up] 1 wk [week]." The PA-C signed the note on 2/10/25 and it was marked "noted MAR [medication administration record] updated 2/10/25."

b. Review of the MAR and Treatment Administration Record (TAR) showed start dates for both orders were 2/15/25.

c. Interview with the DON on 3/20/25 at 11:46 AM revealed the nurse failed to update the physician orders for wound care and antibiotic therapy and the delayed orders were identified on 2/15/25.

d. Interview with the Orthopedic Surgeon on 3/20/25 at 1:15 PM revealed the facility failed to notify them of a delay to start wound care and Keflex orders.

3. Review of the policy titled "Skin Integrity" last revised January 2025 showed "...6. If skin impairment is noted after admission (in addition to the above steps), the LN [licensed nurse]:..b. Completes (and documents) notifications to the physician and Resident or Resident

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F 580	Continued From page 6 Representative...8. Wounds are evaluated weekly by center clinicians. arterial, pressure, stasis, and venous ulcers, significant surgical wounds, and burns are evaluated, measured, and findings documented in the medical record. This evaluation includes pain associated with the wound during care. If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified. If a new treatment order is obtained the LN: a. Re-evaluates POC [plan of care] and resident's condition (e.g. off-loading pressure from skin impairment area, nutritional intake, blood sugars, and lab values)..."	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative and staff interview, medical record review, and policy review, the facility failed to provide quality of care for 3 of 10 sample residents (#2, #4, #10). This failure resulted in actual harm to resident #4 who was hospitalized for sepsis infection. The findings were: 1. Review of the quarterly MDS assessment	F 684	1.Residents #2, #4, and #10 are currently discharged from the facility. 2.Facility wide audit done by Director of Nursing or designee to validate residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by	4/4/25

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F 684	Continued From page 7 dated 12/27/24 showed resident #4 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included diabetes mellitus, neuropathy, and renal insufficiency, renal failure, or end-stage renal disease. Further review showed the resident was at-risk for developing pressure ulcers/ injuries, had no venous or arterial ulcers, and no other ulcers, wounds, or skin problems present. Review of the care plan initiated on 1/27/25 showed "I have potential for pressure ulcer development and skin breakdown ..." and interventions which included an air mattress for skin integrity. The following concerns were identified: a. Review of a progress note dated 2/13/25 and timed 4:46 AM showed " ...Skin Issue (New/Worsened/Change) Acute signs and symptoms (s/s): tachycardia, fever, chills, n/v, wound drainage, pain, mentation, interventions, outcomes, Vitals: Right (Rt) buttock wound noted with increased depth from last week. Upper aspect noted yellow/green sluff [sic] and blackened area. Noted foul odor, cleansed with NS and gauze. Applied zinc cream as ordered. Please advise, thank you." Further review showed no additional notes related to wound condition or possible infection until 2/21/25. b. Review of a progress note dated 2/21/25 and timed 8:12 PM showed " ...MD evaluated resident due to swollen left side of face. Orders received to culture drainage. Drainage cultured by day shift and sent to lab. Orders received for Rocephin 1 gram IM/IV every 24 hours times 6 days. Orders received for Metronidazole 500 milligram (mg) oral (po) every 8 hours times 7 days. Orders entered and faxed to pharmacy." c. Review of a progress note dated 2/22/25 and timed 5:10 AM showed " ...Infection Signs/symptoms tachycardia, fever/chills, n/v,	F 684	DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and responsible party. Facility wide audit conducted to validate neuro checks are completed based on company policy. 3.Director of Nursing or designee educated wound care nurse regarding timely physician notification for any treatment changes. Director of Nursing or designee educated Nursing staff to validate they are notifying physicians and responsible parties of change in conditions, changes in antibiotic therapy, wound care changes, wound treatment orders and neuro checks are completed based on company policy. Director of Nursing or designee educated Nurse Management to validate they are reviewing all new wound care orders received to validate they are entered into the TAR and orders are followed. 4.Executive Director or Designee will audit weekly for 90 days to validate residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and responsible party and neuro checks are completed based on company policy. The Director of Nursing or designee will	

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F 684	Continued From page 8 pain, mental status. List clinical findings.: Resident continues on oral antibiotics for UTI. Resident remains A&O at baseline. Starting IM abx [antibiotic] injections this afternoon for possible facial infection. Resident resting in bed with eyes closed. vital signs (VS) stable. No adverse reactions noted. WCTM [will continue to monitor]. Vitals: 113/76, 97.3, 93, 15, 92%." d. Review of a progress note dated 2/22/2025 and timed 7:35 AM showed "Family came in to visit resident. Family concerned about residents [sic] condition. Family requesting resident to be sent to WMC ER for evaluation due to "not being [him/herself]" per granddaughter. MOD [manager on duty] notified and came to unit to assist. VS obtained and resident was tachypneic and hypoxic at 82% on 2L. Oxygen adjusted up to 5L and sats [saturation] rose to 88%. 911 called and left with resident at 738 AM. MD called by MOD and notified of situation." e. Interview with the resident's representative on 3/19/25 at 1:38 PM revealed they were not notified of the skin breakdown or tunneling of the wound until 2/22/25. The representative revealed upon hospitalization it was learned the resident was septic and s/he should have gone to the hospital sooner. 2. Review of an admission MDS assessment dated 1/29/25 showed resident #10 had a BIMS score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included displaced bicondylar fracture of right tibia, subsequent encounter for closed fracture with routine healing and history of falling. Further review showed the resident had a surgical wound. The following concerns were identified: a. Review of physician communication dated 2/10/25 showed "Orders paint surgical incisions	F 684	report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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[with] betadine 2 x [times] daily begin keflex 500 mg QIb [sic] until follow up. FU [follow up] 1 wk [week]." The PA-C signed the note on 2/10/25 and it was marked "noted MAR [medication administration record] updated 2/10/25."

b. Review of the MAR and Treatment Administration Record (TAR) showed start dates for both orders were 2/15/25.

c. Interview with the DON on 3/20/25 at 11:46 AM revealed the nurse failed to update the physician orders for wound care and antibiotic therapy and the delayed orders were identified on 2/15/25.

d. Interview with the Orthopedic Surgeon on 3/20/25 at 1:15 PM revealed the facility failed to notify them of a delay to start wound care and Keflex orders.

3. Review of the admission MDS dated 1/21/25 showed resident #5 had severely impaired cognitive skills for daily decision making, and diagnoses which included depression. Further medical record review showed a diagnosis of altered mental status, and a Morse Fall Scale of 80, which indicated s/he was at a high risk for falls. The following concerns were identified:

a. Review of a progress note dated 1/22/25 at 5:34 PM showed the resident fell in his/her room. Further review showed no observed bruising, skin tears or abrasions, range of motion to all extremities with no difficulties, and neurological checks were started at 5:15 PM.

b. Review of a progress note dated 1/23/25 at 5:19 AM showed "Resident noted walking down the hall without walker/wheelchair/oxygen. Staff responded to assist [him/her] back to [him/her] room and in w/c. Upon assessment noted bruising under left eye, on bridge of nose, and an abrasion area on forehead. When asked resident

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F 684	Continued From page 10	F 684		

if [s/he] had fallen [s/he] stated 'you know I did you helped me up and then took me to eat dinner. I was walking up that incline and then was on the floor on my face' [sic] Resident did have an unwitnessed fall last evening at 15:04 [3:04 PM] in his/her room. Neuros have been WNL. Resident pleasantly confused..."

c. Review of the neurological evaluation showed one neuro assessment documented on 1/22/25 at 5 PM, and no further assessments documented, with a note on the form stating "refused."

d. Review of the emergency room report dated 1/23/25 at 11:16 PM showed a maxillofacial CT had been completed with the result of a nondisplaced acute nasal bone fracture.

e. Interview with the DON on 3/19/25 at 4:15 PM revealed the resident had an unwitnessed fall in his/her room on 1/22/25, and there was a red mark on his/her forehead but no bruising at that time. Further interview revealed the facility protocol for neuro checks after a fall was every hour for the first 4 hours, and every 4 hours for the next 24 hours, with fall charting for 72 hours to monitor for any symptoms.

f. Interview with the DON on 3/20/25 at 11:55 AM revealed she was the nurse on duty on 1/23/25 at 5:19 AM when the resident came out of his/her room and said s/he had fallen again, though the DON was unaware of any other falls. Further interview revealed neuro assessments had been completed but she did not know where the records were, or why the facility only had the first set of vitals taken.

4. Review of the "Fall Management and Neurological Check" policy last updated January 2025 showed "...Head Injury/Unwitnessed Fall...1. In the event of a head injury or fall that is

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 unwitnessed and the occurrence leads the nurse to conclude a head injury is likely, neurological checks are initiated...a. Example of when neurological checks may not be required: i. Resident is cognitively intact and able to state what occurred and there is no evidence of head injury...b. Neurological checks are completed per evidenced based guidance (See reference below): i. Hourly for four (4) hours then. ii. Every four (4) hours for 24 hours. c. Neurological checks include: i. Vital signs ii. Pupillary Response using light accommodation. iii. Motor function including 1. Hand grasp 2. Extremity Review iv. Monitoring for seizure, new onset vomiting, new onset headache, and new onset amnesia ..."	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative and staff interview, and medical record review, the facility failed to ensure residents received	F 686	1.Residents #9 is currently discharged from the facility. 2.Facility wide audit done by Executive	4/4/25

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	535042	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 686	Continued From page 12 necessary treatment and services to promote healing, prevent infection, and prevent new ulcer development for 1 of 5 sample residents (#9) review for pressure ulcers. This failure resulted in actual harm to resident #9 who required additional surgical intervention. The findings were: 1. Review of the admission MDS assessment dated 10/7/24 showed resident #9 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and diagnoses which included wound infection, displaced simple supracondylar fracture without intercondylar fracture of the right humerus, unspecified open wound of the right elbow, and methicillin resistant staphylococcus aureus. Further review showed the resident had a surgical wound. Review of the care plan, initiated on 10/22/24 showed " ...I admitted with a right elbow surgical wound that has an infection" and interventions included dressing changes as ordered. The following concerns were identified: a. Review of the medication administration record (MAR) for October 2024 showed the resident was to receive a wound vac change on Monday, Wednesday, and Friday which was ordered on 10/2/24. Further review showed the order was discontinued on 10/7/24. b. Review of a physician notification to the facility physician dated 10/7/24 showed the wound nurse requested to discontinue the wound vac and the reason showed "Per wound nurse not applied." The order was signed by the PA-C on 10/7/24. There was no evidence the orthopedic surgeon was notified. c. Review of the "Operative Note Final Report" dated 10/11/24 showed "...postop approximately 6 weeks status post Open	F 686	Director/ADNS or designee to validate residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and responsible party. 3.Director of Nursing or designee educated wound care nurse regarding timely physician notification for any treatment changes. Director of Nursing or designee educated Nursing staff to validate they are notifying physicians and responsible parties of change in conditions, changes in antibiotic therapy, wound care changes and wound treatment orders. Director of Nursing or designee educated Nurse Management to validate they are reviewing all new wound care orders received to validate they are entered into the TAR and orders are followed. 4.Executive Director or Designee will audit weekly for 90 days to validate residents meeting the criteria of a change in condition or treatment change, have been evaluated and the physicians/ resident/ responsible parties have been notified of such change. Facility wide audit done by DNS or designee to validate residents requiring wound care, have appropriate orders, facility is following physician orders, and any changes to orders are relayed to doctor, surgeon, and	

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F 686	Continued From page 13 Reduction and Internal Fixation (ORIF) right distal humerus extra-articular fracture and 2 weeks status post right elbow wound dehiscence Incision and Drainage (I & D) with placement of A stem cell therapy (A cell) and wound vac. Patient presented to clinic yesterday and has been staying at a skilled nursing facility. [S/he] is present with [his/her] wound Vac not in place and states that the facility decided to discontinue the wound vac. In clinic, the triceps tendon was obviously exposed and began developing eschar overlying it. Given the concern for possible contamination and the need to have a wound vac in place to provide a healthy soft tissue bed for potential plastic surgery coverage, we recommend returning to the OR for irrigation debridement of wound and placement of wound vac." d. Review of a progress note dated 10/13/24 and timed 10:54 PM showed "Daily Skilled Evaluation for Fracture/Orthopedic Surgery/Spinal Surgery: Pt with hx [history] of falls, fracture of right elbow with post-surgical infection of deep tissue. NWB [non weight bearing] RUE [right upper extremity]. Pt had debridement of wound yesterday at [hospital] per [clinic] with a wound vac placed ..." e. Review of progress note dated 10/14/2024 and timed 3:36 PM showed " ...Pt had surgical debridement 10-11-24 on [his/her] right elbow wound making this the 4th surgical intervention. Pt returned with a wound vac in place and no new orders for a F/U or future wound care. This nurse did add wound vac orders on 10-12-24 to change every MWF [Monday, Wednesday, Friday] as that is standard for a wound vac. On this date this nurse went in to change wound vac per [clinic name], [clinic staff member name]. Wound vac canister was found with minimal clear drainage	F 686	responsible party. The Director of Nursing or designee will report the tracking and trending of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 686	Continued From page 14	F 686		

(75% of dry pack still dry). Wound vac dressing removed in which black foam was used and directly on Tendon that was thought to be fascia in prior assessment. Wound is completely dry at this time and foam stuck to parts of wound. Tendon is dry and frayed in areas. Facility PA-C in room during the entire assessment. PA-C agrees to not put wound vac back on as it is causing more damage. PA-C called [clinic name] whom stated both the surgeon and PA, [name] are out of the office this date, but they will have their nurse call back. This nurse placed hydrogel impregnated gauze over entire wound to help add moisture then secured it in place. Approximately 1 hour later [clinic name] nurse called PA-C with this nurse present. This nurse explained what wound looked like and that this nurse will not be able to replace the wound vac as it is contraindicated. [Clinic name] nurse states one of her providers will call back. A phone call was received from [clinic name's] PA, [name]. Both our facility PA-C and this nurse informed [PA] of what the wound looked like and that the black foam was placed directly on the tendon the PA, [name] stated at that time that she did not place the wound vac and that this nurse should place adaptic over tendon before placing the black foam, this nurse informed [name], PA that she will not be able to place the wound vac as it is not appropriate [name], PA became very mad and stated she did not want to talk to this nurse, so this nurse left the room. Per transportation [name], PA called to have appt set up for 10-15-24 with [clinic name] for wound vac placement. Transportation also states [clinic name] has now requested a consult with [alternate clinic name] on this date 10-14-24 for a skin graft. That appt is 10-17-24."

f. Interview with the Orthopedic Surgeon on

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F 686	Continued From page 15 3/20/25 at 1:15 PM revealed the resident required additional surgeries due to the facility's failure to apply the wound vac per the surgeon's orders. g. Interview with the DON on 3/20/25 at 11:46 AM revealed the wound care nurse contacted the facility's provider related to the wound vac and it was decided the vac was causing damage to the wound. The DON revealed the order was changed by the facility provider with the wound care nurse; however, she revealed the wound care nurse should have notified the surgeon and confirmed the surgeon was not notified.	F 686		