AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 5, 2023

Ms. Alyssa Maker-Lawal, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Maker-Lawal:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **April 7, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING ______ B. WING ______	C 04/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of two facility reported incident on 3/23/2023 through 4/7/23. The following regulatory deficiencies were identified:	F 000		5/10/2023
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655	Specific Corrective Action Resident #2 expired at the facility on 04/14/2023. Resident #3 was discharged on 04/16/2023. Resident #4 was discharged on 04/05/23. Resident #5 currently has a Care Plan in place to meet his needs. Method to Assess for Others An audit of resident's baseline care plans were completed to validate care plans are in place that include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. Systematic Process The facility developed baseline care plans within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. Licensed staff/IDT will be re-educated to this process.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE [signature] 5/12/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 655	Continued From page 1 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 4 applicable residents (Residents #2, #3, #4, and #5). Findings include: 1. Resident #2 was admitted to the facility on 1/30/2023 and has diagnoses that include: heart failure, hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's care plan for risk for skin break down was created on 3/22/2023, 51 days after admission, and his/her care plan for risk for falls was created on 3/30/2023, 59 days after admission. 2. Resident #3 was admitted to the facility on 2/3/2023 and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #2's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission.	F 655	Quality Assurance DON/Designee will complete random weekly audits of resident's CP to validate that they are in place within 48hrs of admission. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 655 POC accepted on 5/5/23 by S. Stem/P. Cota**	

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F 655	Continued From page 2 3. Resident #4 was admitted to the facility on 1/25/2023 and has diagnoses that include: dementia, bipolar disorder, repeated falls, abnormalities of gait and mobility, COPD, major depressive disorder, and hypertension. Resident #4's care plan for risk for skin break down was created on 3/24/2023, 58 days after admission, and his/her care plan for risk for falls was created on 3/23/2023, 57 days after admission. 4. Resident #5 was admitted to the facility on 1/31/2023 and has diagnoses that include: hypertension, repeated falls, osteoarthritis, type 2 diabetes, spinal stenosis, depression, and abnormalities of gait and mobility. Resident #5's care plans for risk for skin break down and risk for falls were created on 2/8/2023, 8 days after admission. Facility policy titled "OPS416 Person-Centered Care Plan", last revised on 10/24/2023, states that "a baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient..." On 3/23/2023 at 12:45 PM, the Director of Nursing confirmed that some baseline care plan areas have not been completed for all residents and stated that the unit manager had just received education on creating and revising care plans. On 3/23/2023 at 2:52 PM, the Unit Manager stated that s/he was made aware "yesterday" of the care areas that are required to be in baseline care plans. On 4/7/2023 at 11:12 AM, the Market Clinical	F 655		

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F 655	Continued From page 3 Lead confirmed that the above residents did not have baseline care plans for the above areas within 48 hours of admission.	F 655		
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, record review, and interview, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for 1 applicable resident (Resident #1) with existing non-pressure ulcer wounds by failing to: accurately perform and document skin inspections (skin checks), accurately and regularly perform non-pressure ulcer wound evaluations per facility schedule, perform and document daily monitoring of non-pressure ulcer wounds or dressings, follow physician's orders for treatment and implement care plan interventions related to wound treatment. Findings include: Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of	F 684	F 684 Specific Corrective Action Resident # 1 orders for wound care to LLE were reviewed and are affirmed in place per order. The resident's care plan has been updated. Resident was evaluated, preventative skin care is in place as per his updated care plan. Licensed nursing staff was educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. LNA staff was educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, diabetic and foot care, and preventive skin care.	

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F 684	Continued From page 4 gait and mobility. A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A provider note dated 3/9/2023 reveals that Resident #1 had complaints of pain to his/her left ankle/heel and right rib cage; and left foot bruising and swelling 3 days post fall. A change in condition note dated 3/10/2023 reveals the following nursing observations: "LLE [left lower extremity] presents swollen bruised on 3/8 with open area to the planter area of the left foot, now red hot to touch, initial xray negative for fx [fracture], Resident with marked decreased in physical abilities and requires max assist with adls [activities of daily living], WBC [white blood cells] elevated. Refusing meals. Significant decline from usual baseline." A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. An emergency department provider note dated 3/11/2023 states that Resident #1's "diagnosis of septic shock likely secondary to cellulitis and potential pneumonia." A Podiatry note dated 3/13/2023 reveals that Resident #1 had "L [left] foot with full thickness ulceration plantar [bottom of the foot] L 2nd metatarsal [foot bones that connect to the toes] head "present for months" with probe to bone, exposed bone, and purulence," and recommendations were made for "daily dressing changes, avoidance of anything but paper tape, and use of a prevalon or comparable heel offloading boot." A hospital provider progress note dated 3/14/23 states that the source Resident #1's septic shock was from a "diabetic foot wound with osteomyelitis/cellulitis LLE." A hospital discharge summary dated 3/20/2023 reveals that Resident #'s 1 wound on	F 684	Method to Assess for Others A facility wide skin sweep was performed and completed by 03/27/23 by DON/designee to evaluate each resident's skin status to determine if any follow-up care and services were indicated. This is continued bi weekly individualized resident head to toe skin observations. A resident record audit was also performed to evaluate compliance with preventative skin care, head to toe skin assessment, shower schedule, treatment, notification of change. Systematic Process An ad hoc QAA was performed to complete a systematic review with revisions as determined/ indicated. New LNAs will be oriented and annually educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, Diabetic and foot care, and preventive skin care.	

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F 684	Continued From page 5 the plantar surface of his/her left foot had been there for months, probed down to the bone, and had purulent drainage. It stated that Resident #1 did not want surgical management of his/her foot but agreed to wound treatment, dressing changes, pain medication, and antibiotics as needed. The note refers to the podiatrist's instructions regarding wound care/dressing changes to left foot and to consult a wound care nurse to evaluate and treat patient's foot wounds. A nurse note dated 3/20/2023 states that Resident #1 was readmitted from the hospital and had "Dressing to left foot, moderate amount sero/sang drainage [Serosanguineous; pink watery fluid] to dressing. Dressing not removed at this time, awaiting wound care instructions." On 3/23/2023 at approximately 1:00 PM, Resident #1 was observed in bed. His/her legs were bare, and his/her left foot was dressed with multiple bandages and pressed into the footboard of the bed. The outer dressing was visibly bloody, along with the fitted bed sheet. On 3/23/2023 at 1:19 PM, a Licensed Nurse Aide (LNA) stated that Resident #1 needed supervision with some ADLs before s/he went to the hospital. Since Resident #1 has returned, they have had a change in ability and now require staff assistance for ADLs. The LNA noted that Resident #1 has not left his/her bed since s/he was readmitted. On 3/23/2023 at 1:55 PM, a Licensed Practical Nurse (LPN) and the Director of Nursing (DON) were observed inspecting Resident #1's dressings. A gauze wrap was removed from the lower section of the foot which was soiled with	F 684	Licensed nurses will be oriented and annually educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. A risk evaluation is now completed on admission, re-admission, weekly for the first month of stay, quarterly and with any possible significant change. Each facility resident now has a formalized schedule head to toe skin checks weekly, bi-weekly bathing, foot observations during care and during specific individualized ankle to toe foot care as noted on order sets and documented on the treatment administrative records, LNA documentation and resident individualized care plan for individualized preventative care. In the event of change of condition or status and or non-pressure related observations, the resident's practitioner will be alerted for guidance and orders, resident and or responsible party will be notified with the care plan individually updated. The Unit Manager/designee will do	

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F 684	Continued From page 6 blood and fluid. Two padded bandages were revealed wrapping the back of Resident #1's left ankle area. These bandages were dated 3/19/23. At approximately 2:00 PM on 3/23/2023, an LPN stated that Resident #1 was not receiving appropriate wound care because the bandage that was on the wound was not appropriate for the amount of fluid that was coming out of it. S/he stated that sometimes s/he has to change the dressing twice in a shift because it gets so bad and that the wound has been there for a long time. On 3/23/2023 at 2:10 PM, the DON stated that Resident #1 does have a chronic diabetic foot ulcer and there are physician orders to treat it. S/He thinks that the wound has a history of opening and closing. S/he also thinks that the nursing staff were waiting to get dressing orders before doing a wound assessment and a dressing change per the nursing note on 3/20/23. Facility policy titled NSG236 Skin Integrity and Wound Management, last revised on 2/1/2023, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." Practice Standards include: "6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds;	F 684	daily review of the electronic health record (EHR) to evaluate documentation of the completion of scheduled skin care, weekly head to toe skin checks, shower schedule and wound care. The Unit Manager/designee will make weekly skin care rounds. The Unit Manager/designee will make daily visual rounds to visualize care to evaluate staff completion and competency as well as individual resident skin status. Quality Assurance The Director of Nursing (DON) will be responsible for ensuring that this system is in place. The DON will also complete a weekly audit of eight residents per month to evaluate their skin status, confirmation that anything present has been appropriately identified by the system and that the system was followed through detection, notification of change, care and documentation.	

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F 684	Continued From page 7 6.4 Perform and document skin inspection on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition; 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds; 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing." Further review of Resident #1's medical record reveals the flowing: Resident #1's care plan includes the following focus: "[Resident] has Diabetic Ulcer r/t Diabetes, Lack of sensation to affected area," created on 5/31/2022. Interventions include: "Ensure appropriate protective devices are applied to affected areas," created on 5/31/2022, "Monitor/document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, Document progress in wound healing on an ongoing basis. Notify MD as indicated," created on 5/31/2022, and "Treat wound as per facility protocol," created on 5/31/2022. Skin checks on 2/7/2023, 2/10/2023, 2/17/2023, 2/25/2023, and 3/4/2023 do not include documentation of Resident #1's diabetic foot ulcer. There are no physician's orders for wound care in February or the beginning of March 2023. The following physician's orders started on 3/9/2023: "Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every 1 hours as needed	F 684	Any concerns identified will be addressed at the time of recognition. Results of the DON audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determined appropriate. **Tag F 684 POC accepted on 5/5/23 by S. Stem/P. Cota**	

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F 684	Continued From page 8 for wound care," and 3/10/2023: "Ball of left foot. Cleanse with wound cleanser, pat dry, apply double layer xeroform to wound bed. Cover with DPD. every day shift for wound." There is no documentation in the treatment administration record (TAR) or medication administration record (MAR) that the wound was treated when Resident #1 returned from the hospital on 3/20/2023 through 2:00 PM on 3/23/2023. There are no weekly wound assessments or documentation of daily wound monitoring, of Resident #1's diabetic foot ulcer in February or March prior to 3/24/2023. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that skin assessments should include all wounds, even if they are not new, until they are resolved. S/He confirmed that Resident #1 did not have: accurate skin assessments prior to transferring to the hospital on 3/10/2023, physician orders for his/her diabetic ulcer until 3/9/2023, and that wound assessments and monitoring did not occur until 3/24/2023.	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	F 686	Specific Corrective Action Resident # 1 was evaluated. Pressure injury orders are in place and being followed. The CP has been updated to include treatment of pressure injuries and prevention of newly developed areas. Resident # 2 expired at the facility on 04/14/2023. Resident #3 was discharged on 04/16/2023.	

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F 686	Continued From page 9 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, record review, and interview, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for 3 of 3 sampled residents (Residents #1, #2, and #3) to prevent and treat existing pressure ulcers by failing to: accurately perform and document skin inspections (skin checks), accurately and regularly perform pressure ulcer wound evaluations per facility schedule, perform and document daily monitoring of pressure ulcer wounds or dressings, obtain treatment orders from physician, follow physician's orders for treatment, implement care plan interventions related to wound treatment, and revise care plans to meet resident's skin and wound care needs. Findings include: 1. Record review and interview reveal that Resident #2 was at risk for developing pressure ulcers and developed three pressure ulcers after admission. The facility failed to provide timely and accurate skin and wound assessments, provide pressure ulcer treatment and dressing changes, create and revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers placing Resident #2 at increased risk for wound complications and developing additional pressure ulcers. Record review reveals that Resident #2 was admitted to the facility on 1/30/2023 and has diagnoses that include: Heart failure,	F 686	Method to Assess for Others Licensed nursing staff was educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. LNA staff was educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, diabetic and foot care, and preventive skin care. Method to Assess for Others A facility wide skin sweep was performed and completed by 03/27/2023 by DON/designee to evaluate each resident's skin status to determine if any follow-up care and services were indicated. This is continued with weekly head to toe skin evaluations. A resident record audit was also performed to evaluate compliance with preventative skin care, head to toe skin assessment, shower schedule, treatment, notification of change.	

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F 686	Continued From page 10 hypertension, history of stroke, type 2 diabetes, and neurogenic bladder. Resident #2's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/6/2023 reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. On admission Resident #2 had the following physician orders: left heel protector to left heel at all times every shift," and "calazimine to redness on coccyx [the lowest part of the back, directly below the sacrum], penis and scrotum two times a day for redness." On 2/7/2023, A skin assessment notes "Pressure Area(s): Location(s): Redness/excoriation on sacrum and under both butt cheeks. Calazime cream applied." A progress note dated 2/12/23 reveals that a "CNA [Certified Nurse Aide] alerted RN [Registered Nurse] of blister on left heel. No pain on assessment. Sponge dressing applied for protection. MD and DON [Director of Nursing] aware. Left voicemail for family. Foam foot protector in place." A 2/14/2023, a skin check notes that no skin injuries/wounds are identified. Resident #2 was transferred to the hospital on 2/19/2023 due to an altered mental state. A wound consult note from the hospital reveals that Resident #2 has right and left heel deep tissue injuries, a reddened area to the sacrum, and a pink area to the right medial thigh. The following recommendations were made for treatment to the	F 686	Systematic Process An ad hoc QAA was performed to complete a systematic review with revisions as indicated. New LNAs will be oriented and annually educated on pressure relieving devices, nutrition/hydration, repositioning, change in condition, shower schedule, diabetic and foot care, and preventive skin care. Licensed nurses will be oriented and annually educated on change in condition, skin integrity and wound management, wound care dressing guidelines, and documentation of skin care provided. A risk evaluation is now completed on admission, re-admission, weekly for the first month of stay, quarterly and with any possible significant change. Each facility resident now has a formalized schedule head to toe skin checks weekly, bi-weekly bathing, foot observations during care and during specific individualized ankle to toe foot care as noted on order sets and documented on the treatment administrative records,	

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F 686	Continued From page 11 sacrum and right medial thigh: "provide skin hygiene with soap and water, pat dry, apply zincoxide skin barrier (orange tube), apply skin prep to periwound skin, apply small sacral mepilex [foam dressing] to sacrum, apply 4x4 mepilex to right medial thigh, and change dressing every 3 days and prn [as needed]." The following recommendations were made for treatment to the heels: "provide hygiene to the lower extremities, pat dry, apply Lubriderm to shins and feet, paint heels with betadine and allow to dry, cover with mepilex, apply booties to bilateral feet, change dressing every other day and prn." Resident #2 was readmitted to the facility on 2/21/2023. A readmission nursing assessment identifies the following "Rash(es): Description: On buttock, red, fungal MASD [moisture associate skin damage]: Description: coccyx Skin Tear(s): Description: small abrasions on coccyx, healing Pressure(s): Description: Left heel has purple blisters and small scab .5 cm." On 2/27/2023, a provider note reveals the following "Pressure ulcer of right and left heel: Stable. Skin of bilateral heels are intact. Continue with wound care and heel protector boot on left foot. Groin rash: Stable." A 3/4/2023 skin check reveals injury to the buttocks area. There is no documentation of right or left heel wounds. A 3/10/2023 wound evaluation reveals that Resident #2 has an unstageable left heel pressure ulcer. On 3/10/2023, the treatment administration	F 686	LNA documentation and resident individualized care plan for individualized preventative care. In the event of change of condition or status and or non-pressure related observations, the resident's practitioner will be alerted for guidance and orders, resident and or responsible party will be notified with the care plan individually updated. The Unit Manager/designee will do daily review of the electronic health record (EHR) to evaluate documentation of the completion of scheduled skin care, weekly head to toe skin checks, shower schedule and wound care. The Unit Manager/designee will make weekly resident skin care rounds. The Unit Manager/designee will make daily visual rounds to visualize care to evaluate staff completion and competency as well as individual resident skin status. Quality Assurance The DON will be responsible for ensuring that this system is in place to support adherence to the pressure injury program.	

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F 686	Continued From page 12 record (TAR) shows the first physician order for wound treatment to Resident #2's left heel. On 3/11/2023, the TAR shows the first physician order for wound treatment to Resident #2's right heel. A 3/11/2023 skin check reveals a scratch on Resident #2's nose. There is no documentation of the injuries/wounds to Resident #2's heels or sacrum. On 3/15/2023, the first wound evaluation was completed for Resident #2, revealing an unstageable left heel ulcer. No evaluations were done for Resident #2's sacrum or right heel. On 3/22/2023, wound evaluations reveal an unstageable left heel ulcer and a stage 3 pressure ulcer [full thickness skin loss] to the coccyx. On 3/22/2023, the TAR shows the first physician order for wound treatment to Resident #2's coccyx. On 3/22/2023, 51 days after admission, a care plan was created for Resident #2 with the following focus: "Resident at risk for skin breakdown related to advanced age (great than 75 years), frail fragile skin, impaired cognition, incontinence and has actual skin breakdown." On 3/24/2023, wound evaluations reveal an unstageable left heel ulcer, a stage 2 pressure ulcer [partial-thickness skin loss with exposed dermis] to the right heel, a stage 3 pressure ulcer to the coccyx, and a deep tissue injury to the left hand.	F 686	The DON/ designee will complete a weekly audit of eight residents per month to evaluate their skin status, confirmation that anything present has been appropriately identified by the system and that the system was followed through detection, notification of change, care and documentation. Any concerns identified will be addressed at the time of recognition. Results of the DON/ designee audit and process will be included in the facility monthly risk management/quality improvement meeting for additional consideration as determined appropriate. **Tag F 686 POC accepted on 5/5/23 by S. Stem/P. Cota**	

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F 686	Continued From page 13 There is no documentation of daily wound monitoring of Resident #2's wounds prior to 3/24/2023. 2. Record review and interview reveal that Resident #1 was readmitted to the facility from the hospital on 3/20/2023 with a stage 2 pressure ulcer. The facility failed to provide timely and regular skin and wound assessments, provide pressure ulcer treatment and dressing changes, revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers, placing Resident #1 at increased risk for wound complications and developing additional pressure ulcers. Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1's MDS dated 2/21/2023 reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. A Podiatry note dated 3/13/2023 reveals that Resident #1 had "Partial thickness wounds medial and lateral ankle areas and posterior heel," and recommendations were made for "daily	F 686		

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F 686	Continued From page 14 dressing changes, avoidance of anything but paper tape, and use of a prevalon or comparable heel offloading boot." A hospital wound assessment dated 3/16/2023 reveals that Resident #1 had a stage 2 pressure ulcer on his/her left ankle. A hospital discharge summary dated 3/20/2023 refers to the podiatrist's instructions regarding wound care/dressing changes to left foot and to consult a wound care nurse to evaluate and treat patient's foot wounds. A nurse note dated 3/20/2023 states that Resident #1 was readmitted from the hospital on 3/20/2023 and had "Dressing to left foot, moderate amount sero/sang drainage [Serosanguineous; pink watery fluid] to dressing. Dressing not removed at this time, awaiting wound care instructions." On 3/23/2023 at approximately 1:00 PM, Resident #1 was observed in bed. His/her legs were bare, and his/her left foot was dressed with multiple bandages and pressed into the footboard of the bed. The outer dressing was visibly bloody, along with the fitted bed sheet. At 1:55 PM, a Licensed Practical Nurse (LPN) and the Director of Nursing (DON) inspected the dressings. A gauze wrap was removed from the lower section of the foot which was soiled with blood and fluid. Two padded bandages were revealed wrapping the back of Resident #1's left ankle area. These bandages were dated 3/19/23. On 3/23/2023 at 2:10 PM, the DON stated that s/he thinks that the nursing staff were waiting to get dressing orders before doing a wound assessment and a dressing change per the nursing note on 3/20/23. S/He confirmed that the readmission skin assessment did not include the	F 686		

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F 686	Continued From page 15 wound on Resident #1's ankle and that there were no physician orders for treatment of the wound on his/her ankle. Further review of Resident #1's medical record reveals the flowing: Upon return to the facility, the 3/20/2023 nursing skin assessment does not document the pressure ulcer located on Resident #1's ankle. There are no physician's orders for wound care for Resident #1's pressure ulcer upon returning to the facility on 3/20/2023 through 3/32/2023. There is no wound assessments or documentation of daily wound monitoring of Resident #1's pressure ulcer from 3/20/2023 through 3/24/2023. Resident #1's care plan was not revised to include actual skin breakdown related to his/her left ankle pressure ulcer until 3/23/2023. On 3/23/2023 at 2:10 PM, the DON confirmed that no one in the facility has assessed Resident #1's wound, treated his/her wound, or updated his/her care plan to reflect the actual wound. 3. Record review and interview reveal that Resident #3 was at risk for developing pressure ulcers and developed three pressure ulcers after admission. The facility failed to provide timely and accurate skin and wound assessments, revise his/her care plan to reflect his/her clinical skin condition and needs, and provide daily monitoring of existing pressure ulcers placing Resident #3 at increased risk for wound complications and developing additional pressure ulcers.	F 686		

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F 686	Continued From page 16 Record review reveals that Resident #3 was admitted to the facility on 2/3/2023 and has diagnoses that include: heart failure, Alzheimer's disease, chronic embolism and thrombosis, osteoarthritis, hypertension, and anemia. Resident #3's MDS dated 2/10/2023 reveals that s/he is at risk for developing pressure ulcers. These clinical conditions and comorbidities are risk factors for developing pressure ulcers. Resident #3's care plan for risk for skin break down was created on 2/10/2023, 7 days after admission. On 3/7/2023, a skin check reveals that resident #3 has "3 blood filled blisters to left outer foot and heel and rt [right] heel." On 3/10/2023, wound evaluations reveal a deep tissue pressure injury of the right heel, a deep tissue pressure injury of the left lateral foot, and a deep tissue pressure injury of the left heel. Skin checks on 3/21/2023 and 3/22/2023 do not reveal any skin injuries/wounds for Resident #3. On 3/23/2023, a skin check reveals that resident #3 has deep tissue pressure injuries to the left and right heel and an unstageable pressure ulcer to the left malleolus [ankle area]. Resident #3's care plan was not updated to reflect actual wounds until 3/23/2023. Facility policy titled NSG236 Skin Integrity and Wound Management, last revised on 2/1/2023, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influences skin health, skin/wound	F 686		

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F 686	Continued From page 17 impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed."Practice Standards include: "6. A licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds 6.4 Perform and document skin inspection on all newly admitted/readmitted patients weekly thereafter and with any significant change of condition 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing." "9. Notify physician/APP to obtain orders." "11. Review care plan and revise as indicated." On 3/23/2023 at 2:10 PM, the Director of Nursing stated that skin checks should document all skin injuries and wounds, even if they have been there for a while. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed that skin assessments should include all wounds, even if they are not new, until they are resolved. S/He confirmed that Residents #1, #2, and #3 did not have consistently accurate skin checks, did not have daily monitoring of wounds and that their care plans were not updated to reflect actual wounds. S/He also confirmed the dates above for the creation of	F 686		

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F 686	Continued From page 18 Resident #1, #2 wound treatment orders.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 3 sampled residents (Residents #1, #4, and #5) remained free of accident hazards as possible regarding implementing interventions to reduces hazards and risks and assessing interventions for effectiveness. Findings include: 1. Resident #1 was initially admitted to the facility on 8/31/2021 and readmitted to the facility from the hospital on 3/20/2023 with diagnoses that include: type 2 diabetes, dementia, peripheral vascular disease, absence of two left toes, heart disease, major depressive disorder, and abnormalities of gait and mobility. Resident #1's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 3/11/2023 reveals that s/he needs staff supervision for transferring and toileting, had a fall since the last MDS assessment, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls.	F 689	Specific Corrective Action Resident #1 and #5 care plans were updated to include new post-fall interventions to prevent future falls. Resident #4 was discharged on 04/05/23. Method to Assess for Others The DON/Designee will complete a review of residents with falls within the last 30 days to validate new post-fall interventions to prevent future falls were adde to the resident's plan of care. Systematic Process The facility implements interventions to reduces hazards and risks including assessing interventions for effectiveness. DON/Designee will educate nursing staff on the Fall Management Program. Quality Assurance The DON/Designee will audit 5 residents with falls per week for 4 weeks then monthly for 2 months to validate falls management program followed including identifying falls, documenting circumstances, and new post-fall interventions to prevent future falls. The DON/Designee will report findings to the QAPI committee for review. **Tag F 689 POC accepted on 5/5/23 by S. Stem/P. Cota**	

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F 689	Continued From page 19 A facility incident report reveals that Resident #1 had falls on 3/6/2023 and 3/10/2023. A provider note dated 3/9/2023 reveals that Resident #1 had complaints of pain to his/her left ankle/heel and right rib cage; and left foot bruising and swelling 3 days post fall. A change in condition note dated 3/10/2023 reveals the following nursing observations: "Resident with bruised right sided rib cage, with pain upon deep breathing and or cough, xrays on the 6th negative for FX [fracture] or infiltrates, LLE [left lower extremity] presents swollen bruised on 3/8 with open area to the planter area of the left foot, now red hot to touch, initial xray negative for fx [fracture], Resident with marked decreased in physical abilities and requires max assist with adls [activities of daily living], WBC [white blood cells] elevated. Refusing meals. Significant decline from usual baseline." A nursing note dated 3/11/2023 states that Resident #1 was sent to the hospital on 3/10/2023 for further evaluation. Resident #1's care plan includes the following focuses: "[Resident #1] is at risk for falls," created on 8/31/2021, and "[Resident #1] has an ADL Self Care Performance Deficit r/t [related to] Unsteady gait, back pain, dizziness/giddiness," created on 8/31/2021. Interventions reveal that Resident #1 is independent with ambulation, bed mobility, and toileting. No interventions were created or revised after 7/14/2022 for his/her fall or ADL care plan. On 3/23/2023 at 1:19 PM, a Licensed Nurse Aide (LNA) stated that Resident #1 needed supervision with some ADLs before s/he went to the hospital. Since Resident #1 has returned, they have had a change in ability and now require staff assistance for ADLs. The LNA noted that Resident #1 has not left his/her bed since s/he	F 689		

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F 689	Continued From page 20 was readmitted. 2. Resident #4 was admitted to the facility on 1/25/2023 and has diagnoses that include: dementia, bipolar disorder, repeated falls, abnormalities of gait and mobility, COPD, major depressive disorder, and hypertension. Resident #4's MDS dated 2/1/2023 reveals that s/he needs staff assistance for transferring, toileting, and locomotion, had falls in the month prior to admission, wanders daily, and was receiving antianxiety and antidepressant medications. These clinical conditions and comorbidities are risk factors for falls. A facility incident report reveals that Resident #4 had falls on 1/29/2023, 3/6/2023, 3/8/2023, 3/9/2023, and 3/12/2023. Resident #4's care plan for risk for falls was created on 3/23/2023, 57 days after admission. 3. Resident #5 was admitted to the facility on 1/31/2023 and has diagnoses that include: hypertension, repeated falls, osteoarthritis, type 2 diabetes, spinal stenosis, depression, and abnormalities of gait and mobility. Resident #5's MDS dated 2/7/2023 reveals that s/he needs staff assistance for transferring and toileting, had falls in the month prior to admission, and was receiving antidepressant medications. These clinical conditions and comorbidities are risk factors for falls. A facility incident report reveals that Resident #5 had falls on 2/15/2023, 3/3/2023, and 3/11/2023. Resident #5's care plans for risk for falls was created on 2/8/2023, 8 days after admission, and was not revised after the above falls.	F 689		

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F 689	Continued From page 21 Facility policy titled "NSG215 Falls Management," last revised on 6/15/2022, states under practice standards to "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Adjust and document individualized intervention strategies as patient condition changes." On 3/23/2023 at 12:45 PM, the Director of Nursing stated that s/he is aware care plans are not being created or revised consistently in the facility and that residents should have risk for falls on their baseline care plans. S/he confirmed that Resident #1, #4, and #5's care plans were not updated after the falls listed on the facility incident report. On 4/7/2023 at 11:12 AM, the Market Clinical Lead confirmed the following: revisions were not made to Resident #1's care plan after his/her falls and that his/her care plan interventions for ADLs did not reflect his/her actual need; Resident #4 did not have a care plan for falls until 3/23/2023 and should have been developed within 48 hours of admission; and revisions were not made to Resident #5's care plan after his/her falls.	F 689		