STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115322	A. Building B. Wing	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Health Center by Harborview	3888 Lavista Road Tucker, GA 30084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34575 Based on staff interviews, record review, and a review of the facility's policy titled, Admission Criteria, review, the facility failed to ensure the Level 1 Pre-Admission Screening and Resident Review (PASARR) included accurate mental health diagnoses for 2 of 4 residents (R) (#61 and #50) reviewed for PASARR assessments. Findings included: Review of a facility policy titled, Admission Criteria, revised March 2019, specified, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The policy indicated, The facility conducts a Level 1 PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD and he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. The policy further indicated, The social worker is responsible for making referrals to the appropriate state-designated authority. 1. A review of an Admission Record indicated the facility admitted R#61 on 05/22/2020 with diagnoses that included major depressive disorder, post-traumatic stress disorder (PTSD), and anxiety disorder. The admission Minimum Data Set (MDS), dated [DATE], revealed R#61 was not considered by the state Level II PASARR process to have a serious mental illness. The Brief Interview for Mental Status (BIMS) revealed the resident had a score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated R#61's active diagnoses included psychiatric/mood disorders of anxiety disorder, depression, and PTSD. The annual MDS, dated [DATE], revealed R#61 was not considered by the state Level II PASARR process to have a serious mental illness. The BIMS revealed the resident had a score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated R#61's active diagnoses included psychiatric/mood disorders of anxiety disorder, depression, and PTSD. Review of R#61's care plan, initiated on 05/22/2020, revealed the resident had impaired cognitive function related to PTSD, impaired decision-making, long-term memory loss, and psychotropic drug use. The care plan further indicated R#61 had a mood problem related to major depression and anxiety. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R#61's Preadmission Screening/Resident Review (PASRR) Level 1 Assessment (Form DMA-6), completed 05/05/2020 by the referring hospital, revealed the response of No to the presence of diagnoses of depressive disorder, anxiety disorder, and other mental disorder. Interview on 02/14/2023 at 2:24 p.m., the Social Service Assistant (SSA) stated the Social Worker (SW) was responsible for the PASARRs and indicated she did not have anything to do with the PASARRs. She indicated that the SW was unavailable and was on leave due to a family emergency. Interview on 02/16/2023 at 3:46 p.m., the Administrator stated the hospital would complete the PASARR Level 1 prior to admission to the facility. The Administrator further stated if the PASARR was incomplete it would be verified and corrected by the MDS Director. The Administrator stated verification for accuracy would include looking at the diagnoses. The Administrator did not know what had to happen if the PASARR was inaccurate and was not able to speak to the process of correcting an inaccurate PASARR. The Administrator further stated the MDS Director, and the SW were the staff who had been trained on PASSARs. The Administrator stated if the Level I PASARR was inaccurate it could impact a resident's ability to receive additional services. The Administrator stated it was his expectation the PASARR be reviewed at the time of admission for accuracy. Interview on 02/16/2023 at 4:06 p.m., the MDS Director stated the PASARR was completed by the hospital before a resident came to the facility, but if their diagnoses changed after admission, the facility was responsible to resubmit a Level 1 for review by the state. The MDS Director stated the social worker completed the PASARRs and verified them for accuracy. She stated if the social worker found something was inaccurate, she would resubmit a corrected PASARR. The MDS Director further stated she was responsible for the coding of the MDS and not for the completion of the PASARR. 28196 2. A review of R#50's Admission Record revealed the resident was admitted on [DATE] with diagnoses that included anxiety disorder, opioid abuse with opioid-induced psychotic disorder with hallucinations, borderline personality disorder, mood disorder, and major depressive disorder. A review of R#50's admission Minimum Data Set (MDS), dated [DATE], revealed they were not currently considered by the state Level II PASARR process to have a serious mental illness. R#50 had a Brief Interview of Mental Status (BIMS) score of 13, indicating they were cognitively intact. A review of R#50's PASARR Level I Application (DMA-613), undated, revealed the form indicated the resident did not have a primary diagnosis of serious mental illness or mental disorder. Diagnoses of depressive disorder, anxiety disorder, substance use related disorder, and other mental disorder were unchecked. Interview on 02/14/2023 at 2:24 p.m., the Social Service Assistant (SSA) said the Social Worker (SW) was responsible for the PASARRs and indicated she did not have anything to do with them. She confirmed the SW was off and was not available for interview. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/16/2023 at 3:46 p.m., the Administrator said the residents were supposed to be admitted with a Level I PASARR from the hospital, but if they were not, the SW or the Business Office Manager (BOM) were responsible for completing the Level I PASARR. He also indicated the MDS Director was responsible for ensuring the accuracy of the Level I PASARR, whether it came completed by the hospital or if it was completed at the facility. He also indicated that the Level I PASARR needed to be accurately completed to ensure the resident received all the necessary care and services related to their mental illness. He confirmed that he expected the Social Service Assistant to fill in when the SW was absent and indicated the SW and the MDS Director had received PASARR training. Interview on 02/16/2023 at 4:19 p.m., the MDS Director looked at R#50's diagnosis in the electronic health record and confirmed the resident was admitted with diagnoses that included anxiety disorder, psychotic disorder, major depression, and suicide attempt. After reviewing the Level I PASARR, she indicated that none of those mental illness diagnoses were noted on the Level I PASARR and said it was not accurate. She also indicated that since it was not accurate, the resident may not be receiving all the care and services for their mental illnesses.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34575 Based on observations, resident and staff interviews, record review, and a review of the facility policy titled, Resident Showers, the facility failed to provide activities of daily living (ADL) care to ensure good grooming and personal hygiene for 1 of 6 residents (R) (#21) reviewed for ADL care. The failure had the potential to negatively impact residents quality of life. Findings included: Review of a facility policy titled, Resident Showers, dated 12/01/2022, specified, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy. Review of the most recent annual Minimum Data Set (MDS), for R#21 dated 01/04/2023, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident was dependent on two staff members for transfers, dressing, toileting, and bathing. The MDS further indicated the resident required extensive assistance from one person for personal hygiene. Record review of the care plan for R#21 dated 03/08/2022, revealed the resident had an ADL self-care performance deficit related to limited mobility and required extensive assistance of one to two staff with bathing and showering twice a week and as necessary. Interview on 02/13/2023 at 11:20 a.m. with R#21 stated they had only received two showers since last March, and they wanted to have showers. The resident was observed to be dressed in clothes that were not clean (wrinkled), the resident's hair was not groomed, and there was a faint odor of urine on the resident's person. Record review of the C.N.A. [Certified Nursing Assistant] Skin Inspection Report, revealed three skin inspection reports were completed for R#21 since 12/01/2022. The reports were dated 01/17/2023, 01/20/2023, and 02/03/2023. Registered Nurse (RN) #9, the Unit Coordinator, confirmed at the time of the review there was no other shower documentation for R#21. Interview on 02/14/2023 at 3:30 p.m. with CNA #10 stated she had worked in the facility since June 2022 and worked the 3:00 p.m. to 11:00 p.m. shift. CNA #10 stated when a resident was given a shower or a bath, then she filled out a skin inspection report. CNA #10 stated that whenever she would provide a shower she would document on the skin sheet, and if a shower was not provided, the skin sheet would be completed and would indicate if the shower was not given and why. Although review of the record revealed CNA #10 completed two of the three skin inspection reports, CNA #10 stated she had never put R#21 in the shower as it took three to four people to manage the resident, and the shower bed was not wide enough for the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/14/2023 at 4:00 p.m. with Registered Nurse (RN) #9 stated the C.N.A Skin Inspection Reports were completed by the CNAs when they gave a resident a shower or a bath. She stated if a resident refused a shower, it was supposed to be documented by the nurse. RN #9 reviewed the clinical record and stated there were no shower refusals documented for R#21. RN #9 further stated, It takes a lot to shower the resident, but it can be done, and staffing varied on evening shift and sometimes there was not enough staff in the evening. They generally had four to five aides, but if anyone calls out there would not be sufficient staffing. RN #9 stated R#21 was scheduled to receive two showers per week. Interview on 02/15/2023 at 3:36 p.m. with CNA #11 stated she had worked at the facility for two to three months. CNA #11 further stated there was a shower book on the unit that specified which days and shifts the residents received their showers, and a shower sheet (skin inspection report) was completed for each shower. CNA #11 stated if a resident refused to be showered it would be documented on the shower sheet. Interview on 02/16/2023 at 4:57 p.m. with the Administrator and the Interim Director of Nursing (DON), the interim DON stated the showers were to be administered as scheduled. If the resident refused, it should be documented in their record and the family should be notified.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34575 Based on observations, staff interviews, record review, and a review of the facility policy titled, Wound Treatment Management, the facility failed to provide treatment and services to promote healing for 2 of 4 residents (R) (#68 and #249) reviewed for pressure ulcers. The facility failed to assess R#68's heels weekly after non-blanchable redness was identified to both heels on 01/28/2023. In addition, the facility failed to assess R#249's pressure ulcers upon readmission to the facility and failed to ensure treatment to the pressure ulcers was provided as ordered by the physician. Findings included: Review of a facility policy titled, Wound Treatment Management, dated 12/01/2022, specified, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy indicated, Treatment decisions will be based on b. characteristics of the wound: i. pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size-including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of the peri-wound skin. Further review of the policy revealed, The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include a. Lack of progression towards healing. b. Changes in the characteristics of the wound. The effectiveness of treatments will be monitored through ongoing assessment of the wound (see above). 1. Record review of the Admission Record for R#68 indicated a readmission on 01/27/2023 with a diagnosis that included a stage four sacral pressure ulcer. Record review of the Admission/Readmission Evaluation, for R#68 dated 01/27/2023, revealed the resident had a pressure ulcer to the sacrum. The evaluation revealed the resident had a dressing to the sacral wound and was admitted to hospice services. Record review of the care plan, for R#68 dated 01/27/2023, a care plan, dated 01/31/2023, for a pressure ulcer to the right first toe that was present on admission. The facility developed interventions that included heel protectors, a low air loss mattress, and weekly skin assessments. Record review of skin/wound Progress Notes, dated 01/28/2023 at 3:49 p.m., revealed R#68 had a deep tissue injury (DTI) to the right first toe. Furthermore, a skin/wound note dated 01/28/2023 at 6:00 p.m., written by Licensed Practical Nurse (LPN) #12, revealed a readmission skin assessment was completed. R#68 was readmitted with a stage four pressure ulcer to the sacrum and a description of the wound. Review of the Braden Scale for Predicting Pressure Sore Risk, completed on 01/28/2023, revealed R#68's score was 12, which indicated high risk for developing a pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the most recent significant change Minimum Data Set (MDS), dated [DATE], revealed R#68 was at risk of developing pressure ulcers. The MDS indicated the resident had a stage four pressure ulcer that was present upon admission/readmission and three DTIs also present on admission/readmission. Record review of R#68's Wound Evaluation and Management Summary, dated 01/31/2023 and signed by the wound care medical doctor (WCMD), revealed the resident had a stage four pressure wound to the sacrum and an unstageable DTI of the right medial first toe. There was no mention of a second or third DTI. Record review of the physician orders for R#68 revealed that on 01/31/2023 an order was placed to cleanse the right and left heels with normal saline, blot the areas dry, apply skin prep solution on Tuesdays, Thursdays, and Saturdays, and leave the heels open to air for preventative measures. Record review of the Weekly Wound Evaluations, for R#68 dated 02/02/2023, revealed two wounds were assessed, a stage four to the sacrum and a DTI to the right medial toe. There were no evaluations conducted for the bilateral heels. Interview on 02/15/2023 at 12:20 p.m. with Licensed Practical Nurse (LPN) #13 provided a note dated 02/03/2023 with an effective date of 01/28/2023, written by LPN #12. The note indicated R#68 had non blanchable redness on bilateral heels. Record review of a Treatment Administration Record for R#68 dated February 2023 revealed the treatments were provided to the left and right heels as ordered. Record review of the change of condition Progress Notes, for R#68 dated 02/07/2023, revealed the WCMD now classified the resident's left and right heel non-blanchable redness as DTIs with the skin intact. The DTI to the right heel measured 6 centimeters (cm) long by (x) 5 cm wide. The right heel measured 7 cm long x 5 cm wide. Record review of the Wound Evaluation and Management Summary, for R#68 dated 2/07/2023 and signed by the WCMD, revealed the wounds to the bilateral heels had been present for more than nine days. The left and right heels were described as unstageable DTIs with intact skin that resulted from pressure. Additional wound details revealed the DTIs were not new. The WCMD made no changes in treatment orders for the areas. Record review of the care plan for R#68 revealed on 02/07/2023 the facility revised the resident's care plan to include admit unstageable deep tissue injuries (DTIs) to the bilateral heals. Observation on 02/13/2023 at 11:10 a.m. R#68 was observed lying in the bed with covers over the resident. The resident was unable to answer any questions. An air mattress was in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/15/2023 at 3:09 p.m., with the wound care nurse LPN #12 revealed the nurses on the hall were responsible for weekly skin assessments. If an issue with skin was found, the nurses communicated the skin alteration verbally. Sometimes the nurses may leave notes on the inside of the treatment cart. When a wound was found, the physician and the responsible party (RP) were also expected to be notified and treatment started immediately. LPN #12 stated that most of the time the floor nurse called the physician for treatment orders, which automatically transferred to a treatment sheet. Further, if a wound was found, one of the treatment nurses assessed the wound within 24 hours, including weekends. She stated that the nurse who found a wound only describe the wound and did not measure or stage the wound. The wound care MD and the treatment nurses were responsible for measuring and staging. LPN #12 revealed there should be weekly documentation of wounds, including measurements, a description of the wound, and progress of the wound. The RP was updated weekly, and the notification was documented on the wound evaluation. If a resident was at risk for pressure ulcers on admission, but had no actual wounds, the facility usually applied heel protectors, sometimes foam, over bony areas, and used barrier cream. LPN #12 further stated they tried to observe high risk residents to make sure they were turned every two hours. Observation on 02/15/2023 at 8:26 a.m. LPN #12 was observed to attempt to provide wound care to R#68's bilateral heels and to measure the areas of concern. The resident was observed lying in the bed with their eyes closed. There were bilateral heel protector boots in place. When the nurse attempted to reposition the resident's legs or to remove the heel protector boots the resident moaned and said No. The nurse was unable to continue due to the discomfort expressed by the resident. LPN #12 stated she did not know why she had not completed a weekly wound evaluation of the heels. LPN #12 stated she had seen redness on the resident's heels on 01/28/2023, and there were interventions in place including an air mattress and heel protector boots. LPN #12 stated non-blanchable redness could be identified as a stage one pressure injury. LPN #12 further revealed this was not a normal finding and the wound care nurses should have monitored the areas. In the absence of treatments, LPN #12 stated the wound care nurses would still look at the areas of concern, but LPN #12 did not document those observations. LPN #12 stated she wanted the WCMD to look at the resident's heels on 02/07/2023 as the areas appeared darker and the surface area was larger. LPN #12 stated a weekly wound evaluation should have been conducted of the resident's heels on 02/02/2023. Interview on 02/15/2023 at 11:53 a.m. with LPN #13 stated R#68 was readmitted with heel wounds. A follow-up interview on 02/16/2023 at 9:23 a.m. with LPN #13 revealed R#68's heels were initially considered a stage one pressure injury due to non-blanchable redness. LPN #13 stated a stage 1 pressure ulcer triggered a treatment be put in place and the physician and family be notified. LPN #13 further stated there were other treatments in place; for example, heel protector boots, and a skin prep treatment was added on 01/31/2023. LPN #13 further revealed it was not their practice to conduct weekly wound evaluations on any skin concern below a stage II. LPN #13 stated she would look at the heels when she provided treatment to R#68's sacral wound and staff would remove the heel protectors when turning the resident and the heels would be observed at that time. LPN #13 stated she did not think there was any change to the heels until 02/07/2023 when she asked the WCMD to look at the resident's heels. LPN #13 was not able to speak to the pressure ulcer policy. She was unsure if there was a policy or what it instructed staff to do. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/15/2023 at 3:45 p.m., the Registered Dietician (RD) stated she had worked at the facility since August 2022 and came to the facility two days each week. The RD revealed her practice was to pull the new admission report, conduct a chart review, and review the hospital notes to determine residents' nutritional status. The RD stated when R#68 returned to the facility after a lengthy hospitalization , the resident had experienced significant weight loss and was on tube feeding. The resident was placed in hospice shortly after readmission. The RD stated she was aware of the resident's sacral wound but was not made aware of any other skin breakdown because the wound notes were made after the RD's evaluation. The RD further stated she was not surprised that the resident experienced skin breakdown as the resident had declined significantly during hospitalization and the resident's family had opted to discontinue the resident's tube feeding on 02/12/2023. The RD further stated she would expect the resident to have worsening/additional wounds since the resident was no longer receiving protein through tube feedings. Interview on 02/16/2023 at 9:59 a.m., the WCMD stated he came to the facility every week and conducted rounds with the wound care nurses, who told him which residents needed to be seen. The WCMD described non-blanchable skin as a stage one pressure injury, the injury being superficial through the dermis (skin) and described a DTI as tissue injury that goes through the fascia and possibly through the subcutaneous tissue all the way to the muscle. The WCMD stated there was no way of knowing the extent of the injury once a DTI was identified. The risk of a DTI was dependent on the co-morbidities the resident had present, which included weight, and the existence of diagnoses such as diabetes, peripheral vascular disease, or neuropathy. The WCMD stated a treatment should be initiated for a DTI. The treatment could include offloading, monitoring, and assessing, and did not have to be a treatment that was applied to the heel. The WCMD further stated if the Braden scale showed a high risk for pressure ulcers, the resident should be monitored more closely. In reference to R#68, the WCMD stated he was not aware of the DTIs to the resident's heels until 02/07/2023. He stated there were significant co-morbidities pre-disposing the resident to a high risk for developing wounds. Pressure management was ongoing every day and every hour by utilization of heel protection boots and floating of the heels. The WCMD could not speak to the day-to-day monitoring or assessments of wounds but stated that once a non-blanchable skin area was noted it could take a couple of hours for a DTI to develop. Interview on 02/16/2023 at 4:57 p.m., the interim Director of Nursing (DON) and the Administrator stated wounds should be monitored routinely and frequently to assess the interventions in place. The interim DON added that treatments needed to be adjusted with worsening wounds, and documentation done accordingly. 22445 2. Record review of the Admission Record for R#249 revealed the facility admitted the resident on 11/18/2021 with diagnoses that included a stage 2 sacral pressure ulcer. Record review of an Admission Data Collection, for R#249 dated 11/18/2021, indicated skin was intact. A review of the Braden Scale for Predicting Pressure Sore Risk section indicated R#249 was at very high risk for pressure ulcers. There were no interventions identified on the Skin Integrity Care Plan included on the admission assessment form. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Baseline Care Plan and Summary, for R#249 dated 11/18/2021, indicated the resident had pressure ulcers. There was no description of the pressure ulcer, and no care plan interventions were initiated for pressure ulcers. Record review of the Weekly Pressure Ulcer Record, for R#249 dated 11/20/2021 and completed by Licensed Practical Nurse (LPN) #12, a wound care nurse, revealed the resident had a stage 2 left buttock pressure ulcer with an onset date of 11/19/2021. The pressure ulcer measured 4 centimeters (cm) long by (x) 5 cm wide x 0 cm deep. LPN #12 documented the resident was admitted with the stage 2 pressure injury on the left buttock and described the wound bed as pink with no drainage. The LPN documented a treatment of barrier cream and stated the treatment would continue. Record review of the Treatment Administration Record [TAR], dated November 2021, indicated R#249 had an area requiring wound care located on the left buttock. The treatment orders indicated the area would be cleaned with normal saline, blot the area dry, and apply barrier cream daily and as needed. The order was written with a start date of 11/21/2021, which was three days after the resident's admission to the facility. Review of the entry on the TAR revealed no treatment was completed until 11/23/2021, which indicated R#249 received the first wound treatment five days after admission. Record review of the Weekly Pressure Ulcer Record, dated 11/27/2021 for R#249, LPN #12 documented the stage 2 left buttock pressure ulcer had healed. Record review of nursing Progress Notes for 12/08/2021 indicated R#249 was transferred to the hospital for a decrease in the resident's level of consciousness. Further review of Progress Notes revealed the resident returned to the facility on [DATE] with boots to the feet and a pressure ulcer to the sacrum covered with a dressing. Record review of skin/wound Progress Notes dated 12/17/2021 at 4:02 p.m., revealed LPN #12 documented that R#249 had been readmitted from the hospital with multiple pressure ulcers, including the following: - an unstageable sacral ulcer measuring 12 cm x 6 cm x 0.2 cm, - an open area on the right upper arm with no measurements/description, - a deep tissue injury (DTI) on the right heel with no measurements/description, - an unstageable pressure ulcer on the left outer ankle measuring 2.5 cm x 2.5 cm x 0.2 cm, and - a DTI on the right outer ankle with no measurements/no description. The note indicated the RR was notified of the skin issues. (continued on next page)

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	115322	A. Building B. Wing	03/07/2023

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R#249's December 2021 TAR revealed a treatment to the sacrum was ordered to start on 12/17/2021 that included cleaning the sacrum with normal saline, blotting the area dry, applying calcium alginate, and covering with a dry protective dressing three times weekly on Tuesday, Thursday, and Saturday and as needed. The TAR also indicated a treatment to apply skin prep to the DTI/unstageable areas to the left and right heel, right lateral foot, and right outer ankle three times per week and as needed was started on 12/18/2021. Further review revealed a treatment for the left outer ankle beginning 12/18/2021 to cleanse with normal saline, blot dry, apply Santyl, and a dry protective dressing every day and as needed. Record Review of the Weekly Pressure Ulcer Record, dated 12/17/2021, indicated R#249 the wound was described to have a wound bed of 50% adherent thick black tissue (dead tissue), 50% slough (yellow tissue that is not viable), with odorless, moderate, serosanguinous (watery bloody) drainage. LPN #12 documented she notified R#249s resident representative about the resident's wounds on 12/17/2021. There was no information on the weekly pressure ulcer record regarding any other wounds to include measurements or descriptions, including the areas mentioned in the 12/17/2021 Progress Notes. A review of an Initial Wound Evaluation & Management Summary revealed on 12/21/2021, four days later, a wound care medical doctor (WCMD) described the following pressure ulcers that had been identified, but not assessed by the facility on 12/17/2021: - an unstageable (due to necrosis [dead tissue]) sacrum pressure ulcer measuring 8 cm x 6.7 cm x 0.5 cm with a treatment order change to apply Santyl daily for 30 days after cleaning with a Dakin's solution (a Clorox and water solution). The WCMD documented he debrided (surgical removal of dead tissue in order to expose viable tissue) the sacral wound. The physician recommended limiting sitting to 60 minutes and off-loading the wound. - a shear wound to the right arm that measured 2.4 x 1.5 x unmeasurable depth to be treated with a Xeroform sterile gauze and covered with an island gauze with a border. - an unstageable DTI of the right heel measuring 2.5 cm x 3.5 cm x unmeasurable depth to continue to be treated with skin prep applied three times per week for 30 days. - an unstageable DTI of the right, lateral (outer) ankle measuring 2 cm x 2 cm x unmeasurable depth to continue to be treated with application of skin prep three times a week for 30 days. - an unstageable DTI of the left, lateral (outer) ankle measuring 2 cm x 2 cm by unmeasurable depth with the treatment to be changed to skin prep three times a week for 30 days. Further review of the Initial Wound Evaluation & Management Summary, dated 12/21/2021, revealed the WCMD also identified the following areas that had not been identified by the facility: - an unstageable DTI of the right, distal, medial foot (the inner side/big toe side of the foot) measuring 1 cm x 1.6 cm x unmeasurable depth to be treated with skin prep three times per week for 30 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an unstageable DTI of the right, lateral foot (on the little toe side of the foot) measuring 3 cm x 2 cm x unmeasurable depth to be treated with the application of skin prep to the area three times a week for 30 days. According to the resident's TAR, a treatment was already in progress for this area. Continued review of the December 2021 TAR indicated treatments ordered by the WCMD on 12/21/2021 were not initiated until 12/23/2021, two days after the WCMD wrote the order for treatment. In addition, the treatment to the right distal medial foot was provided daily, not three times per week as ordered by the physician. Record review of care plan for R#249, initiated 12/17/2021, revealed the facility developed a care plan for treatment of the sacral pressure ulcer with interventions that included administering treatments as ordered, turning and repositioning at frequent intervals, providing incontinence care after each incontinence episode, and conducting weekly treatment documentation to include measurement of each area of skin breakdown. There was no documented evidence the facility developed a care plan for the pressure ulcer to the right distal medial foot, right heel, right lateral foot, left lateral ankle, or right lateral ankle until 01/21/2022, approximately one month after the pressure ulcers developed. There was no evidence the facility implemented interventions that the WCMD recommended on 12/21/2021 that included limiting sitting to 60 minutes and off-loading the wound. A telephone interview on 02/14/2023 at 10:30 a.m. with R#249's representative (RR) who stated the staff told the representative about the sacral wound and the stage but was unable to remember the stage. The RR stated the facility had not educated him/her of the severity of R#249's wound. The RR stated not being a medical person, when staff mentioned stage of the wound, it meant nothing to the representative. Interview on 02/15/2023 at 3:35 p.m. with Certified Nursing Assistant (CNA) #18 stated she remembered R#249 required total assistance for activities of daily living, and when the resident was admitted , the resident was able to feed himself/herself. The CNA stated R#249 had an overall decline in health and had pressure ulcers. CNA #18 stated interventions for R#249 included a low air loss mattress, boots on the feet, and was repositioned as needed. Interview was held on 02/15/2023 at 3:09 p.m. with LPN #12 and LPN #13, the wound care nurses, who both agreed if there were blanks (empty spaces) on a TAR that meant the treatment was not completed as ordered. Interview on 02/16/2023 at 9:40 a.m. with treatment nurse LPN #13, stated the treatment nurses were responsible for weekly evaluations and documentation of wounds that were stage 2 or greater. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/16/2023 at 11:36 a.m. with LPN #12 stated if R#249 was assessed as high risk of skin breakdown the nurse assessing the resident should have implemented interventions for prevention of skin breakdown. LPN #12 reviewed the TAR for R#249 and stated she started treatment for the left buttock on 11/19/2021 when she completed the assessment, but mistakenly wrote the treatment order to start on 11/21/2021. However, LPN #12 acknowledged there were blanks for 11/21/2021 and 11/22/2021 and treatment had not started until 11/23/2021. LPN #12 stated the resident's buttock wound healed quickly. LPN #12 then reviewed the head-to-toe assessment completed on 12/17/2021 and stated the nurse that completed the assessment had obviously not looked at R#249's skin since the resident returned from the hospital with multiple pressure ulcers. LPN #12 also reviewed the weekly pressure ulcer assessment she had completed and acknowledged she had measured and described only one of the resident's six pressure ulcers. LPN #12 stated she had documented measurements of the other wounds in the nurse's notes. LPN #12 then reviewed the nurse's note she had written on 12/17/2021 and acknowledged she had not included measurements for three of R#249's wounds. The LPN stated the facility policy required weekly documentation to include measurements and descriptions of each wound on the weekly pressure ulcer report and stated the only reason she could think that she had not completed the assessment was that she was working alone as the treatment nurse at that time and felt overwhelmed. LPN #12 stated there was no documentation that the WCMD's recommendations from 12/21/2021 had been completed. Interview by telephone on 02/16/2023 at 10:00 a.m. with WCMD stated he rounded weekly, which included reviewing the resident's chart, assessing the resident, and making recommendations. The WCMD stated there was an understanding with the primary care physician that the primary care physician agreed with any recommendations made by the WCMD and staff would write orders for the recommendations. He stated his recommendations were communicated to the treatment nurses verbally on rounds and written in his notes. The WCMD stated treatment of a wound would be dependent upon the site of the wound, but treatment should be started when the wound was identified. He stated he expected measurements and descriptions of wounds to also be completed when a wound was found. The WCMD stated he did not remember R#249. Interview on 02/16/2023 at 4:20 p.m. with Interim Director of Nursing (DON) stated when wounds were found she expected treatment to start immediately. The Interim DON stated the treatment nurses were expected to assess wounds weekly and note any changes. She stated waiting six days to start treatment on a wound was not acceptable. According to the Interim DON, turning and positioning a resident and floating the heels were done per nursing judgement, were automatic interventions, and had not required an order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on staff interviews, record review, and review of the facility's policy titled, Administering Medications,, the facility failed to provide pharmacy services to ensure the accurate acquiring of drugs to meet the needs of residents for 1 of 2 residents (R) (#250) reviewed for pain. Findings included: A review of the facility's policy titled, Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. Record review of R#250's Admission Record revealed the facility admitted the resident on 11/18/2022 with a diagnosis that included fusion of the spine. Record review of the admission Minimum Data Set (MDS), dated [DATE], revealed R#250 the resident received both scheduled and as-needed pain medications but received no non-medication interventions for pain. The MDS indicated the resident had no pain in the previous five days. Record review of the care plan for R#250, initiated on 12/06/2022, indicated the resident was at risk for acute/chronic pain related to neuropathy. Interventions to manage the resident's pain included providing medications prior to treatments and therapy, anticipating the resident's need for pain relief and responding, observe/record/report to the nurse the resident's complaints of pain, and report to the nurse any change in the resident's usual activity. Record review of the physician's orders for R#250 revealed an order for methadone hydrochloride (HCl) (an opioid pain medication) tablet 5 milligrams (mg) by mouth at bedtime for back pain. Record review of the Medication Administration Record (MAR) for R #250 dated November 2022 revealed the methadone HCl was not marked as administered on 11/18/2022, 11/19/2022, 11/22/2022, and 11/23/2022. On 11/18/2022, the nurse signed the MAR and placed the code 4 in the space, which indicated the nurse's notes should be referenced. The 4 had also been entered for 11/19/2022, 11/22/2022, and 11/23/2022. Record review of the Progress Notes for R#250 revealed there was no note to indicate why the methadone was not given on 11/18/2022. Further review of the Progress Notes revealed on 11/19/2022 at 7:36 p.m., the note indicated the reason the methadone was not given was waiting for pharmacy delivery. There were no further notes to explain why the medication was not given on 11/18/2022, 11/19/2022, 11/22/2022, and 11/23/2022. A review of a narcotic count sheet for R#250 indicated that on 11/20/2022, the facility received three methadone tablets for the resident. The first methadone tablet was given on 11/20/2022. This was two days after R#250 was admission to the facility. A review of a second narcotic count sheet indicated the facility received additional methadone tablets for R#250 on 11/25/2022, which indicated R#250 went an additional two days without pain medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/16/2023 at 3:45 p.m. with Licensed Practical Nurse (LPN) #7 verified those were his initials beside the methadone entry for 11/19/2022 and 11/20/2022. The LPN #7 stated he remembered R#250 received pain medication. The LPN #7 stated he had placed a NA (not applicable) in the section of the entry for pain level due to the fact the resident had no methadone available. LPN #7 further revealed the medication for R#250 arrived the next day (11/20/2022). Interview on 02/16/2023 at 4:00 p.m. with Registered Nurse (RN) #17 verified those were her initials for 11/22/2022. The RN #17 stated the 4 beside her initials meant R#250 had not received the ordered methadone. RN #17 stated R#250 may not have received the medication due to the pharmacy not having a prescription from the provider for the medication. The RN #17 further revealed a reason why the resident had not received the medication should be documented in the nurse progress notes. RN #17 reviewed the nurse progress notes with the Regional Nurse Consultant (RNC) and both confirmed there was not a note that indicated why the resident had not received the ordered medication. RN #17 stated even though she had not documented attempts to call the physician and the pharmacy to get the medication for R#250, that she knew she had called and other staff had called both the physician and the pharmacy. Interview on 02/16/2023 at 4:25 p.m. with Interim Director of Nursing (DON) stated if a resident was admitted with a narcotic medication, such as methadone, and no prescription came with the order, the staff were expected to call the physician to obtain an order for the medication. The Interim DON further revealed that when the physician gave the order for the narcotic, the physician also called the pharmacy to verify receipt of the prescription. The Interim DON stated there was no reason any resident should go without pain medication. The Interim DON stated she expected the nurses to document all conversations with the physician and the pharmacy about pain medication in the nurse's notes. The Interim DON stated the negative effects of R#250 not receiving the ordered pain medications could have included withdrawal symptoms or unresolved pain. Telephone interview on 02/16/2023 at 5:00 p.m. with the Pharmacy Director of Quality (PDQ) stated that in addition to being the PDQ, she was also a registered pharmacist. The PDQ stated R#250's provider first contacted the pharmacy on 11/19/2022 at 1:56 p.m. and gave a verbal order for three days' worth of methadone for R#250. The PDQ revealed the methadone order was qued for clarification by the pharmacy, which meant they would review the order to assure it was not for opioid dependence. The PDQ stated the next activity occurred on 11/24/2022 at 4:26 p.m., when the pharmacy received a valid prescription for R#250's methadone. The PDQ stated it was hard to tell the effects of R#250 not receiving the methadone without knowing the resident's history. She added it was helpful that R#250 had received other medications to help alleviate pain.