STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Elms	7449 Fair Oaks Drive Clemmons, NC 27012

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49295 Based on record review, observations, interviews with staff, Dermatologist, and Medical Director, the facility staff failed to notify medical provider of a change in condition for a nonverbal resident with a diagnosis of diabetes when new skin wounds were observed on 7/22/24. The Medical Director was notified on 7/23/24 and Resident #1 was sent to the Emergency Department (ED) on 07/23/24 and was diagnosed with deep partial thickness burns to the anterior (front) and medial thighs bilaterally as well as the mons pubis (fatty tissue that covers the pubic bone). Resident #1 was hospitalized from 07/23/24 to 07/25/24, had an indwelling catheter inserted to help with wound healing, had daily wound care treatment with Silvadene cream (a topical antibiotic used in partial thickness and full thickness burns to prevent infection) and was administered oxycodone (opioid pain medication used to treat severe pain) for pain. This deficient practice occurred for 1 of 3 resident reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE], with diagnosis that included lumbar degenerative disc disease, fibromyalgia, foot drop, right hand contracture, diabetes, heart failure, chronic kidney disease, and vascular dementia without behavioral disturbance. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was severely cognitively impaired and rarely/never made self-understood and sometimes understood others (responds adequately to simple, direct communication only). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Incident report dated 07/22/24 at 10:00 PM, completed by Nurse #1 was reviewed. The report revealed, on 07/22/24 at 10:00 PM Nurse Aide (NA) #1 notified Nurse #1 that Resident #1 had skin tears to both thighs noted during resident's scheduled shower. NA #1 stated that Resident #1 was scratching inner thighs during shower. NA #1 attempted to prevent Resident #1 from scratching; however, each opportunity that arose (while NA #1 bathed other parts of body/obtained wash cloth towel, etc.) Resident #1 continued to scratch at both thigh areas and in between legs. NA #1 stated that once the skin broke, it could be visually seen that the skin was 'rolling up' causing the exposed areas. Nurse #1 went into resident's room and assessed Resident #1 skin. Both Left and Right upper thighs had redness and thin layer of skin off thigh areas at time of assessment- rectangular in shape. There was small square shape reddened area in the middle of the mons pubic area. Resident #1 was still attempting to scratch when nurse was assessing areas of injury. Resident #1 was encouraged to not scratch and given one of her teddy bears to hold as a possible deterrent from scratching. Resident #1 shows no signs of discomfort not pain; no verbal responses to pain nor facial grimaces displayed. Area was cleaned with saline and covered with dressing in an attempt to prevent infection and also to prevent further scratching by resident. Note made in PEC (Physician Elder Care) book concerning this incident. The incident report further indicated the Physician (Medical Director) was notified on 07/23/24 at 7:18 AM and family member was notified on 07/23/24 at 1:19 AM. An interview was conducted with Nurse #1 on 08/06/24 at 8:11 AM. Nurse #1 indicated she worked a 4-hour shift (7:00 PM to 11:00 PM) on 07/22/23. Nurse #1 confirmed that she relieved Nurse #3 who had just worked a 12-hour day shift (7:00 AM to 7:00 PM). Nurse #1 stated that during report from Nurse #3, no skin alterations were reported in reference to Resident #1. Nurse #1 revealed that on 07/22/24 at about 9:00 PM, NA #1 notified her of a change in Resident #1 skin after completing giving Resident #1 a shower. Nurse #1 indicated that NA #1 stated that Resident's #1 skin started peeling off during shower. Nurse #1 explained she went to Resident #1's room to complete an assessment immediately upon notification. Nurse #1 confirmed that Resident #1 was non-verbal and did not have any non-verbal signs of pain noted. Nurse #1 revealed that the top layer of skin on both Resident #1's upper thigh were gone, and the top of her mons pubis was red. Nurse #1 indicated that the middle of Resident #1 mons pubis had skin peeled off and some of her pubic hair had fallen out. Nurse #1 explained that she cleaned the wounds with normal saline and dressed both thighs with ABD pads to protect the area from infection. Nurse #1 indicated at the end of her shift (11:00 PM) she passed on the information to the oncoming Nurse #2 during shift report. Nurse #1 indicated that she did not notify the medical provider of a change in Resident #1's condition because she did not have time to. Nurse #1 stated that she communicated with Nurse #2 during shift change at 11:00 PM, who confirmed that she (Nurse #2) would notify medical provider. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Nurse #2 on 08/06/24 at 8:38 AM. Nurse #2 confirmed that she worked an 8-hour shift (11:00 PM to 7:00 AM) on 07/22/24 and she relieved Nurse #1. Nurse #1 reported to Nurse #2, that Resident #1 had an incident where she was rubbing her thighs in the shower according to NA #1. Nurse #1 told her Resident #1 had ABD pads to her bilateral upper thighs and the areas were red but not inflamed. Nurse #2 explained that she went with NA #3 at about 11:30 PM to assess Resident #1. Nurse #2 confirmed Resident #1's pubic area had red patchy areas, and pubic hair had fallen out. Nurse #2 indicated that Resident #1 did not have any nonverbal signs of pain. Nurse #2 stated that she did not do anything else for Resident #1 throughout her shift. Nurse #2 indicated that by morning (7:00 AM) on 07/23/24, the areas on Resident #1's genitalia and bilateral upper thighs was more reddened and irritated. Nurse #2 confirmed that at the end of her shift on 07/23/24 at 07:00 she reported Resident #1's wounds to Wound Nurse and Nurse #3. Nurse #2 indicated on 07/23/24 at about 7:30 AM she assessed Resident #1 with the Wound Nurse and Nurse #3, after which she left as her shift had ended. Nurse #2 indicated that she did not notify Medical Provider because she had instructed Nurse #1 to notify Medical Provider and Family when Nurse #1 was completing the incident report. Progress note that was completed on 07/23/24 at 7:52 AM by Nurse #3 was reviewed. The documentation indicated that Prior nurse reports of red area to groin, pubic area, and blister noted to inside of left dorsal/lateral thigh. Nurses enter room noting skin peeling, beefy red, in bi lat (bilateral) groin areas, front of upper thigh, fluid filled blister to dorsal/lateral left thigh. Wound nurse notified and assessed resident with new order to send to hospital for further evaluation. An interview was conducted with Nurse #3 on 08/05/24 at 4:01pm. Nurse #3 confirmed that she returned to work on 07/23/24 to start her shift at 7:00 AM and during report, Nurse #3 revealed that Nurse #2 reported Resident #1's skin had peeled completely off in between her thighs and groin area. Nurse #3 recalled Nurse #2 told her Resident #1 had received a shower from NA #1 at 8:00 PM on 07/22/24 and during that shower, the skin peeled off. Nurse #3 confirmed she observed Resident #1's skin with the Wound Nurse present on 07/23/24 at about 8:00 AM and the skin had completely peeled off her bilateral anterior thighs and she had a redness to the pubic area with patchy areas of peeled skin and pubic hair coming out. There was also a blister to the back/posterior left thigh. Nurse # 3 stated that the bilateral upper thighs and pubic area skin looked bad (very red and raw). Nurse #3 indicated that Wound Nurse notified ADON via phone about Resident #1 wounds while in Resident #1's room. Nurse #3 indicated that ADON was on the phone with Wound Nurse and ADON notified provider. Nurse #3 recalled the ADON communicated by phone the provider had been notified and Resident #1 had orders to be transferred to the emergency room . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Wound Nurse on 08/06/24 at 12:03 PM. The Wound Nurse confirmed that Resident #1 did not have any wounds or skin alterations prior to being discharged to hospital on 07/23/24. The Wound Nurse stated on 07/23/24 she was notified by Nurse #3 to come urgently to Resident #1's room. The Wound Nurse stated that she assessed Resident #1 in the presence of Nurse #3 and Resident #1's brief was open to air to avoid it from touching the wounds on her bilateral thighs, groin and pubic area. Wound Nurse explained the skin on Resident #1's bilateral thighs was peeled, raw and red approximately the same size (both wounds were approximately the same shape and size) from the inner thighs to the medial lateral side (from the inside of the thighs to the middle of the thighs) of the upper thigh. The Wound Nurse noted Resident #1's pubic area had patchy areas of missing skin and hair, and the dorsal (upper side) side of the left leg had an intact blister about 2 inches wide. Wound Nurse indicated that there was a little bit of drainage to bilateral upper thighs and pubic areas wounds. The Wound Nurse indicated that Resident #1 was nonverbal and did not have any nonverbal signs of pain during the assessment. Wound Nurse revealed that she notified ADON on 07/23/24 via phone about Resident #1 wounds while in Resident #1's room. Wound Nurse stated that ADON notified provider, while on the phone with her. Wound Nurse further explained that ADON communicated by phone that the provider had been notified and Resident #1 had orders to be transferred to the emergency room . An interview was conducted with the Assistant Director of Nursing (ADON) on 08/06/24 at 12:19 PM. The ADON indicated that she received a call on 07/23/24 at 7:15 AM from the Wound Nurse stating something had happened to Resident #1 and things were not adding up. ADON indicated that Wound Nurse described the areas were on Resident #1's bilateral upper thighs and had quite a large area of skin peeled off and raw tissue exposed, pubic area had patches of skin peeled off and pubic hair fallen off and the back of her thigh had an intact blister. The ADON noted after the Wound Nurse communicated with her on 07/23/24 at about 7:30am, she notified the provider of Resident #1 new wounds, per the description she obtained from Wound Nurse. ADON indicated that she notified MD and MD indicated to send resident to ED. ADON indicated that she instructed the Wound Nurse to send Resident #1 out to ED. Progress note that was completed on 07/23/24 at 9:00 AM by Nurse #3 was reviewed. The documentation indicated that EMS was notified at 08:00 AM. The note further revealed that EMS transferred resident onto stretch and departed the facility at 8:35 AM. ED provider notes dated 07/23/24 indicated that Resident #1 presented with deep partial thickness burns to the anterior and medial thighs bilaterally as well as the mons pubis. ED provider notes included Resident #1 vital signs on 07/23/24 at 9:07 AM to be a body temperature of 100.2 ?, blood pressure of 147/84, pulse rate of 82 beats per minute and respirations of 16 breaths per minutes. It was noted Resident #1 came from nursing home today with burns to her thighs. Supposedly she had a shower last night at the nursing home and now she has burns. Resident #1 is nonverbal and as such unable to offer any history. The ED provider notes further indicated that Resident #1 had severe contractures (shortening of muscles, tendons, skin and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) to bilateral lower extremities, knee extension and hips. ED notes indicated that Resident #1 had right upper extremity flexion contracture. ED notes indicated that Resident #1 only moved left upper extremity spontaneously-grossly 3/5 (medical muscle strength assessment that indicated Resident #1 could move her left arm on her own without assistance, but the strength would be rated as 3 out of 5, indicating moderate weakness. A score of 5 would represent normal strength.) (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Medical Director conducted on 08/06/24 at 1:56 PM. MD indicated that she received a call on 07/23/24 at 7:30 AM from Assistant Director of Nursing (ADON). The MD indicated that ADON indicated that Resident #1 had an area to the groin and bilateral thighs, and it looked like a burn. MD indicated she gave orders for Resident #1 to be sent out. MD indicated that the description given was that the area was inflamed, extensive to the bilateral thighs and groin, blister to the back/posterior right thigh. MD further indicated based on the severity and how the skin injury happened quickly, and this was new for Resident #1, the facility should have contacted MD upon change of condition. A Dermatology consultation report dated 08/07/24 was reviewed and indicated that skin lesions to bilateral upper thighs appeared consistent with thermal injury (skin injuries caused by excessive heat), as they were evenly and broadly denuded (removal of skins surface layers) with rounded edges and spare with folds. The report further indicated that no bullae (fluid-filled sacs or lesions that appear when fluid is trapped under a thin layer of skin), or inflammation was noted and there was evidence of re-epithelialization (wound healing) and repigmentation regaining normal skin color) in a follicular (densely packed follicles of varying size lined by a single later of epithelium) pattern. The report also indicated that the skin lesions were not consistent with autoimmune blistering disorder, contact dermatitis, infection, self-excoriation, or a medication reaction like fixed bullous drug eruption or Stevens-Johnson Syndrome (SJS) (a rare and serious disorder that affects skin, mucous membrane, genitals and eyes. It causes flu like symptoms along with painful rash that spreads and blisters) and Toxic Epidermal Necrolysis (TEN) (severe form of SJS, diagnosed when more than 30% of the skin surface is affected and the moist linings of the body). The report noted a second dermatologist reviewed the clinical images for Resident #1 and agreed with thermal burns from something hot sitting on Resident #1's lap. Recommendations from the report included to use Mepilex Ag dressings (dressing that absorbs drainage and inactivates wound pathogens) to be changed every three days and to discontinue treatment once the skin was completely re-epithelialized. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Dermatologist who examined Resident #1 on 08/07/24 was conducted on 08/19/24 at 12:15 PM. The Dermatologist indicated that she examined Resident #1 on 08/07/24 and that Resident #1 was accompanied to the dermatologist office by her daughter and a non-administrative nurse from the facility. The Dermatologist stated that she spoke to the Administrator and a nurse manager over the phone on 08/07/24 and the Administrator indicated that she wanted Dermatologist to examine the wounds that had just have been found one day on Resident #1. The Dermatologist shared that she had already reviewed the resident's hospital records the day prior to her coming into the dermatology office. The Dermatologist indicated that facility never shared with her any incident had occurred and the facility Administrator indicated via phone on 08/07/24 just found the wounds one day. The Dermatologist stated that Administrator was very vague, and Dermatologist did not dwell on asking more details from Administrator. The Dermatologist stated she examined Resident #1, and her assessment was that Resident #1 sustained a thermal burn. She was sure that Resident #1 had a thermal burn, and her injuries were not associated with any other cause. The Dermatologist also stated that some burns were not painful at all, but in this case because this were second degree burns, they were painful. Dermatologist further explained that often deeper and more in-depth wounds like a third-degree burn, one would not feel pain because the nerves are burned away. The Dermatologist added that it would have been best for the facility to have notified the medical provider when the injuries occurred, because the skin was denuded, and this increased the risk of infection and due to her being high risk due to diabetes. The Dermatologist further stated that anytime skin was denuded like Resident #1's skin, there is a risk for high infection. She also indicated that burns have a higher risk of infection and that was why the hospital used the Silvadene cream to treat it. The Dermatologist confirmed Resident #1's injuries were not caused by any scratches but could have been caused by hot water or could also have been caused by a washcloth that was wet and hot, that sat on Resident #1 lap. The Dermatologist further stated that it looked like Resident #1 could have been covered with a washcloth on that area at some point. The Dermatologist continued to explain that the burns spared the skin folds, so it was possible that her legs were clamped together, which is why water did not run between them. Or it was something more solid that was placed on her. Dermatologist indicated she would expect that the Resident #1 wound have scars and that there would be change to the color and texture of the skin on the areas. The Administrator was notified of the immediate jeopardy on 08/06/24 at 4:39 PM. The facility provided the following corrective action plan for IJ removal. How corrective action will be accomplished for those residents found to have been affected: On 7-22-24, Nurse #1 was called by Nurse Aide #1 to assess Resident #1 after a shower. Nurse Aide #1 reported that Resident #1 was in the shower room on a shower gurney, receiving a shower using the handheld showerhead when wounds on thighs were noted. Nurse #1 came to assess Resident #1, Resident #1 had new wounds on bilateral thighs and mons pubis which were treated per physician's group wound protocol by Nurse #1. Nurse #1 described the wounds as, bilateral upper anterior thighs near groin area are altered. Appearing pink in color with rectangular shaped areas that appeared to have top layer of skin absent. Resident #1 had no signs of pain per Nurse #1. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident's family was notified on 7-22-24 by Nurse #1. On 7-22-24 Nurse #1 placed resident #1 on Physician follow up list to be seen in the morning of 7-23-24 per physician wound protocol. The standing orders for skin care guidelines from the physicians' group states: For stasis and traumatic wounds, the skin care guidelines provide treatment options and state the patient should be placed on problem list for follow-up by clinician on their next visit. On 7-23-24, Nurse #3 called wound nurse to look at the wound, wound nurse called assistant director of nursing, assistant director of nursing called resident #1's medical director to notify the medical director of Resident #1's skin condition. The medical director gave orders to send Resident #1 to the hospital for further evaluation to determine the etiology of the skin condition and the appropriate treatment. How corrective action will be accomplished for those residents having potential to be affected: On 7-23-24, the facility administrator, director of nursing and assistant director of nursing reviewed incident reports for the past 30 days to ensure the physician was contacted for any incidents involving skin per policy. Physicians were properly notified per policy and physician guidelines for all incidents reviewed. What measures will be put into place or systemic changes made to ensure that the practice will not occur. On 7-23-24, education was conducted by the assistant director of nursing and the staff development coordinator for nursing staff on reporting to physicians and standing facility protocols, per facility policies. The education stated that a physician should be notified when there is a significant injury or change in condition, per policy. The education was completed for all nursing staff on 7-31-24. On 7-23-24, education was provided to all nursing staff, licensed nurses and nursing assistants, by staff development coordinator and assistant director of nursing on the shower protocol. The shower protocol education contained a bullet stating report immediately to nurse and administrative nurse for any possible signs of any type of injury or any type of skin changes. The education was completed for all nursing staff by 7-31-24. Beginning 7-23-24, a QAPI is in place that the administrator or director of nursing will audit all skin and wound incident reports five days per week to ensure the physician was contacted appropriately and timely for one month, then will audit incident reports weekly for one month, then will audit monthly for one quarter. The incident reports are internal documents used for reporting certain incidents and are used for quality assurance. The reports that will be reviewed contain information about any new skin conditions such as wounds, pressure ulcers, skin tears, bruises, etc. These reports are only completed by nurses, and nurses are responsible for notifying the physician as required by the facility and physician protocols. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Quality Assurance Performance Improvement plan was initiated on 7/23/2024. The findings of the audits will be reported by the administrator to the Quality Assurance Committee at each quarterly meeting for one year. Alleged date of IJ removal: 08/01/24 Validation of the immediate jeopardy removal plan was conducted in the facility on 08/20/24. The facility's initial plan audit was verified and signature sheet for education reviewed with no concerns. Facility nurses were interviewed and were aware of the pain management protocol, how and when to assess pain, and how to appropriately respond to a resident's request or nonverbal signs of pain. Facility medication aides, nurse aides, dietary staff, housekeeping staff and rehabilitation staff were also aware of the pain protocol and how to observe for nonverbal signs of pain and how to respond to resident's request or nonverbal signs of pain. The facility's immediate jeopardy removal date of 08/01/24 was validated.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49295 Based on record review, observations, and interviews with staff, Hospital Case Manager, Plumbing Contractor, Dermatologist, and the Medical Director, the facility staff failed to supervise a severely cognitively impaired and nonverbal resident in the shower room. On 7/22/24 Nurse Aide (NA) #1 left Resident #1 unattended and naked on the shower bed with the water running on her body. When NA #1 returned to the shower spa, Resident #1 had a pool of water over her bilateral thighs and genital area. NA #1 took a washcloth to remove the puddle of water and noticed that Resident #1's top layer of skin on her bilateral upper thighs was peeling off. Resident #1 was sent to the Emergency Department (ED) 07/23/24 and was diagnosed with deep partial thickness burns to the anterior (front) and medial thighs bilaterally as well as the mons pubis (fatty tissue that covers the pubic bone). Resident #1 was hospitalized from 07/23/24 to 07/25/24, had an indwelling catheter inserted to help with wound healing, had daily wound care treatment with Silvadene cream (a topical antibiotic used in partial thickness and full thickness burns to prevent infection) and was administered oxycodone (opioid pain medication used to treat severe pain) for pain. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE], with diagnosis that included lumbar degenerative disc disease, fibromyalgia, foot drop, right hand contracture, diabetes, heart failure, chronic kidney disease, and vascular dementia without behavioral disturbance. Review of the physician orders revealed that Resident #1 had an order initiated on 03/16/24. Minerin Creme (skin protectant cream)- Apply to arms, legs, face topically one time a day for dry skin Apply to arms, legs, face and other external areas needed. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was severely cognitively impaired and rarely/never made self-understood and sometimes understood others (responds adequately to simple, direct communication only). The MDS assessment further indicated Resident #1 had functional limitation in range of motion impairment on one side of her upper extremity (shoulder, elbow, wrist, hand) and impairment on both sides of her lower extremities (hip, knee, ankle, foot). The assessment noted Resident #1 had no unhealed pressure ulcers/injuries, or any other ulcers, wounds or skin problems. The MDS assessment also indicated that Resident #1 was not receiving any opioid medication and did not have an indwelling catheter. Review of Resident #1's care plans last revised on 06/26/24 revealed no care plan for behaviors including scratching herself. The functional performance-long term care resident; unable to care for herself; Needs assistance with all care - care plan indicated that Resident #1 required total assistance of two-person physical assistance with a total lift for transfers. The care plan revealed that Resident #1 had impaired cognitive function and thought processes related to Alzheimer's. The care plan also indicated that staff needed to apply right hand palm protector in the morning and remove in the evening due to Resident #1's right hand contracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Aide electronic documentation (Documentation Survey Report) revealed on 07/21/24, Nurse Aide (NA) #5 noted that Resident #1 did not have any behaviors observed. Documentation revealed that for the task monitor skin observation, NA #5 noted that Resident #1 had none of the above (scratched, red area, discoloration, skin tear, open area) observed. An interview was conducted on 08/05/24 at 3:48 PM with NA #5. NA #5 indicated that she provided care to Resident #1 on 07/21/24 during the evening shift (3:00 PM to 11:00 PM). NA #5 indicated that Resident #1 did not have any skin issues. NA #5 stated that Resident #1 did not have any verbal or nonverbal signs or symptoms of pain. Skin only evaluation assessment that was completed on 07/22/23 at 6:33 PM by Nurse #3 was reviewed. The documentation indicated that Resident #1 skin was warm and dry, skin color within normal limits, and turgor was normal. The documentation further indicated Resident #1 had dryness noted to all extremities and treatment was applied per orders. Written statement from NA #1 dated 07/23/24 was reviewed. On Monday 07/22/24 Resident #1 was due for a shower. So, with help the NA student help with cleaning her bowel movement. We cleaned her and ready her for the shower. We put her on a gurney to be transported by stretcher (gurney) to shower room. While in the shower room the student aides had to leave. So I was left with task on going to get the body wash after I had wet Resident #1 body. I hung up the running shower head on the wall. Resident #1 had been digging between her legs. Having washed her before I thought it would be alright to proceed to clean where she had been scratching which was nothing new, she had done it before while being clean. This time I notice her skin began to peel as I washed with a washcloth. I finish cleaning all body part and hair. I lower the temperature to remove the excess bowel movement between her legs and dried her off. Reported to the nurse. An interview with the facility Administrator was conducted on 08/06/23 at 11:18am. The Administrator explained that NA #1 had requested to be taken off the schedule on 07/24/24 and asked to leave facility while at work. Administrator stated that NA #1 had not returned or communicated with the facility since 07/24/24 even after multiple attempts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 08/08/24 at 11:04 AM, the facility had arranged for NA#1 to come to the facility and the interview was conducted over the phone. The surveyor was continuing the survey remotely due to adverse weather. The surveyor could hear people whispering in the room between questions during the interview with NA #1. NA #1 would pause answering questions during telephone interview and SA could hear whispering in the background, after which NA #1 would change the response to a question he had previously answered. NA #1 indicated that he worked second shift (3:00 PM to 11:00 PM) on 07/22/24. NA #1 stated Resident #1 was not able to bend her knees, and that the only part of Resident #1's body that she could move was her left arm. NA #1 noted Resident #1 was a total care and had a shower scheduled on 07/22/24. NA #1 stated that between 7:30 PM and 8:00 PM he and two NA students went to Resident #1's room to prepare for her shower. While in the room, NA #1 revealed that Resident #1 had a bowel movement and needed to be cleaned prior to transferring Resident #1 onto the shower bed. NA #1 confirmed that when providing perineal care to her genital and rectal area, NA #1 did not observe any scratches, bruises, blisters, skin tears or any skin alterations. NA #1 indicated that together with the two NA students, Resident #1 was wheeled to the spa room. NA #1 noted the two NA students had to leave at 8:00 PM which left him alone in the spa room with Resident #1. NA #1 revealed that Resident #1's head was positioned against the wall that had a mounted handheld showerhead. NA #1 indicated that Resident #1's legs were facing away from the wall that had the mounted handheld showerhead. NA #1 confirmed that he turned on the water for the handheld showerhead and tested the water on his hand. NA #1 revealed that the water felt good to him and did not want to answer if it was hot, but adamantly stated it felt good to me. NA #1 indicated that the water did not have steam. NA #1 stated that after he had rinsed Resident #1 with the water, he realized he did not have soap to use for the shower. NA #1 stated that he placed the handheld showerhead, with water still running, back on the mount on the wall. The stream of the water was directed at Resident #1's body, not at her face. NA #1 indicated that he did not want to use the soap that was mounted in the shower room because it was hand soap. NA #1 confirmed that he then left Resident #1 unattended and walked to the storage room which was down another hall. NA #1 stated that he did not use the call light mounted in the spa room because he was just going to the storage area and back. NA #1 confirmed that he left Resident #1 unattended and naked because she did not move at all, and she was fine. NA #1 indicated he got the soap from the storage room, walked back to the spa room. At first NA #1 stated Resident #1 was left unattended in the shower spa for 30 seconds and later stated it was 10 seconds. NA #1 revealed that when he returned to the spa room, Resident #1 had a pool of water over her bilateral upper thighs and around the genital area. NA #1 confirmed that he noted Resident #1 was grimacing, scratching herself down there and he moved Resident #1's left hand off her genital area because she was scratching. Her fingernails were not long. NA #1 indicated that he tested the water and lowered the temperature of the water because the skin on her genital area started peeling. NA #1 stated that he took a washcloth to remove the puddle of water and noticed that Resident #1's top layer of skin on her bilateral upper thighs was peeling off. NA #1 stated Resident #1 seemed comfortable after he lowered the temperature of the water but could not explain this as he noted the resident was nonverbal. NA #1 indicated he continued to wash Resident #1's entire body with the washcloth including her genital area and upper thighs even though he observed the skin was peeling off. When he was done with the shower, he covered her with a towel and took her back to her room and transferred her into her bed. After that NA #1 went to get Nurse #1 and told her when he was giving Resident #1 a shower her skin was peeling off. NA #1 explained that Nurse #1 came to Resident #1's room, assessed the resident and took a picture of the resident with her phone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation was made on 08/06/24 at 1:40 PM of the [NAME] spa room where Resident #1 received her shower on 07/22/24 from NA #1. To get to the storage room you would exit the spa room and go right down the hall, then make a left onto another hallway, walk a couple of steps, and make a left onto a third hallway to get to the storage room. It took the surveyor approximately 45 seconds to walk from the [NAME] spa room to storage room and back to the storage room, without entering the storage room. Nurse Aide electronic documentation revealed that on 07/22/24 at 10:38 PM NA #1 provided shower to Resident #1. Documentation confirmed on 07/22/24 at 10:28 PM, NA #1 noted that Resident #1 did not have any behaviors observed. Documentation revealed that for the task monitor skin observation, on 07/22/23 at 10:38 PM, NA #1 noted that Resident #1 had a skin alteration observed. Incident report dated 07/22/24 at 10:00 PM, completed by Nurse #1 was reviewed. The report revealed, on 07/22/24 at 10:00 PM Nurse Aide (NA) #1 notified Nurse #1 that Resident #1 had skin tears to both thighs noted during resident's scheduled shower. NA #1 stated that Resident #1 was scratching inner thighs during shower. NA #1 attempted to prevent Resident #1 from scratching; however, each opportunity that arose (while NA #1 bathed other parts of body/obtained wash cloth towel, etc.) Resident #1 continued to scratch at both thigh areas and in between legs. NA #1 stated that once the skin broke, it could be visually seen that the skin was 'rolling up' causing the exposed areas. Nurse #1 went into resident's room and assessed Resident #1 skin. Both Left and Right upper thighs had redness and thin layer of skin off thigh areas at time of assessment- rectangular in shape. There was small square shape reddened area in the middle of the mons pubic area. Resident #1 was still attempting to scratch when nurse was assessing areas of injury. Resident #1 was encouraged to not scratch and given one of her teddy bears to hold as a possible deterrent from scratching. Resident #1 shows no signs of discomfort not pain; no verbal responses to pain nor facial grimaces displayed. Area was cleaned with saline and covered with dressing in an attempt to prevent infection and also to prevent further scratching by resident. Nurse Aide electronic documentation revealed that on 07/22/24 at 10:28 PM, NA #3 noted that Resident #1 did not have any behaviors observed. Documentation revealed that for the task monitor skin observation, NA #3 noted that Resident #1 had none of the above (scratched, red area, discoloration, skin tear, open area) observed. Written statement from NA #3 dated 07/23/24 documented while putting Resident #1 back to bed, I did not notice anything. I changed her and her skin was fine. Resident #1 legs and groin area was normal. Multiple attempts were made to reach NA #3 for an interview were unsuccessful. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Written statement from Nurse #1 dated 07/23/24 at 1:20 PM revealed, I worked at [facility name] for a as needed (prn)shift (07:00 PM to 11:00 PM) on 07/22/24. During my shift, around 10:00 PM, I was notified by NA #1 of Resident #1 skin injury. Resident #1 was said to have been scratching her thighs intensively while being given a shower. Once notified by NA #1, I went into Resident #1's room and assessed the newly noted skin alterations. At his time Resident #1 thighs, bilaterally, (upper anterior thighs, near groin area) were altered, appearing pink in color, and ironically, both had rectangular shaped areas that appeared to have the top layer of skin absent. Per NA #1 recollection and report to me, while showering he attempted to prevent Resident #1 from scratching her thighs but Resident #1 persistently kept doing so. NA #1 stated that Resident #1 skin was broken from her scratching and Resident #1 skin just rolled/pulled off. When in resident's room completing assessment of the area, Resident #1 was attempting to scratch the thigh area. A teddy bear in her nightstand was given to her in her left hand in at attempt to deter resident from scratching. There was also a pink area in the center of the mons pubis. Resident #1 had no signs or symptoms of pain or discomfort at this time. No moaning, yelling, no facial grimacing. In an attempt to clean and cover the areas, I cleaned both thighs and mons pubis with saline and covered both thighs with dressings. Resident #1 was sitting in shower chair at the time of assessment. Resident was continued to be monitored. (no bleeding nor drainage noted). An interview was conducted with Nurse #1 on 08/06/24 at 8:11 AM. Nurse #1 indicated she worked a 4-hour shift (7:00 PM to 11:00 PM) on 07/22/23. Nurse #1 confirmed that she relieved Nurse #3 who had just worked a 12-hour day shift (7:00 AM to 7:00 PM). Nurse #1 stated that during report from Nurse #3, no skin alterations were reported in reference to Resident #1. Nurse #1 revealed that on 07/22/24 at about 9:00 PM, NA #1 notified her of a change in Resident #1 skin after completing giving Resident #1 a shower. Nurse #1 indicated that NA #1 stated that Resident's #1 skin started peeling off during shower. Nurse #1 explained she went to Resident #1's room to complete an assessment immediately upon notification. Nurse #1 confirmed that Resident #1 was non-verbal and did not have any non-verbal signs of pain noted. Nurse #1 revealed that the top layer of skin on both Resident #1's upper thigh were gone, and the top of her mons pubis was red. Nurse #1 indicated that the middle of Resident #1 mons pubis had skin peeled off and some of her pubic hair had fallen out. Nurse #1 explained that she cleaned the wounds with normal saline and dressed both thighs with ABD pads (large gauze wound dressings) to protect the area from infection. Nurse #1 indicated at the end of her shift (11:00 PM) she passed on the information to the oncoming Nurse #2 during shift report. Written statement from Nurse #2 dated 07/23/24 revealed, I came in on 3rd (11:00 PM to 7:00 AM) shift on 07/22/24 behind Nurse #1. Nurse #1 reported an incident related to Resident #1. Stated that Resident #1 had skin that peeled back on thighs. Nurse #1 asked if she needed to do an incident report, and I said yes and call family and doctor. I went down with NA#2 and NA #6 to check on Resident #1. Resident #1 had dressings on inner thighs. I assessed Resident #1's thighs. They were light pink without signs of infection. New sterile ABD pads added and covered areas. Resident #1 had no signs or symptoms of pain. Nurse #3 put a clean rolled up towel between knees to help. Resident #1 did have some pink, red area to her pubic hair area also. Oncoming Nurse #3 and Wound Nurse notified in the morning. I did call Resident #1 daughter and notify her at around 07:00 AM. Area to inner thighs looks darker and worse than earlier. Wound light pink-no extra skin -no bleeding, uneven edges. No signs or symptoms infection to inner bilateral thighs and no signs or symptoms of pain. Pink/Red area pubic area. This was observed at beginning of my shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Nurse #2 on 08/06/24 at 8:38 AM. Nurse #2 confirmed that she worked an 8-hour shift (11:00 PM to 7:00 AM) on 07/22/24 and she relieved Nurse #1. Nurse #2 stated that Resident #1 was not known to have any wounds or skin alterations prior to 7/22/24. Nurse #2 confirmed that Resident #1 was nonverbal. Nurse #2 stated that Resident #1 did not have a history of scratching, and no one had reported any concerns about any new behaviors. Nurse #1 reported to Nurse #2, that Resident #1 had an incident where she was rubbing her thighs in the shower according to NA #1. Nurse #1 told her Resident #1 had ABD pads to her bilateral upper thighs and the areas were red but not inflamed. Nurse #2 explained that she went with NA #3 at about 11:30 PM to assess Resident #1. Nurse #2 confirmed Resident #1's pubic area had red patchy areas, and pubic hair had fallen out. Nurse #2 indicated that Resident #1 did not have any nonverbal signs of pain. Nurse #2 stated that she did not do anything else for Resident #1 throughout her shift. Nurse #2 indicated that by morning (7:00 AM) on 07/23/24, the areas on Resident #1's genitalia and bilateral upper thighs was more reddened and irritated. Nurse #2 confirmed that at the end of her shift on 07/23/24 at 07:00 she reported Resident #1's wounds to Wound Nurse and Nurse #3. Nurse #2 indicated on 07/23/24 at about 7:30 AM she assessed Resident #1 with the Wound Nurse and Nurse #3, after which she left as her shift had ended. Nurse Aide electronic documentation revealed that on 07/23/24 at 12:44 AM, NA #2 noted that Resident #1 did not have any behaviors observed. Documentation revealed that for the task monitor skin observation, NA #2 noted that Resident #1 had none of the above (scratched, red area, discoloration, skin tear, open area) observed. Written statement from NA #2 dated 07/23/24 revealed, I arrived at work at 11:00 PM, the NA from second shift took me to show me what happened to Resident #1 when he gave a shower earlier. Resident #1 thigh and part of her pubic area was gone. It was pink area in color. I had the Nurse #2 to come and look at it as well. Multiple attempts were made to reach NA #2 for an interview were unsuccessful. Progress note completed on 07/23/24 at 7:52 AM by Nurse #3 was reviewed. The documentation indicated, Prior nurse reports of red area to groin, pubic area, and blister noted to inside of left dorsal/lateral thigh. Nurses enter room noting skin peeling, beefy red, in bilateral groin areas, front of upper thigh, fluid filled blister to dorsal/lateral left thigh. Wound nurse notified and assessed resident with new order to send to hospital for further evaluation. Written statement from Nurse #3 dated 07/23/244 at 7:40 AM stated: this nurse completed skin check between 1315-1330 (1:15 PM and 1:30 PM) with no wound noted to skin. Resident had not yet had shower due to 3-11pm shower. No CNAs reported to this nurse no new areas to skin after skin check completed. A second written statement from Nurse #3 dated 07/28/24 documented: prior to this nurse notifying 911 for transport of Resident #1, I asked Wound Nurse what Resident #1 was being transferred to ED for and how to word injury. I notified 911 for transport to [local hospital] for skin injury to groin and pubic area being treated as abuse investigation. 911 operator asked this nurse if I thought it was abuse or sexual I stated no. When EMS arrives to transport Resident #1, they asked how the injury occurred. I could only give information passed from prior nursing report. That resident was given a shower late the night before the NA that was assisting reported to the 3:00 PM to 11:00 PM nurse Resident #1 was scratching upper thigh area, skin tear reported that nurse treated area with wound spray and completed incident report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Nurse #3 on 08/05/24 at 4:01pm. Nurse #3 revealed that she provided care to Resident #1 on 07/21/24, 07/22/24, and 07/23/24. Nurse #3 confirmed that she worked a 12-hour shift (7:00 AM to 7:00 PM) on 07/22/24. Nurse #3 stated that Resident #1 required two-person assistance with providing incontinence care, bathing and showers. Nurse #3 confirmed that Resident #1 could move her left arm and rub or scratch her right arm. Nurse #3 confirmed that Resident #1 had never scratched herself to the point of having any skin alterations. Nurse #3 also indicated that Resident #1 was nonverbal. Nurse #3 explained that on 07/22/24 she assisted NA #3 with providing incontinence care to Resident #1 and Resident #1 did not have any skin alterations. Nurse #3 indicated that Resident #1 had dryness on her face and was ordered skin protectant cream once a day. Nurse #3 confirmed that she returned to work on 07/23/24 to start her shift at 7:00 AM and during report, Nurse #3 revealed that Nurse #2 reported Resident #1's skin had peeled completely off in between her thighs and groin area. Nurse #3 recalled Nurse #2 told her Resident #1 had received a shower from NA #1 at 8:00 PM on 07/22/24 and during that shower, the skin peeled off. Nurse #3 confirmed she observed Resident #1's skin with the Wound Nurse present on 07/23/24 at about 8:00 AM and the skin had completely peeled off her bilateral anterior thighs and she had a redness to the pubic area with patchy areas of peeled skin and pubic hair coming out. There was also a blister to the back/posterior left thigh. Nurse # 3 stated that the bilateral upper thighs and pubic area skin looked bad (very red and raw). Nurse #3 indicated that Wound Nurse notified the Assistant Director of Nursing (ADON) via phone about Resident #1 wounds while in Resident #1's room. Nurse #3 indicated that ADON was on the phone with Wound Nurse and ADON notified provider. Nurse #3 recalled the ADON communicated by phone the provider had been notified and Resident #1 had orders to be transferred to the emergency room . Skin only evaluation assessment that was completed on 07/23/23 at 8:36 AM by Wound nurse was reviewed. The documentation indicated, Resident #1 Skin warm & dry, skin color WNL and turgor is normal. Right palm protector External device removed, and site inspected: Head, neck, and ears intact with scattered dry skin and moles. Trunk inspected and intact with scattered moles. BUE intact with scattered dry skin. Back, buttock, and sacrum intact. Peeled open wounds to bilateral thighs and inner thighs with an intact blister to the left dorsal/lateral thigh. Lower half of bottom extremities intact with scattered moles and dry skin. Slight redness to heels, toes intact. Written statement from Wound nurse dated 07/23/24 was reviewed. The Wound Nurse documented, I was texted by Nurse #3 at 7:05 AM about an urgent assessment needed on Resident #1. I arrived a few minutes later to find nursing staff at bed side with Resident #1 brief open to air with a large raw bilateral wound to the legs and pubic area with an intact blister to the dorsal area of the left leg. ADON notified at 07:11 AM of injuries, zeroform (bacteriostatic wound dressing) and ABD pads applied. A full skin assessment was completed. All skin was intact, old wound area noted on the back of the knee. Resident #1 was clean and dressed at bedside, visibly stable, and management was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Wound Nurse on 08/06/24 at 12:03 PM. The Wound Nurse confirmed that Resident #1 did not have any wounds or skin alterations prior to being discharged to hospital on 07/23/24. The Wound Nurse stated on 07/23/24 she was notified by Nurse #3 to come urgently to Resident #1's room. The Wound Nurse stated that she assessed Resident #1 in the presence of Nurse #3 and Resident #1's brief was open to air to avoid it from touching the wounds on her bilateral thighs, groin and pubic area. Wound Nurse explained the skin on Resident #1's bilateral thighs was peeled, raw and red approximately the same size (both wounds were approximately the same shape and size) from the inner thighs to the medial lateral side (from the inside of the thighs to the middle of the thighs) of the upper thigh. The Wound Nurse noted Resident #1's pubic area had patchy areas of missing skin and hair, and the dorsal (upper side) side of the left leg had an intact blister about 2 inches wide. Wound Nurse indicated that there was a little bit of drainage to bilateral upper thighs and pubic areas wounds. The Wound Nurse indicated that Resident #1 was nonverbal and did not have any nonverbal signs of pain during the assessment. An interview was conducted with the ADON on 08/06/24 at 12:19 PM. The ADON indicated that she received a call on 07/23/24 at 7:15 AM from the Wound Nurse stating something had happened to Resident #1 and things were not adding up. ADON indicated that Wound Nurse described the areas were on Resident #1's bilateral upper thighs and had quite a large area of skin peeled off and raw tissue exposed, pubic area had patches of skin peeled off and pubic hair fallen off and the back of her thigh had an intact blister. The ADON indicated that at that time they did not have an idea of what was the cause. The ADON stated she got more information that it was in relation to a shower and self-inflicted scratching from an interview she conducted with NA #1. The ADON explained she interviewed NA #1 in the presence of the Administrator and MDS Nurse #1. ADON stated that NA #1 indicated that he took Resident #1 to the spa room to give her a shower on 07/22/24, on a shower bed. NA #1 indicated that he turned on the handheld shower and began to rinse Resident #1 and he did not have any soap and had to leave Resident #1 in the shower room alone and unattended to get soap. NA #1 indicated that when he returned to the spa room, Resident #1 was scratching her genital area. NA #1 reported the skin started to peel off Resident #1's bilateral upper thighs and he continued to wash her with a washcloth. NA #1 indicated after completing shower, he returned Resident #1 to her room and notified Nurse #1. NA #1 indicated to them he wanted to finish showering Resident #1 then notify the nurse. The ADON indicated that she was concerned that NA #1 left Resident #1 alone in the spa room with water running on her skin. ADON indicated that NA#1 knew not to leave a severely impaired resident alone and unattended in the spa room. The ADON noted after the Wound Nurse communicated with her on 07/23/24 at about 7:30am, she notified the provider of Resident #1 new wounds, per the description she obtained from Wound Nurse. Progress note completed by Nurse #3 on 07/23/24 stated: Prior nurse reports of red area to groin, pubic area, and blister noted to inside of left dorsal/lateral thigh. Nurses enter room noting skin peeling, beefy red, in bilateral groin areas, front of upper thigh, fluid filled blister to dorsal/lateral left thigh. Wound nurse notified and assessed resident with new order to send to hospital for further evaluation. Progress note that was completed on 07/23/24 at 9:00 AM by Nurse #3 was reviewed. The documentation indicated that EMS was notified at 08:00 AM. The note further revealed that EMS transferred resident onto stretch and departed the facility at 8:35 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ED provider notes dated 07/23/24 indicated that Resident #1 presented with deep partial thickness burns to the anterior and medial thighs bilaterally as well as the mons pubis. ED provider notes included Resident #1 vital signs on 07/23/24 at 9:07 AM to be a body temperature of 100.2 ?, blood pressure of 147/84, pulse rate of 82 beats per minute and respirations of 16 breaths per minutes. It was noted Resident #1 came from nursing home today with burns to her thighs. Supposedly she had a shower last night at the nursing home and now she has burns. Resident #1 is nonverbal and as such unable to offer any history. The ED provider notes further indicated that Resident #1 had severe contractures (shortening of muscles, tendons, skin and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) to bilateral lower extremities, knee extension and hips. ED notes indicated that Resident #1 had right upper extremity flexion contracture. ED notes indicated that Resident #1 only moved left upper extremity spontaneously-grossly 3/5 (medical muscle strength assessment that indicated Resident #1 could move her left arm on her own without assistance, but the strength would be rated as 3 out of 5, indicating moderate weakness. A score of 5 would represent normal strength.) ED notes dated 07/23/24 indicated, Resident #1 cleaned up due to voiding. Wound rinsed with water and pat dried. New chux pad (disposable under pads) applied and new gown applied. An emulsion dressing was placed around the burned area and put a PC (permanent catheter-indwelling) on. ED notes dated 07/24/24 stated Resident #1 was repositioned on her right side with pillow support. Call light within reach. After visit summary note dated 07/25/24 indicated the medications administered to Resident #1 while in the hospital on 07/23/24 at 09:50 AM to include Acetaminophen (Tylenol) and silver sulfadiazine topical dressing on bilateral thighs. Hospital wound care notes dated 07/24/24 indicated: Patient seen today for skin/wound consult. Heels clear. Feet overall very dry. Raw reddened burn like areas to suprapubic area and bilateral inner thighs. Right thigh wound is approximately 12 centimeters(cm) x 17 cm x 0.2 cm. Right thigh wound noted to have a thick pale layer of tissue sloughing. Left thigh wound is approximately 11.5 cm x 14 cm x 0.2 cm. Perineum is a combination of open areas and discoloration. Open area is approximately 4.5 cm x 6.5 cm. Black discoloration extending down both labia. Darker discolored skin will likely slough as well. Would hold off on purwick (purwick is a female external catheter for collecting urine) placement at this time due to discolored areas on labia. Discussed concerns with MD (Medical Doctor). Patient is also incontinent of urine at baseline. Appears to be partial thickness burns of thighs. No other burned areas noted on body. Patient keeps legs very tight together. Abdominal fold and breast fold clear. Bilateral upper extremities clear. Back clear. Shinny gray yeasty appearance to bilateral inner buttocks, gluteal crease and peri rectum. Skin currently intact. Patient on pressure redistribution surface. Records discussed with MD and nurse. Hospital Focused Physical Therapy initial evaluation dated 07/24/24 indicated: Patient presents from long term care facility with burns to inner thighs from bath water. Patient also unable to follow commands-did not follow one command this session. Spoke with nursing. Nursing cleared patient to participate in therapy. No pain reported, no grimaces noted. No pain reported, did not observe patient in any discomfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345565	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Elms	7449 Fair Oaks Drive Clemmons, NC 27012

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A statement written by Minimum Data Set (MDS) Nurse #1 dated 07/23/24 revealed: Interview with NA #1. NA #1 stated that around 8:00 PM on Monday evening 7/22/24, he began to get Resident #1 ready for her shower. Resident #1 had a BM and he cleaned her before putting her on the stretcher. 2 student CNAs were present and assisted him with incontinence care prior to placing her on the stretcher. The students then had to leave. He rolled her to the shower room and proceeded to turn on the water and I [TRUNCATED]