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PRINCESS ANNE HEALTH & REHABILITATION CENTER	1948 LANDSTOWN CENTRE WAY VIRGINIA BEACH, VA 23456

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 2/18/25 through 2/21/25 and 2/24/25 through 2/27/25. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Eight complaints were investigated during the survey; VA00059474 - Unsubstantiated for lack of sufficient evidence; VA00063229 - Substantiated without a deficiency; VA00061293 - Substantiated without a deficiency; VA00062791 - Substantiated with a deficiency; VA00062598 - Substantiated with a deficiency; VA00062590 - Substantiated with a deficiency; VA00060204 - Substantiated with a deficiency; VA00059319 - Substantiated with a deficiency; The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 13 current Resident/closed record reviews (Residents 1 through 13).	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/27/2025

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(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to notify the Physician and Responsible Party of changes for

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one resident (Resident # 2) in a survey sample of 11 Residents.

The findings included:

For Resident # 2, the facility staff failed to notify the physician and Responsible Party of initial discovery of two wounds identified as unstageable pressure ulcers.

Resident # 2 was admitted to the facility on 3/14/2024. Diagnoses included but were not limited to: Chronic Heart Failure, History of Malignant Neoplasm of Renal Pelvis with right nephrectomy, Hypertension, Chronic Kidney Disease-Stage 3A, Atrial Fibrillation, Surgery of the Cervical Spine, Pulmonary Embolism, and a history of Venous Thrombosis and Embolism.

The most recent Minimum Data Set (MDS) assessment was an Admission assessment with an assessment reference date (ARD) of 3/18/2024. Resident # 2 was coded with a Brief Interview of Mental Status score of 8 indicating severe cognitive impairment. The Resident required extensive assistance, to complete dependence, on staff for all activities of daily living.
Section M-Skin Conditions was coded as "No" for the question regarding "pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device."
There were no other skin conditions noted.
There was a "yes" for
B. pressure reducing device for the bed.
C. Turning/repositioning program-No
D. Nutrition or hydration intervention to manage skin problems-No
E. Pressure ulcer/injury care-No

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F 580	Continued From page 3 F. Surgical wound care-Yes G. Application of nonsurgical dressings (with or without topical medications) other than to feet-No H. Applications of ointments/medications other than to feet-Yes The MDS was signed on 3/22/2024 at 3:14 p.m. Review of the clinical record was conducted from 2/18/2025-2/27/2025. Review of the clinical record revealed no documentation of the physician and family being notified on 3/19/2024 of the discovery of two unstageable pressure wounds until 3/21/2024 when the nurse signed the note. There was no treatment ordered until 3/21/2024. On 2/18/2025 at 3:26 p.m., an interview was conducted with Licensed Practical Nurse-7 who stated the nurses should notify the physician regarding any changes in condition to include new wounds. Licensed Practical Nurse-7 stated the Responsible Party would be notified too of changes in condition and any new orders. On 2/25/2025 at 11:30 a.m., an interview was conducted with the Director of Nursing who stated the facility staff should notify the Physician and Responsible Party of changes in condition. During the end of day debriefing on 2/26/2025 and 2/27/2025, the facility Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records	F 583		

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F 583	Continued From page 4 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility	F 583		

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documentation review, the facility staff failed to ensure personal privacy was afforded to 3 residents (Residents # 3, #10 , and # 11) in a survey sample of 11 residents.

The findings included:

1. For Resident # 3, the facility staff failed to close the window curtain while providing Wound Care on 2/25/2025

Resident # 3 was admitted to the facility on 9/5/2024 with the diagnoses of, but not limited to: Dementia with Agitation, Diabetes, Hypertension, and Legal blindness.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 1/7/2025. Resident # 3's BIMS (Brief Interview for Mental Status) Score was a 13 out of 15, indicating no cognitive impairment.

Review of the clinical record was conducted on 2/25/2025 to 2/27/2025.

On 2/25/2025 at 11:00 a.m., the Wound Care Nurse Practitioner was observed providing evaluation of wounds and wound care Resident # 3. The Wound Care Nurse Practitioner was checking the areas on the lower abdomen when the surveyor entered the room. The room was a private room. There was no curtain around the bed. The curtain to the window faced the Courtyard. Resident # 3 was visible to anyone who came into the room and visible to anyone who might be in the Courtyard. Two surveyors went into the Courtyard with the Unit Manager and observed the Nurse Practitioner still providing

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care to Resident #3 .

The Unit Manager stated the curtain should be closed while staff members were providing care. She stated it was important to provide privacy.

On 2/25/2025 at 3:15 p.m., an interview was conducted with Registered Nurse-B who stated it was important for the residents to have privacy in their rooms.

On 2/25/2025 during the end of day meeting, the Administrator, Corporate Nurse Consultant and Director of Nursing were made aware of the findings. They stated privacy should be maintained for all residents.

No further information was provided.

2. For Resident # 10, the facility's therapy staff failed to close the window curtain while providing assistance with ADL(Activities of Daily Living) Care on 2/25/2025.

Resident #10 was admitted on with diagnoses including but not limited to:

Resident # 10's most recent MDS (Minimum Data Set) was a Quarterly Assessment with an ARD (Assessment Reference Date) of 12/27/2024 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of 15 indicating no cognitive impairment.

Review of the clinical record was conducted on 2/18/2025 to 2/27/2025.

On 2/25/2025 at 11:34 a.m. during rounds, two

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staff members from Therapy were observed in the room with Resident # 10. They identified themselves as the Occupational Therapist and the Physical Therapist.
The Resident was sitting on the side of the bed wearing a shirt and an incontinence brief. The Occupational Therapist was standing near the resident. The Physical Therapist was squatting in front of the Resident. The therapists assisted the Resident with putting on pants. The incontinence brief was visible prior to the pants being pulled up.

The window curtain was not closed while care was being provided. The window faced the outside circular driveway to the entrance of the facility. The area outside the window was a high traffic area.

The surveyor left the room to observe what was visible in Resident # 10's room from the outside. There were cars observed driving in the entrance. Visitors were observed walking past the window. People could easily see inside Resident # 10 's room from the driveway and sidewalk.

Resident # 10 was in a private room. There was no privacy curtain in the room around the bed.

On 2/25/2025 at 2:25 p.m., an interview was conducted with the Occupational Therapist who stated that she normally would have closed the curtains but somehow got distracted while talking with the Physical Therapist who was also helping the resident. The Occupational Therapist stated she understood that it was important to keep the residents covered and to protect their privacy.

On 2/25/2025 during the end of day meeting, the

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Administrator, Corporate Nurse Consultant and Director of Nursing were made aware of the findings that the staff failed to provide visual privacy while ADL care was being provided.

No further information was provided.

3. For Resident # 11, the facility staff failed to honor the resident's right to privacy and maintain confidentiality of medical records when the computer screen for documentation of Medication Administration was left open for others to easily view on 2/26/2025.

Resident # 11 was admitted to the facility on 9/5/2024 with the diagnoses of, but not limited to: Dementia, Diabetes, Major Depressive Disorder, Anxiety, Depression, Vitamin B 12 deficiency and Dysphagia.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment Quarterly with an Assessment Reference Date (ARD) of 11/7/2024. Resident # 11's BIMS (Brief Interview for Mental Status) Score was a "00" out of 15, indicating severe cognitive impairment.

Review of the clinical record was conducted on 2/26/2025-2/27/2025.

While touring the facility on 2/26/2025 at 10:38 a.m., the computer on the medication cart was observed to be open with a visible Medication Administration Record and unattended by a staff member. The picture and personal information for a resident was openly displayed on the screen. The surveyor could read the information clearly. The medication cart was located in the hallway

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F 583	Continued From page 9 near the dining room on the unit. There was no nurse observed in the hallway near the medication cart. There were two staff members observed talking to each other near the nurses station. There was a visitor observed at the other end of the hallway. Another surveyor came down the hallway and observed the unattended medication cart with the open computer screen. On 2/26/2025 at 10:42 a.m., a nurse came to the medication cart 4 minutes after the surveyor observed the unattended cart. The nurse stated she knew she should have closed the computer screen prior to leaving the medication cart but stated she "left to check on another" resident. The nurse stated due to privacy, the computers should always be closed prior to leaving the carts. The resident was identified and placed in the survey sample as Resident # 11. On 2/27/2025 at 10:50 a.m., an interview was conducted with the Director of Nursing who stated the nursing staff should not leave the Medication Administration Records open and unattended where others can view the information. During the end of day debriefing on 2/27/2025, the facility Administrator, Regional Nurse Consultant and Director of Nursing were informed of the findings. No further information was provided.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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Based on observation, resident interview, staff interview and facility documentation review, the facility staff failed to ensure a clean, comfortable homelike environment for one resident (Resident # 1) out of a survey sample of 11 residents.

The findings included:

1. For Resident # 1, the facility staff failed to ensure the rooms did not have a foul smell and dirty carpet.

Resident # 1 was admitted to the facility on 11/9/2023. Diagnoses included but were not limited to:

The most recent Minimum Data Set (MDS) was a Assessment with an Assessment Reference Date (ARD) of 11/3/2024. Resident # 1's BIMS (Brief Interview for Mental Status) Score was a out of 15, indicating no cognitive impairment. Resident # 91 required assistance with Activities of Daily Living.

Review of the clinical record was conducted on 2/18/2025-2/27/2025.

The Facility Administrator stated it was important for the facility to be clean, comfortable and homelike.

On 2/18/2025 at 2:30 p.m., an interview was conducted with CNA (Certified Nursing Assistant)-1 who stated that sometimes the rooms did smell terrible. She stated the staff was expected to inform the supervisor and Housekeeping staff.

During the days of the survey, there were

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F 584	Continued From page 12 observations of rooms and hallways with odors. There were soiled linen barrels in the hallway with lids not secured tightly in some areas. During the end of day debriefings on 2/26/2025 and 2/27/2025, the Administrator and Director of Nursing were informed of the findings of failure to provide a clean, comfortable, homelike environment. There was documentation that the residents complained about the smell of urine in carpets and foul smelling bathroom. No further information was provided.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

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rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop and implement a comprehensive person-centered care plan comprehensive care plan for care and services to maintain the highest practicable well-being for one Resident (Resident #2) in a survey sample of 11 Residents.

The findings included:

For Resident #2, the facility failed to develop a comprehensive care plan with measurable goals and interventions that addressed the potential for development of pressure wounds.

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Resident # 2 was admitted to the facility on 3/14/2024. Diagnoses included but were not limited to: Chronic Heart Failure, History of Malignant Neoplasm of Renal Pelvis with right nephrectomy, Hypertension, Chronic Kidney Disease-Stage 3A, Atrial Fibrillation, Surgery of the Cervical Spine, Pulmonary Embolism, and a history of Venous Thrombosis and Embolism.

The most recent Minimum Data Set (MDS) assessment was an Admission assessment with an assessment reference date (ARD) of 3/18/2024. Resident # 2 was coded with a Brief Interview of Mental Status score of 8 indicating severe cognitive impairment. The Resident required extensive assistance, to complete dependence, on staff for all activities of daily living.
Section M-Skin Conditions was coded as "No" for the question regarding "pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device."
There were no other skin conditions noted.
There was a "yes" for
B. pressure reducing device for the bed.
C. Turning/repositioning program-No
D. Nutrition or hydration intervention to manage skin problems-No
E. Pressure ulcer/injury care-No
F. Surgical wound care-Yes
G. Application of nonsurgical dressings (with or without topical medications) other than to feet-No
H. Applications of ointments/medications other than to feet-Yes
The MDS was signed on 3/22/2024 at 3:14 p.m.

Review of the clinical record was conducted 2/18/2025-2/27/2025.

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Review of the care plan revealed the following plan for pressure wounds:

"The resident is at risk for pressure ulcers related to advanced age, chronic health conditions
Created on: 03/22/2024
Goal: the resident will not have a skin impairment thru the review
period
Interventions:
assist the resident to turn and reposition often-(not measurable)
draw sheet for turning and repositioning while in bed
Keep skin clean and dry as possible (how often)
Pressure relieving mattress
skin assessments as indicated (it does not state how often skin assessments should be done)

Another problem regarding pressure wounds was listed but was vague. It did not document the stages or sizes of each wound:

"The resident has a chronic wound or pressure ulcer to the (bilateral buttocks)
The resident has a risk for worsening wound(s) or the development of additional wounds related to: advanced age, chronic health conditions, frequent incontinence, immobility
Goal: the resident will not develop any further skin impairment thru
the review period
Created on: 03/22/2024
the resident's wound will show s/s (signs and symptoms) of healing thru the review period

assess resident for risk of skin breakdown
assist the resident to turn and reposition often

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draw sheet for turning and repositioning while in bed
Keep skin clean and dry as possible
pressure relieving mattress
referral to Registered Dietician
referral to skilled therapy
referral to wound physician as indicated
skin assessments as indicated
Treatment per TAR (Treatment Administration Record)
Wound reviews as indicated"

The care plans were not tailored to Resident # 2. They did not specifically describe what condititons increased the risk of development of pressure ulcers, did not state how often interventions should be implemented and were not measurable. They did not list the issue of incontinence of bowel and bladder.

The second care plan was not specific to Resident # 2. It did not identify the sizes and stages of the wounds. It did not state how often interventions should be completed. Some interventions were vague.
It did not state how often skin assessments should be done.

On 2/18/2024 at 6:40 p.m., an interview was conducted with the Regional MDS Consultant who stated care plans should be developed and implemented to address the needs, goals and strengths of each resident. She stated

On 2/26/2025 at 11:40 a.m., an interview was conducted with the Director of Nursing who stated care plans should be tailored to each resident and with specific, measurable goals and interventions. The care plan would help the

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F 656	Continued From page 17 resident reach the highest potential. During the end of day debriefing on 2/26/2025, the facility Administrator, Director of Nursing and Regional Nurse Consultant were informed of the findings that the care plan was not tailored to Resident # 2. No further information was provided.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to follow the professional nursing standards of quality regarding medication administration and failed to follow physicians orders for one resident (Resident # 2) in survey sample of 11 residents. Findings included: For Resident # 2, the facility staff failed to seek treatment for two pressure wounds identified as unstageable ulcers at discovery resulting in harm, failed to ensure medications were administered as ordered by the physician, failed to send a urine specimen for urinalysis and culture and sensitivity for 3 days after collection. Resident # 2 was admitted to the facility on	F 658		

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3/14/2024. Diagnoses included but were not limited to: Chronic Heart Failure, History of Malignant Neoplasm of Renal Pelvis with right nephrectomy, Hypertension, Chronic Kidney Disease-Stage 3A, Atrial Fibrillation, Surgery of the Cervical Spine, Pulmonary Embolism, and a history of Venous Thrombosis and Embolism.

The most recent Minimum Data Set (MDS) assessment was an Admission assessment with an assessment reference date (ARD) of 3/18/2024. Resident # 2 was coded with a Brief Interview of Mental Status score of 8 indicating severe cognitive impairment. The Resident required extensive assistance, to complete dependence, on staff for all activities of daily living.
The MDS was signed on 3/22/2024 at 3:14 p.m.

Review of the clinical record was conducted 2/18/2025-2/27/2025

Review of the Progress Notes revealed a note from the provider which ordered Levaquin 500 mfg (milligrams) for two days and to follow up on Monday. The Medical note read:

"03/16/2024 4:29 PM
Remove Foley and re-insert obtain specimen for urine analysis and culture, Levaquin, 500 mg times two days follow up on Monday with primary care for continuance, push fluids, PYRIDIUM hundred milligrams, three times a day for two days for dysuria, monitor report any change may have Tylenol 650 mg Q 4(every 4) hours PRN (as needed) pain/fever. Notify a clinician of any change in condition"

There was no documentation of the order written

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by the physician on 3/16/2024 at 4:29 p.m. for Levaquin 500 milligrams times two days and "follow up on Monday with primary care for continuance" It was not in the orders and not on the Medication Administration Record (MAR)

Also, there was no documentation of the medication, Pyridium 100 milligrams three times a day for two days for dysuria.(not in the orders nor on the MAR/

Review of the Medication Administration Record revealed an entry of:
Levaquin Tablet 500 MG (milligrams) (Levofloxacin)
Give 1 tablet by mouth one time a day for infection for 7 Days-Order Date 03/16/2024 2313

There was no documentation of the order for Levaquin for 7 days as was entered on the Medication Administration Record.

Levaquin was administered only 6 of the 7 days ordered. Given 3/18-3/23/24. a "9" for 3/17/2024-not administered. There was no progress note indicating why the medication was not administered. There was no indication that the antibiotic was extended an additional day to cover the missed dose. There was no documentation that the physician was informed that the entire course of antibiotics was not completed.

Further review of the Medication Administration Record revealed medications were not administered as ordered.

All scheduled medications were not documented as given on 3/24/2024. The signature slots were blank. There was no documentation of refusal of

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medications.

There was no explanation in the Nurses Progress Notes explaining why the medications were not given.

Triamcinolone Acetonide External Cream 0.025 % (Triamcinolone Acetonide (Topical))
Apply to affected area topically two times a day for skin condition-Order Date 03/14/2024 1628-D/C Date 03/18/2024 135 only given twice- 3/15/24 at 5 p.m. and 3/17/24 at 9 a.m.
All 5 other doses were listed as "5" indicating "hold,

On 2/18/2025 at 12:50 p.m., an interview was conducted with Licensed Practical Nurse-1 who stated nurses should give medications as ordered and document them immediately after administration. She also stated the nurse should notify the provider if medications are not available or if omitted.

On 2/18/2025 at 3:43 p.m., an interview was conducted with the Director of Nursing who stated nurses were expected to follow physicians orders and to administer medications as ordered by the physician. The Director of Nursing stated the facility used Lippincott for professional guidance.

On 2/18.2025 at 4:10 p.m. an interviews was conducted with LPN-3 who stated - "nurses have to document the medications they give. If it is not documented, it was not done."

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On 2/27/2025 at 5:15 p.m., an interview was conducted with LPN-2 who stated "If it is not documented, it was not done."

According to the Mayo Clinic, "antibiotics are important drugs that can successfully treat infections caused by bacteria. Antibiotics can prevent the spread of disease. The way drugs are used affects how quickly and to what degree resistance occurs."
It also stated:
"You need to to take the full treatment to kill the disease-causing bacteria. If you do not take an antibiotic as prescribed, you may need to start treatment again later. If you stop taking it, it can also promote the spread of antibiotic-resistant properties among harmful bacteria."

The article also stated that Drug resistant infections can cause many problems including:
"More-serious illness, longer recovery, more-frequent or longer hospital stays, more health care provider visits and more- expensive treatments.
Complete the entire treatment."

According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record..."

Guidance from the National Institutes of Health in

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F 658	Continued From page 22 the article "The nurses medication day" stated that "Nurses serve as a barrier, protecting residents from potential hazards. Calls were also common to request 'missing meds' (medications) followed by waits until they were delivered. Waiting reflected system failures...." ncbi.nlm.nih.gov accessed 3/12/2025. During the end of day debriefings on 2/26/2025 and 2/27/2025, the facility Administrator and Director of Nursing were informed of the findings that included but not limited to nurses were not following physicians orders, failed to obtain orders for a pressure wound for two days after discovery and failed to ensure that medications were administered as ordered. No further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure proper Activities of Daily Living services were provided for one resident (Residents # 7 in a survey sample of 11 residents. Resident # 7 was admitted to the facility on 12/10/2024 with diagnoses that included but were not limited to: Anemia, History of Prostate Cancer, Dysphagia, and Diverticulosis of the	F 677		

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Large intestine.

Resident #7's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 12/17/2024 was an Admission assessment. The MDS coded Resident # 7 with a BIMS (Brief Interview for Mental Status) score of "15" out of 15, indicating no cognitive impairment. The MDS coded Resident # 7 as requiring staff assistance with Activities of Daily Living. Resident # 7 was coded as occasionally incontinent of bowel and bladder.

Review of the clinical record was conducted from 2/25/2025-2/27/2025.

Review of the ADL (Activities of Daily Living) documentation of care provided by Certified Nursing Assistants revealed missing documentation of care. Numerous dates for ADLs had the code "97" written indicating "not applicable" for consecutive shifts and days. Examples include but not limited to: No bed bath was provided on the evening shift for 14 days-Every day from 12/10-12/23/2024 the code "97" was documented on the evening shift.. On the night shift, a bed bath was provided on only one date-12/16/2024. All the other dates had either "97" or nothing documented.
Only two showers were provided during the two week stay at the facility-(on 12/16/2024 and 12/23/2024). The shower scheduled for 12/19/2024 was documented as "97"-not applicable.

On 2/26/2025 at 2 p.m., an interview was conducted with Licensed Practical Nurse-2 who stated she had heard complaints that residents were left wet for extended periods of time.

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F 677	Continued From page 24 Licensed Practical Nurse-2 stated she believed it could be true depending on the staffing levels. The facility often worked short and some staff members worked at different paces. On 2/27/2025 at 4:30 p.m., an interview was conducted with the Director of Nursing who stated residents should receive a bed bath on each shift and receive hygiene after incontinent episodes. During the survey, there were observations of Residents in need of incontinence care. There was facility documentation of carpets needing to be replaced due to being soaked with urine. During the end of day debriefings on 2/26/2025 and 2/27/2025, the facility Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility documentation review, the facility staff failed to provide care and services consistent with professional standards of practice to prevent the development and worsening of pressure ulcers for two (2) Residents (Resident #2 , #5), resulting in harm for both Residents, in a survey sample of 11 Residents.

The findings included:

1. For Resident #2, the facility staff first identified two wounds (one on the the right buttock and one on the left buttock) as unstageable pressure ulcers, resulting in harm.

Resident #2 was admitted to the facility on 3/14/2024. Diagnoses included but were not limited to: Chronic Heart Failure, History of Malignant Neoplasm of Renal Pelvis with right nephrectomy, Hypertension, Chronic Kidney Disease-Stage 3A, Atrial Fibrillation, Surgery of the Cervical Spine, Pulmonary Embolism, and a history of Venous Thrombosis and Embolism.

The most recent Minimum Data Set (MDS) assessment was an Admission assessment with an assessment reference date (ARD) of 3/18/2024. Resident # 2 was coded with a Brief Interview of Mental Status score of 8 indicating severe cognitive impairment. The Resident required extensive assistance, to complete dependence, on staff for all activities of daily living.
Section M-Skin Conditions was coded as "No" for the question regarding "pressure ulcer/injury, a

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scar over bony prominence, or a non-removable dressing/device."
There were no other skin conditions noted.
There was a "yes" for
B. pressure reducing device for the bed.
C. Turning/repositioning program-No
D. Nutrition or hydration intervention to manage skin problems-No
E. Pressure ulcer/injury care-No
F. Surgical wound care-Yes
G. Application of nonsurgical dressings (with or without topical medications) other than to feet-No
H. Applications of ointments/medications other than to feet-Yes

The Braden Scale for Pressure Sore Risk listed as "Admission" and dated 3/28/2024 was coded with a total score of 20 out of 23 indicating " No Risk". The Score and Category range for the Braden Scale is listed below:
No Risk- total Score 19-23
Mild Risk- total Score 15-18
Moderate Risk- total Score 13-14
High Risk-total Score 19-23
Very High Risk-total Score 9 or less
Further review of the Braden Scale document revealed the staff answered the questions.

Review of the clinical record was conducted from 2/18/2025-2/27/2025.

Review of the Progress Notes revealed documentation of a wound that was identified as an unstageable pressure ulcer when first discovered on 3/19/2024.

"Resident skilled for spondylosis with neck brace. Cervical collar noted."

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Review of the Skin Observation Tool dated 3/19/2024 revealed documentation of two areas described as Unstageable.

Interviews were conducted with Certified Nursing Assistants (CNA) who stated they often were unable to turn and reposition residents every two hours due to staffing shortages. One CNA stated she would provide incontinence care 3 times during her 8 hours shifts. Another stated she tried to provide incontinence care 2 -3 times during the 8 hour shift. They stated that the workload was hard to handle at times. They sometimes did not feel good about the care they provided because they did not have enough help to get everything done. These CNAs were very hesitant to speak with surveyors and asked that their anonymity be preserved as much as possible in any interviews.

Review of the Skin Observation Tool dated 3/19/2024 revealed two unstageable pressure wounds identified (one on the right buttock, one on the left buttock).

Right Buttock-pressure-Length-3 cm (Centimeters), Width-3 cm, Depth-0.1 cm
Left Buttock-pressure-Length-3 cm, Width-3 cm, Depth-0.1 cm

A Wound Evaluation was conducted by the Wound Care Nurse Practitioner ten days after the initial discovery of the unstageable pressure ulcers on the right and left buttocks.

The Wound Assessment Report dated 3/29/2024 described evaluation of a wound on the sacrum measuring Length: 11.00 cm (centimeters) x Width: 10.5 cm and depth: 0.20 cm.

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Location: Sacrum
Etiology: Pressure
Stage/Severity: Unstageable
Acquired in House: No
Date Wound Acquired" 03/14/2024
Wound Status: Present on Admission
% Slough: 100 % slough
% Eschar: 0 % eschar
Exposed Tissue:
Wound Edges: Attached
Periwound: Fragile
Exudate Amount: Moderate
Eudate Description: Serosanguineous
Odor Post Cleansing: none

Treatment:
Dressing Change Frequency: Daily
Clean Wound with: Cleanse with normal saline
Primary Treatment: Santyl
Other Dressings: Bordered foam

Review of the Wound Assessment Report dated 3/29/2024 revealed documentation of a wound on the sacrum decribed as
etiology-"pressure"
stage/severity-unstageable
slough-100%
measurements: Length-11.00 cm (centimeters)
Width-10.5 cm
Depth-0.20 cm

Treatment was in place for daily cleanse with normal saline, Santyl and bordered foam dressing.

Review of the facility's timeline of Resident #2's wounds revealed two areas were first discovered as "unstageable" on 3/19/2024.

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F 686	Continued From page 29 "3/14/24 (Admitted) - No known pressure areas 3/19/24 - Rt (right) & Lt (left) buttocks noted (unstageable) 3/21/24 - Treatment order in place 3/23/24 - Treatment change 3/29/24 - Seen by Wound, NP (nurse practitioner). - Rt & LT buttocks changed to sacrum by Wound, NP, continued as unstageable 4/2/24 - Discharged from the facility" Review of the care plan revealed the that there were interventions that were vague, not patient centered, specific and measureable. Review of Treament Administration Records revealed missing documentation of wound care. Review of ADL (Activities of Daily Living) documentation by Certified Nursing Assistants revealed several shifts of missing documentation (March 14,19, 22, 26, 27, 28, 29 and 30 on the day shifts, March 14, 15-night shift) and numerous dates with the number "97" indicating the care was "not applicable" according to the ledger at the bottom of the document (March 15 through 29 evening shift, March 15 through March 31 night shift). There was conflicting information about wounds documented in the progress notes. On 3/30/2024 at 9:06 pm, Licensed Practical Nurse-4 documented a skilled note. The note stated there were no skin issues. This was the same nurse who documented the discovery of unstageable wounds on the right and left buttocks on 3/19/2024.	F 686		

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Within five days of admission on 3/19/2024, Resident #2 was diagnosed with two unstageable pressure wounds (one on the right and one on the left buttocks). The documentation stated the provider changed the description of the two wounds to one Sacral Wound described as unstageable on 3/29/2024.

Per TAR (Treatment Administration Record)
March 2024
Right Buttock wound care:
Cleanse with DWC.
Apply Hydrogel dressing
Cover with bordered gauze every day shift for Unstageable
Buttock Wound-Order Date
03/21/2024 1434-D/C Date
05/06/2024 2240- missing documentation 3/24 on 3/31- documented "5" hold-see progress notes

Left Buttock wound care.
Cleanse with DWC.
Apply Hydrogel dressing
Cover with bordered gauze every day shift for Unstageable wound to Right Left Buttock-Order Date
03/21/2024 1437-D/C Date
03/23/2024 1144- documented on 3/22-Not documented on 3/23.

During the end of day debriefings on 2/25/2025, 2/26/2025 and 2/27/2025, the facility Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings of two wounds discovered as unstageable and a delay in treatments for two days after discovery, resulting in Harm.

No further information was provided prior to

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survey exit..

2. For Resident #5, the facility staff failed to prevent the development of a wound first identified as an unstageable pressure ulcer, resulting in harm.

Resident #5 was admitted to the facility on 5/2/2020 and readmitted 1/4/2024 with diagnoses that included but were not limited to: Fracture of Right Femur, Systemic Lupus Erythematosus, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Chronic Kidney Disease, Stage 4 Severe, and Dementia.

Resident # 5's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 12/20/2024 was an Annual assessment. The MDS coded Resident # with a BIMS (Brief Interview for Mental Status) score of "10" out of 15, indicating moderate cognitive impairment. The MDS coded Resident # as requiring extensive to total staff assistance with Activities of Daily Living. Resident #5 was coded as incontinent of bowel and bladder.

Review of the clinical record was conducted from 2/18/2025-2/27/2025.

Review of the Progress Notes revealed no documentation of the wounds until the Wound Assessment on 2/6/2025 by the Wound Care Nurse Practitioner. It was written that a Stage 3 wound on the left buttock was acquired in house on 1/21/2025 and,
"Wound Status: First Evaluation of existing wound by new provider
Undermining:
Tunneling:

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% Epithelial: 50% epithelial
% Granulation: 20% granulation
% Slough: 30% slough
% Eschar: 0% eschar
Exposed Tissue: Subcutaneous, Dermis
Wound Edges: Attached
Periwound: Intact
Exudate Amount: Scant
Exudate Description: Serosanguineous"

Thorough review revealed there was no noted documentation of a skin assessment tool dated 1/21/2025. There was no nursing progress note indicating a pressure wound on the date as documented by the Wound Care Nurse Practitioner on 2/6/2025.

The Skin Assessment tool dated 1/29/2025 showed a "rash" on the sacrum.

The Skin Assessment tool dated 2/10/2025 noted wound on the sacrum
noted as pressure measuring 1 cm x 1 cm depth .1 cm.

The Skin Assessment tool dated 2/12/2025 noted wound on the sacrum was described as pressure.

According to the Wound Report dated 2/14/2025, Resident #5 was not seen for a Wound Assessment on 2/14/2025 because she was "out of room."

The facility staff failed to obtain orders for the newly discovered pressure wounds. The facility staff failed to notify the physician and responsible party of the wounds.

The care plan was not reviewed and revised after

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discovery of the pressure wounds on the right and left buttocks.

Review of the Physicians Orders revealed no orders for wound care until 2/11/2025.

Review of the Activities of Daily Living Sheets documented by Certified Nursing Assistants showed missing documentation of care provided to Resident #5.

On 2/26/2025 at 3 p.m., an interview was conducted with Licensed Practical Nurse-2 who stated the Wound Care Nurse Practitioner came to the facility two days a week. On Tuesdays, she assessed the residents on Units 2 and 3 and on Fridays she assessed those on Units 1 and 4. Licensed Practical Nurse-2 stated the Wound Care Nurse Practitioner would see all new admissions on one day and all existing residents on the other day.

On 2/26/2025 at 4:40 p.m., an interview was conducted with the Director of Nursing who stated she monitored wounds by reviewing the 24 hour report, clinical process meeting and talking with the Wound Care Nurse Practitioner. The Director of Nursing stated the Wound Care Nurse Practitioner submits a report each week. The Director of Nursing stated it would be written in the report if a resident was not in the room when the Wound Care Nurse Practitioner attempted to assess wounds that day. The Director of Nursing stated the resident would be seen the following week. When asked why the Nurse Practitioner would not return to the room after the resident returned or be seen the next time in the facility, the Director of Nursing stated she didn't know but that the Wound Care Practitioner saw residents

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F 686	Continued From page 34 on specific units during each visit. During the end of day debriefings on 2/26/2025 and 2/27/2025, the facility Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings a wound on the left buttock was discovered as unstageable pressure ulcer, resulting in Harm. No further information was provided prior to survey exit..	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure that two (2) of eight (8) residents in the survey sample (Residents #8 and #9) received adequate supervision and assistive devices to remain free of accident hazards, which resulted in harm. The findings included: 1. Resident #8 was assessed to require a wander guard due to exit-seeking behavior and scored as high risk for elopement on 11/18/24. The facility staff failed to apply the wander guard and lacked adequate supervision as she eloped on 11/19/24,	F 689		

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fell, and sustained significant injuries, resulting in harm to Resident #8.

Resident # 8 was admitted to the facility on 11/01/2024 with a diagnosis of Altered Mental Status, Difficulty Walking, Diabetes, Muscle Weakness, Hypertension, Hemiplegia and Hemiparesis, and a history of Cerebral Vascular Accidents (Stroke).

Resident #8's care plan, dated 11/18/2024, documented that the resident prefers to smoke and will smoke throughout the review period.

Resident #8's Minimum Data Set (MDS), dated 11/01/2024, shows a Brief Interview for Mental Status (BIMS) score of 1l out of 15, indicating moderate cognitive impairment. The resident was coded for transfer as needing supervision and one-person physical assistance (how the resident moves between surfaces, including to or from bed, chair, wheelchair, or standing position).

On 11/19/2024, around 7:47 PM, Resident #8 walked out of the facility into a busy intersection near the facility. The resident then walked a mile to Walgreens Pharmacy to purchase cigarettes. Unbeknownst to the facility's staff, Resident #8 was away from the facility's property.

An interview was conducted on 2/18/2025 at 3:15 PM with the Resident #8's Responsible Party (RP). She said the resident has had multiple strokes, and after the last stroke, her desire to smoke again became overwhelming and that the resident now remembered she was a smoker. The RP stated that during the resident's admission, she advised the facility of the resident's desire to smoke again and requested a

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wander guard bracelet for her safety. The RP stated that on 11/18/2024, she met with the facility unit manager, RN #2. She said RN #2 came to the resident's room to assess Resident #8 for the wander guard bracelet and stated that Resident #8 qualified for the bracelet and that he would personally apply it. The RP said she left shortly after the assessment and that Resident #8 did not receive the wander guard bracelet as she observed RN#2 in the facility's parking lot driving off in front of her. The wearable wander guard bracelet can be integrated with a resident's security system to alert caregivers when residents have wandered from the protected zone. A nursing facility utilizes a wander guard system, where a resident wears a bracelet that sounds an alarm when the resident tries to go out the door (https://www.accutechsecurity.com/hospitals/residentguard-wander-management/).

The RP stated that on 11/19/2024 at approximately 6:00 PM, she dropped Resident #8 back at the facility after they had dinner together. The RP said that around 10:00 PM, she received a call from her father stating that Resident #8 had fallen. The RP said she returned to the facility to check on Resident #8 and observed her alone in bed upon entering her room. Blood-soaked clothing was in the sink, and there was a large amount of blood on the floor. The RP further stated the resident was bleeding profusely with two steri-strips underneath her chin to what it appeared to her to be a deep cut. A large bruise to the right side of the head and a cut near the eyebrow were also observed. The RP said Resident #8 appeared disoriented, and the facility's staff did not assist in providing care and treatment. The RP stated that the facility did not

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tell her that Resident #8 had wandered from the facility. She said she was unaware that Resident #8 had left the facility until she found a receipt from (local pharmacy name) in the resident's room trash can. She said Resident #8 usually used a walker or wheelchair and that the resident's gait was unsteady since the first stroke several years past. The RP stated the facility did not immediately call for emergency services for Resident #8 until later. The RP submitted several pictures to the surveyor taken on 11/19/2024 of her mother's condition when she arrived in her room, including a picture of the receipt from (local pharmacy name).

On 11/20/24, the RP stated that the Administrator assisted her when she returned to the facility to pick up all of Resident #8's items. The RP stated that the administrator had said he was at a conference during the incident, apologized for what happened, and planned to speak with RN #2 because "This shouldn't have happened to anyone."

Resident #8's fall notes dated 11/19/2024 at 10:31 PM documented, "Resident stated she fell outside. Resident states her legs gave away." The documentation intervention implemented by the facility's staff showed that Resident #8 was educated to be more careful when walking outside in the dark.

Resident #8's progress notes dated 11/19/2024 at 11:12 PM documented a report received from the evening shift nurse that the resident left the building and fell while she was off the premises. The RP came and was upset, citing that she wanted her mother to go to the hospital due to a possible need for stitches to the open area of her

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chin as well as to r/o (rule out) any further injuries as a result of the fall. The RP explained that the resident had previously fallen from past strokes. The progress notes indicated a few scrapes to the left cheek and swelling. EMS was called per the RP's request, and the resident was transported to the local hospital's emergency department for evaluation. The resident did not return to the nursing facility.

An interview was conducted on 2/18/2025 at 6:30 PM with RN #2, the facility's unit manager. RN #2 stated he was informed of Resident #8's leaving the facility on 11/19/2024. RN #2 stated that the staff is required to do frequent rounding on all residents. He said the CNA, while rounding, observed Resident #8's walker in the room and assumed the resident was in the room as well. RN #2 remembered completing Resident #8's wander guard bracelet assessment. RN #2 said that Resident #8 did not receive the wander guard bracelet. RN #2 stated that Resident #8 needed a wander guard bracelet after completing the assessment, but the facility was out of stock of the bracelet. RN #2 said he met with no one regarding this matter before leaving work on 11/18/2024. RN #2 stated he spoke with the facility Administrator the next day, 11/19/2024, regarding the issue of out-of-stock equipment. He was not sure of what time the resident left the facility or how long the resident was gone on 11/19/2024.

An interview was conducted on 2/18/2025 at 7:00 PM with the facility Administrator. Admin #1 remembered Resident #8 and stated that the resident somehow walked out the facility's front door. He was not sure of what time the resident left the facility or how long the resident was gone

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on 11/19/2024. Admin #1 stated that the meeting between him and RN #2 never happened about the Wander guard bracelet being out of stock. Admin #1 said the facility had plenty of wandering bracelets stored throughout the facility. He could not remember when the facility didn't have Wander guard bracelets in stock. The Administrator submitted several facility policies to the surveyor during this time: Missing Persons-Code Orange Policy, Elopement Exit -Seeking Behaviors Policy, Falls Management Program, Patient Smoking Acknowledgement, and Nursing Care & Service. The administrator said the facility's staff conducted a Code Orange Drill on 12/03/24 on all three shifts. Lastly, the Administrator noted this issue was discussed in their QAPI meeting and is an ongoing facility issue.

Resident #8's Facility Elopement Tool, used by the facility to determine residents who may be at risk for elopement, has a score of 0-7 for Low Risk and a score of 8-9 for At Risk for elopement/exit seeking.

Resident #8's Elopement Tool score was 1, dated 11/01/2024 at 8:16 PM.
Resident #8's Elopement Tool dated 11/07/2024 at 12:27 PM scored Incomplete.
Resident #8's Elopement Tool dated 11/18/2024 at 12:06 PM scored a 10.

The Facility Elopement/Exit-Seeking Behavior Policy dated 1/29/2024 states, "If a patient is determined to be at risk of elopement/exit seeking, an intervention using a safety/security system (Wander Guard, Roam Alert, etc.) will be assessed for appropriateness."

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No documentation was presented during the survey to support the facility's staff-activated "Code Orange" for a missing resident on 11/19/2024. Resident #8's progress notes revealed no additional safety/ security system interventions implemented by the facility on 11/18/2024 in response to Resident #8's Elopement score of 10. Additionally, no further information on why the facility delayed transportation to an emergency facility for a resident who had a change of condition.

An interview was conducted on 2/26/2025 at 4:10 PM with the facility Administrator, Director of Nursing, and Regional Clinical Nurse regarding Resident #8. The facility's Administrator stated that the facility had no additional documentation regarding the incident.

2. For Resident #9, the facility staff failed to ensure the resident was assessed to walk outside independently. The resident was not provided adequate supervision and was found outside on the ground, sustaining a severe head injury that resulted in harm.

Resident #9 was admitted to the facility on 5/25/2023 with a diagnosis of Depression, Atherosclerotic Heart Disease, Chronic Kidney Disease, Transient Ischemic Attack, Cerebral Infarction without residual, Orthostatic Hypotension, and Vascular Dementia.

Resident #9's care plan, dated 4/24/2023, documents that the resident is at risk for falls related to requiring assistive devices to walk or a transfer-walking stick for outdoor use. The resident also had Orthostatic Hypotension and pain.

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Resident #9 Minimum Data Set (MDS) dated 4/26/2023 coded resident ability to hear (with hearing aid or hearing appliance if normally used) as moderate difficulty. Resident MDS dated 7/07/2023 at 2:46 PM coded resident for transfer (how resident moves between surfaces, including to or from bed, chair, wheelchair, standing position) as needing supervision.

Resident #9's facility's Fall Note dated 7/11/2023 at 6:09 PM stated that the Resident was doing his daily walk with his cane when he was found behind unit 400, outside on the side of the road.

Resident #9's Progress Notes dated 7/11/2023 at 6:30 PM documented the following: "This writer was notified by the receptionist that a family member found this resident lying on the pavement behind the facility. The resident went out for an evening walk with his cane. This writer found resident lying on the pavement in road on left side. Large Hematoma noted above the left eye with blood-tinged sclera. Bruising noted from left hair line to eye. Abrasion noted to left elbow. Neuro checks initiated. Moving extremities X4 with no acute c/o's. 911 called and this writer with assist X1 helped resident to w/c and to front of building in shade. Paramedics/EMT arrived, and resident transported to an emergency facility."

Resident # 9 was transported to the local emergency room and treated for a head injury. The resident was assessed at the hospital with a parenchymal hemorrhagic contusion of the right temporal lobe. Resident #9 was immediately transported to a higher-level trauma medical center for treatment. The resident did not return to the nursing facility.

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A review of Resident #9's progress notes revealed that the resident had numerous admissions to the facility in 2023. Resident #9's admission timeframe during this investigative accident was from 5/26/2023 to 7/11/2023. There was no facility documentation stating that facility staff had assessed Resident #9 for needing supervision or accident prevention to ensure the resident could walk alone safely outside the facility.

The facility's Rehabilitation Director (Rehab #4) was interviewed on 2/26/2025 at 2:55. Rehab #4 asked to speak with the surveyor regarding Resident #9. Rehab #4 expressed that she does quarterly assessments for all the long-term care residents for Minimum Data Set (MDS) requirements. She said that the rehabilitation department did not assess Resident #9 during the resident accident timeframe from 5/26/2023 to 7/11/2023.

An interview was conducted on 2/26/2025 at 3:00 PM with the facility's Regional Nurse Consultant (RNC #3). She stated that Resident #9 had several visits to the facility in 2023, was independent, and enjoyed walking around the outside of the building almost daily. RNC# 3 stated she remembered the day Resident #9 was found injured outside the building on 7/11/2023. She said it was a very hot day, and staff found Resident #9 lying on the hot asphalt behind the facility in the parking lot. RNC #3 stated that one of the facility's nurses on Unit four (4) was walking down the hall and observed something on the ground outside. She stared through the glass door at the end of the hallway, which was the resident. The facility's staff assessed

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F 689	Continued From page 43 Resident #9, and the facility contacted 911. RNC# 3 stated that the facility had no documentation that Resident #9 was assessed to ensure the resident could safely walk alone without supervision. An interview was conducted on 2/26/2025 at 4:10 PM with the facility Administrator, Director of Nursing, and Regional Clinical Nurse regarding Resident #9. The facility's Administrator stated that the facility had no additional documentation regarding the incident of 7/11/2023.	F 689		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to obtain laboratory services to meet the needs of one Resident (Resident # 2) in a survey sample of 11 Residents. Findings included: For Resident # 2, the facility staff failed to ensure a urine specimen for urinalysis and culture and sensitivity was collected and sent to the laboratory. It was not collected and sent to the	F 770		

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laboratory until 3 days after the order

Resident # 2 was admitted to the facility on 3/14/2024. Diagnoses included but were not limited to: Chronic Heart Failure, History of Malignant Neoplasm of Renal Pelvis with right nephrectomy, Hypertension, Chronic Kidney Disease-Stage 3A, Atrial Fibrillation, Surgery of the Cervical Spine, Pulmonary Embolism, and a history of Venous Thrombosis and Embolism.

The most recent Minimum Data Set (MDS) assessment was an Admission assessment with an assessment reference date (ARD) of 3/18/2024. Resident # 2 was coded with a Brief Interview of Mental Status score of 8 indicating severe cognitive impairment. The Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. The MDS was signed on 3/22/2024 at 3:14 p.m.

On page 6 of 9 of the Progress Notes:

"UA (Urinalysis) & Culture- one time only for dark colored
urine for 1 Day-Order Date 03/16/2024 230 documented as collected on 3/17/2024"

"UA C&S (Culture and Sensitivity)-
The previous sample was collected
on 3/16 and picked up on 3/19.
Must be repeated.
one time only for R/O (rule out) Infection for
3 Days-Order Date
03/19/2024 143"
Review revealed the specimen was collected on 3/19/2024

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Review of Progress Notes: revealed:

Effective Date: 03/16/2024 23:26 Type: Health Status Note
"Note Text : Resident c/o of pain around foley site. Upon assessment there was blood and pus at the site as well as tea colored urine. On-call MD notified and new orders of Levaquin 500 mg, Pyridium, and PRN acetaminophen 650 mg, and a UA with culture were put in place. RP notified."

Date of Service : 03/16/2024 4:29 PM CT
"Primary Chief Complaint : GU: Dysuria
History Present Illness : Patient with the history of cervical surgery surgery, urinary retention Foley since March 6 with noted pus and blood at the Foley insertion urine discolored Amber in nature no known trauma order Line temperature 99.5 patient not on any anticoagulation has been drinking. Denies any abdominal pain back pain, no chills no nausea no vomiting or diarrhea admits to burning penile area."

Review of Systems : ROS (Review of Systems) as per HPI, all other systems reviewed and are negative
"Vital Signs : T: 99.5 (°F)
Physical Exam : Exam findings per nurse and video observation
Physical Exam - Notes : Awake alert no acute distress. Aspen collar in place normal respiratory effort no wheezing. No abdominal extension or superpubic tenderness muscle skeletal intact.
Diagnosis, Assessment/Plan : R300 - Dysuria (Primary)
Remove Foley and re-insert obtain specimen for urine analysis and culture, Levaquin, 500 mg times two days follow up on Monday with primary care for continuance, push fluids, PYRIDIUM

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hundred milligrams, three times a day for two days for dysuria, monitor report any change may have Tylenol 650 mg Q4 hours PRN pain/fever
The patient's condition is worsening.
Orders : Remove Foley and re-insert obtain specimen for urine analysis and culture, Levaquin, 500 mg times two days follow up on Monday with primary care for continuance, push fluids, PYRIDIUM hundred milligrams, three times a day for two days for dysuria, monitor report any change may have Tylenol 650 mg Q4 hours PRN pain/fever
Notify a clinician of any change in condition.
Disposition : Stay at Facility
Technology Used : Audio and video with patient and nurse present
Levaquin Tablet 500 MG (Levofloxacin)
Give 1 tablet by mouth one time a day for infection for 7 Days-Order Date 03/16/2024 2313."

Levaquin was administered only 6 of the 7 days ordered. Given 3/18-3/23/24. a "9" for 3/17/2024-not administered. There was no progress note indicating why the medication was not administered. There was no documentation that the physician was informed that the entire course of antibiotics was not completed.

Further review of the Progress Notes revealed documentation on 3/20/2024 at 12:21 p.m. that Resident # 7 had a scheduled appointment with Urology.
"Note Text: pt has an appt with urology 4/2/24 @ 820..."

Further review of the progress notes revealed documentation that Resident # 2's partner took the Resident to the hospital after the Urology

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Appointment. The note stated:

"Effective Date: 04/02/2024 15:31 Type: Change of Condition
Note Text : Patient's partner took patient to ED (EmergencyDepartment) at (name of hospital redacted) after appointment urology appointment. Patient is being admitted for sepsis"

There was no other information about the status of the discharge from the facility.

During the end of day debriefings on 2/26/2025 and 2/27/2025, the facility Administrator and Director of Nursing were informed of the findings.

Copies of the Hospital Record were requested on 2/18/2025. They were not received prior to the end of survey nor before the submission of this report.

No further information was provided.