DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: May 22, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Complaint survey was conducted at this facility from May 16, 2024 through May 22, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 112. The sample totaled 7 residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 22, 2024: cross refer: F565, F641, F660, and F686.	

Provider's Signature [signature] Title Administrator Date 6/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. BUILDING _____ B. WING _____	C 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD MILFORD, DE 19963

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from May 16, 2024 through May 22, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 112. The sample totaled 7 residents. Abbreviations/definitions used in this report are as follows: BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment; CNA - Certified Nursing Assistant; Braden - An assessment to determine risk of pressure ulcer development. The Score and Category below: Scoring: At risk 15-18 Moderate risk 13-14 High risk 10-12 Very high risk 9 or below; DON - Director of Nursing; EMR - Electronic Medical Record; Eschar - hard dead tissue that can be tan, brown or black; Family Member - FM; LPN - Licensed Practice Nurse; Medication Administration Record (MAR) - list of daily medications to be administered; MDS (Minimum Data Set) - standardized	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/14/2024

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

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F 000	Continued From page 1 assessment forms used in nursing homes; NHA - Nursing Home Administrator; Necrotic - tissue death, usually due to interruption of blood supply or injury; NP - Nurse Practitioner; Pressure Ulcer (PU) - open area of the skin that develops when the blood supply to the skin is cut off due to pressure; Slough - yellow, tan, gray, green, or brown dead tissue; Stages of severity of pressure ulcers (PU): Stage I - intact red skin often over a bony area that does not turn white/light when pressed. Stage II - blister or shallow open sore with red/pink color. Stage III - open sore that goes into the the tissue under below the skin. Stage IV - open sore that extends down into the muscle, tendon or bone may be seen/felt. Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough and/or Eschar. Eschar is a worsened deterioration than slough; Deep Tissue Injury (DTI) - purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue; UM - Unit Manager.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565		6/25/24

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F 565	Continued From page 2 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for pressure ulcers the facility failed to implement the grievance process. Findings include: The facility policy on grievances last updated, 1/8/24 indicated, "Upon receipt of a grievance/concern the grievance form will be	F 565	R#1 Responsible party was notified and informed that the grievance has been investigated Current residents have the potential to be affected by the deficient practice. Current residents with a BIMS 12-15 will be interviewed by the DON/designee to ensure if they presented a grievance	

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F 565	Continued From page 3 initiated by the staff member receiving the concern." Review of R1's clinical record revealed: 3/27/24 - R1 was admitted to the facility. 4/3/24 - An admission MDS assessment documented R1 as cognitively intact with no behaviors. During an interview on 5/17/24 at 9:33 AM, FM1 stated, "On April 26th two CNA's went in [R1's] room and said his "vibe was off" and the woman told him "we are not having any of that now." She went to change him but needed supplies and left the room. The other CNA was sitting in the chair began standing, chanting and naming "Jesus Christ" and "The blood of Jesus." [R1] was very upset and when he asked who was the supervisor she said she "didn't know. I called the nursing home. I got the names of these two staff members, E8 (CNA) and E9 (CNA), from the night supervisor and he said he had already put the names in the system as a complaint. We never heard anything again." During an interview on 5/17/24 12:18 PM, E11 (AD) provided a copy of the grievance policy and stated, "If a resident has concerns, any nurse should grab a form (and) fill it out. If it's abuse, etc., walk it to the DON. If it's simple, fill out the whole form and then hand it to correct department head." During an interview on 5/20/24 at 10:01 AM, E9 (CNA) confirmed working with R1 on 4/26/24. "R1 would not allow me to change him. I went and got the supervisor [E10 (RN)] and they told me not to	F 565	within the last 30 days the grievance process was initiated. Root cause analysis was completed by center leadership and determined the staff did not escalate a concern/grievance because they did not hear it directly from the resident. Current staff have the need for re-education on policy OPS204(see attachment #1) grievances/concerns with an intense focus on once the grievance is received despite who provided them with the grievance they need to initiate the grievance process . NPE/designee will complete the education with the current staff by 6/25/2024 any newly hired staff will receive the education prior to the start of their first shift worked The Director of Nursing/designee will interview 10% of the resident population with a BIMS of 12-15 to identify any concerns that have not been addressed to ensure the grievance process was initiated. Audits will occur weekly x 4 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of the audits will be presented to the monthly QAPI meeting for review	

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F 565	Continued From page 4 go back into the room. E9 denied engaging in any spiritual practices in front of R1. During an interview on 5/20/24 at 10:37 AM, E8 (CNA) confirmed that R1 complained about the care she provided on 4/26/24 to [E10 (RN)]. E8 stated she was unaware why R1 refused to receive care from her and stated that when [E9 (CNA)] left the room, R1 asked asked me who was my supervisor and I said I didn't know because it was my first time at the facility. When E9 came back I told her and she got him the supervisors." E8 denied engaging in any spiritual practices in front of R1. During an interview on 5/21/24 at 9:15 AM, E5 (NP) stated, "(R1) complained to me that two CNA's were dancing and praising the Lord during care, I told [E6 (RN)] about it." E6 then immediately confirmed she did not elevate the concern or file a grievance because she "did not receive the concern from [R1] directly". During an interview on 5/21/24 at 9:23 AM, E10 (RN) confirmed that R1 complained about the conduct of E8 (CNA) and E9 (CNA) on 4/26/24. E10 stated, "[R1] did not like the carrying on and being unprofessional." When asked whether a grievance was filed, E10 stated, "I had them write statements and put it under one of the office doors." During an interview on 5/21/24 at 9:36 AM, E2 (DON) confirmed that a grievance or concern form on behalf of R1 related to the complaints expressed to E10 (RN) and E5 (NP) regarding the conduct of E8 (CNA) and E9 (CNA) during care was not intiated.	F 565		

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F 565	Continued From page 5 Findings were reviewed during the exit conference on 5/22/24 at 2:00 PM with E1 (NHA), E2 (DON).	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R1) out of three residents reviewed for pressure ulcers the facility failed to accurately completed the admission MDS assessment. Findings include: Cross refer F686: Review of R1's clinical record revealed: 3/27/24 - R1 was admitted to the facility. 3/27/24 3:21 PM - An admission note written by E4 (interim ADON) documented, "...Other skin issue. Location: Left heel. Other skin issue description: Dry scaly; covered with pad...Other skin issue. Location: Right heel. Other skin issue description: Dry scaly; covered with pad. Pressure reducing device to bed." 4/3/24 An admission MDS assessment documented, that R1 was at risk for pressure ulcer development but had no unhealed pressure ulcers. 4/10/24 - A wound evaluation documented R1 as having an unstageable pressure ulcer to the right	F 641	R#1 the admission MDS dated 4/3/2024 was modified on 6/7/2024 by the facility CRC manager to reflect the accurate information related to the heel wound Residents newly admitted to the Milford Center have the potential to be affected by the deficient practice. Regional MDS coordinator/designee will audit all the admissions from the last 30 days to ensure the admission MDS assessments are coded accurately to reflect any pressure wounds existing on admission Root cause analysis was completed and determined the MDS coordinator did not thoroughly review the hospital documents on admission to accurately code an existing pressure wound on the admission MDS. The MDS coordinator will require re-education on thoroughly reviewing the admission hospital paperwork received on admission (see attachment #2). Regional MDS coordinator will complete that education by 6/25/2024 any newly hired MDS staff will receive the education prior to the start of their first worked shift	6/25/24

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F 641	Continued From page 6 heel that was present on admission. During an interview on 5/22/24 at 1:50 PM E7 (RN) confirmed the findings, and stated, "He came in with pressure ulcers but I didn't know that. I knew he came in with something on his heel." Findings were reviewed during the exit conference on 5/22/24 at 2:00 PM with E1 (NHA), E2 (DON).	F 641	Regional MDS coordinator/designee will audit all newly admitted MDS admission assessments to ensure pressure wounds existing on admission are accurately coded on the admission MDS assessment audits will occur weekly x 4 weeks or until 100% compliance is achieved. Results of the audits will be presented to the monthly QAPI meeting for review	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform	F 660		6/25/24

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F 660	Continued From page 7 required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based	F 660		

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F 660	Continued From page 8 on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other related documentation, it was determined that for one (R1) out of three residents reviewed for discharge, the facility failed to implement a discharge planning process that included education/training on mechanical lift transfers and pressure ulcer care to R1's caregiver because R1 was unable to perform these task independently. Findings include: The facility policy on discharge and transfer last updated, 11/15/22 indicated, "The registered nurse is ultimately responsible to ensure that there is a safe and coordinated discharge and transfer plan in place for the patient...The inter-professional care team will provide sufficient preparation and orientation to the patient prior to transfer or discharge." 1. Review of R1's clinical record revealed: 3/27/24 - R1 was admitted to the facility. 3/29/24 3:16 PM - The post Admission Pt/Family conference to review the baseline care plans documented, "Patient's stay is expected to be short term. Expectations and goals of care related to transitioning back to the community	F 660	R#1 was discharged on 5/11/2024 and readmitted back to the hospital on 5/14/2024. The center did confirm home health services were in place at the time of the discharge to home from the Milford Center on 5/11/2024. Unable to correct the deficient practice. Current and Future residents discharging from the facility have the potential to be affected by the deficient practice. DON/designee will audit all discharges from the last 30 days to ensure the facility implemented a discharge planning process that included education/training on identified areas. Residents/caregivers identified as not receiving the education/training the unit manager will reach out to the resident/caregiver and follow up related to any identified education/training needs post discharge. The center will identify the need for education at the post admission care conference by the interdisciplinary team who attends the conference. A Root Cause Analysis was performed and determined the interdisciplinary team	

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F 660	Continued From page 9 discussed. Home Health Services are being recommended." Educational needs documented included disease management, equipment, and medications. Wound care was not identified on the form as an educational need. A care plan for discharge was not created. 4/3/24 - An admission MDS assessment documented R1 as cognitively intact. R1 was always incontinent of both bowel and bladder and dependent for toileting. R1 had an impairment on one side of the upper extremity and required moderate assistance with upper body dressing and dependent for lower body dressing, including putting on footwear. R1's functional abilities were assessed as requiring substantial maximum assistance to roll from right to left in the bed. R1's goal for discharge was to discharge to the community. The MDS assessment incorrectly identified that R1 had no pressure ulcer present on admission. 4/23/24 10:33 PM - A wound care note in R1's clinical record written by E5 (NP) documented, "(R1) is being seen today as a new pt (patient) to me as well as for wound rounds. He is alert, verbal and in no acute distress. R heel with an unstageable PU...Sacrum with an unstageable PU...Educated patient on wound assessment and of plan to continue current treatment..." 4/28/24 11:27 - A progress note written by E6 (RN) in R1's clinical record documented, "Teaching done as to importance of continued use of offloading boots. [R1] voices understanding. Call placed to responsible party/wife [FM1] to discuss possibility of Debridement to Right heel."	F 660	was not identifying the needs for education and training during their post admission family care conference and scheduling that training prior to discharge. The current interdisciplinary team needs re-education on OPS406 Discharge Planning Process (see attachment #3) with a focus on ensuring a safe discharge related to implementation of identified education/ training needs and scheduling that education prior to discharge. The Administrator/designee will complete the education by 6/25/2024 and any newly hired interdisciplinary staff will be provided with the education prior to start of their first shift worked DON/designee will audit all newly admitted residents post admission Pt/family conference documentation to ensure that education/training needs are identified and documented as well as those residents who discharged to ensure the identified education/training needs were provided prior to discharge from the facility. Audits will occur daily x 3 days or until 100% compliance is achieved, three times weekly or until 100% compliance is achieved, then monthly x 2 months or until 100% compliance is achieved. Results of the audits will be presented to the monthly QAPI meeting for review	

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F 660	Continued From page 10 5/2/24 2:48 PM - A Social Service note written by E12 (SW) in R1's clinical record documented, "Met with resident and spouse at bedside to inform and discuss discharge plan." The note did not document that teaching regarding wound care and use of mechanical lift was discussed. with FM1. 5/3/24 2:31 PM - A progress note in R1's clinical record documented, "[R1] and his wife [FM1], at time of meeting held at bedside with Social Services, therapist, this nurse and previous DON, voiced concerns." The note did not document that teaching regarding wound care, incontinence care and use of mechanical lift were discussed with FM1. 5/10/24 8:22 AM - The discharge plan written by E14 (RN) documented R1 would be discharged home on 5/11/24 and that home care services would start on 5/13/24. 5/10/24 9:31 AM - An OT discharge summary documented R1 was dependent for toileting, transfers, and lower body dressing including taking on and off footwear. The summary lacked evidence that R1's care give received training/education for the areas that R1 was dependent. 5/10/24 9:35 AM - A PT discharge summary documented the following discharge recommendations: hospital bed with air mattress, mechanical lift, manual wheel chair, rolling walker and home health physical therapy. 5/10/24 - A discharge summary written by E13 (NP) documented, "Skin - multiple wounds right heel sacrum. I spent 35 minutes on patients	F 660		

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F 660	Continued From page 11 discharge today, all scripts written for patient and all questions and concerns addressed." FM1 was not present in the facility. 5/11/24 11:15 - A note in R1's clinical record written by E14 (RN) documented, "Patient discharged to home with transportation. [FM1] called and told her if she had any questions to please call facility. All medications and discharge orders went over with [R1]. Patient had no questions. Patient stable at discharge. Typed up a separate sheet of paper with all wound orders, went over with patient, stated understanding, sent home with wound supplies. Had no questions. Educated on wound care, turning and repositioning, patient stated understanding. Pt left facility on stretcher at 1:15 PM." During an interview on 5/16/24 at 3:41 PM, E14 (RN) confirmed providing discharge teaching on medications and dressing changes to R1 at time of discharge and that R1's caregiver, FM1, was not in attendance. E14 also stated, that R1's "Daughter was here with him towards the end. But not for the teaching. I printed out a list separate because he had such extensive wounds and I gave them to him." E14 confirmed mechanical lift transfer was not reviewed. During an interview on 5/17/24 at 9:33 AM, FM1 stated, "I was not involved with any education regarding his care. So basically he came home with a Hoyer lift, wheel chair and a hospital bed, I wasn't given any instruction on how to use it to get him up. I wouldn't know how to do that or change him, anything. He had no supplies for his wounds, which were ten times worse. No one instructed me on anything."	F 660		

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F 660	Continued From page 12 During an interview on 5/17/24 at 12:54 PM, E6 (RN) stated, "I made numerous telephone calls to set up a time date to come in and teach her. She would make appointments and she would not show up." E6 was unable to provide evidence of attempts to complete teaching regarding R1's pressure ulcer care to R1's caregiver, FM1. Findings were reviewed during the exit conference on 5/22/24 at 2:00 PM with E1 (NHA), E2 (DON).	F 660		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R1, R3 and R5) out of three sampled residents reviewed for pressure ulcer (PU), the facility failed to ensure monitoring for the development of new pressure ulcers and monitoring of existing pressure ulcers was completed. Findings include:	F 686	R#1 Skin check was completed on 4/24/2024. R#3 skin assessment was completed on 5/24/24. R#5, skin assessment was completed on 5/24/24. Current residents have the potential to be affected by the deficient practice. A facility wide skin head to toes skin	6/25/24

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F 686	Continued From page 13 The facility policy on skin and integrity and wound management last updated 5/1/24 directed staff to "Complete comprehensive evaluation of patient upon admission/readmission. Complete risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition. Perform and document skin inspection on all newly admitted/readmitted patients, weekly thereafter and with any significant change in condition. Complete wound evaluation upon admission/readmission, new in-house acquired, weekly and with unanticipated decline in wounds." 1. Review of R1's clinical record revealed: 3/27/24 - R1 was admitted to the facility. 3/27/24 3:21 PM - An admission note written by E4 (interim ADON) documented, "...Other skin issue. Location: Left heel. Other skin issue description: Dry scaly; covered with pad...Other skin issue. Location: Right heel. Other skin issue description: Dry scaly; covered with pad. Pressure reducing device to bed." 3/27/24 - A Braden Scale assessment for predicting pressure ulcer risk was completed for R1 and documented the resident as a "17", at risk for pressure ulcer development. 3/27/24 - Care plans were created for R1's wound management, and pressure ulcers to both heels. Interventions included wound care as ordered, and monitoring of ulcers for size, signs of infection and characteristics. 3/28/24 2:55 PM - A progress note documented R1's bilateral heels were "dry scaly covered with	F 686	assessment was conducted on current residents between 5/23/24 and 5/24/24. Any newly noted skin areas were assessed, provided treatment and continued to be monitored weekly to promote healing Root Cause analysis was completed and determined weekly wound assessments and weekly skin assessments are not consistently being completed per the designated schedule. Nursing leadership will implement a designated day to conduct wound rounds which will include RN unit managers, LPN unit managers, RN wound nurse, and wound NP as available to conduct the rounds to ensure the documentation and assessments are completed. It has also been determined current license nurses need re-education on NSG236 Skin Integrity and Wound Management (see attachment #4) with a focus on performing thorough skin inspections on all newly admitted/readmitted patients and weekly thereafter. NPE will complete education with current licensed nursing staff by 6/25/2024 and any newly hired licensed nurse will receive the education prior to the first shift worked DON/Designee will audit 10% of current residents with pressure ulcers and all newly admitted residents to ensure the facility is monitoring for the development of new pressure ulcers and existing pressure ulcers by auditing weekly skin and wound evaluations and skin assessments and to ensure completion	

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F 686	Continued From page 14 pad." 3/29/24 - A care plan was created for R1's risk for skin breakdown. Interventions included a weekly skin check by licensed nurse. 4/1/24 2:01 PM - A skilled evaluation in R1's clinical record documented the condition of R1's bilateral heels with the exception of measurements and staging. R1's clinical record lacked evidence of a wound assessment/evaluation for characteristics of the wound from 3/27/24 through 4/1/24 prior to this note. This note lacked evidence of staging and measurement of the wound. 4/3/24 - An admission MDS assessment documented R1 as cognitively intact. R1 was always incontinent of both bowel and bladder and dependent for toileting. R1's had an impairment on one side of the upper extremity and his functional abilities were assessed as requiring substantial maximum assistance to roll from right to left in the bed. The MDS assessment incorrrectly documented there were no pressure ulcers. A of risk PU was assessed, and pressure ulcer reducing devices initiated for the bed and chair, and applications of ointments other than to feet. 4/5/24 - A Braden Scale assessment for predicting pressure ulcer risk was completed for R1 and documented the resident as a "18", at risk for pressure ulcer development. 4/10/24 - Wound evaluations that documented characteristics of the wounds, staging, and measurments were completed for R1 and documented pressure ulcer wounds present on	F 686	and identification of new wounds . Audits will occur weekly x 3 weeks or until 100% compliance is achieved, then monthly x 2 months or until 100% compliance is achieved. Results of the audits will be presented to the monthly QAPI meeting for review.	

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F 686	Continued From page 15	F 686		

admission to the resident's right ankle, right heel, and a new facility acquired pressure ulcer to the resident's sacrum. The clinical record lacked evidence of complete wound evaluations prior to this date.

4/12/24 - A Braden Scale assessment for predicting pressure ulcer risk was completed for R1 and documented the resident as a "14", at moderate risk for pressure ulcer development.

4/30/24 - A care plan was created for R1 related to being resistive to care and refusal to turn and reposition.

During an interview on 5/17/24 at 9:33 AM, FM1 stated, "He had a wound on his foot when he came in that was three times worse than it was when he came home. I believe it [dressing] wasn't changed and they can't have looked at it. It worsened and he developed bed sores on his butt."

During an interview on 5/17/24 at 12:54 PM, E6 (RN) confirmed that R1 was admitted with a pressure ulcer to the heel. E6 stated, "He did come with the wounds. It was documented that he would refuse care and teaching was done with that. He was very noncompliant with his care. I started here on the 26th I think, I can't speak on prior but once I got here I contacted the nurse practitioner to come in."

During an interview on 5/21/24 at 1:48 PM, E4 (interim ADON) confirmed that she was R1's admitting nurse and that the dressings to the residents bilateral heels were not removed on admission to allow visualization of the resident's wounds. E4 provided the surveyor with the skilled

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F 686	Continued From page 16 assessments for R1 and confirmed that from the admission note on 3/27/24 until the skilled note 4/1/24 the record lacked evidence that R1's heel wound was visualized under the dressings. 2. Review of R3's clinical record revealed: November 2023 - Review of R3's weekly skin checks and the assessments to identify new wounds lacked evidence of weekly completion with one skin check completed on 11/23/23. There were no documented refusals for skin checks from R3 during that timeframe. 11/24/23 - R3's care plan for at risk for skin breakdown was reviewed/updated. Interventions for the care plan included weekly wound assessment to include measurements and description of wound, along with a weekly skin check by a licensed nurse. 11/27/23 - A quarterly MDS assessment documented R3 as having no cognitive impairment. R3 was also assessed as occasionally incontinent of bladder and at risk for pressure ulcers with no unhealed pressure ulcers. Pressure reducing devices, nutritional supplements and ointments were to be used for pressure ulcer prevention. 12/28/23 1:56 PM - A change of condition note in R3's clinical record documented, "Skin wound or ulcer nursing observations, evaluation, and recommendations are: This nurse was doing wound care and the resident brought to my attention that her spine was hurting and she alerted another nurse a week ago. DON notified. Wound treatment placed...Resident already has pressure relieving mattress. Orders will be	F 686		

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F 686	Continued From page 17 entered for new wound. Resident asked if she would agree to a consult she refused at this time." 12/28/23 - A wound evaluation containing details regarding size, stage, and characteristics of the wound was completed for R3's mid-back pressure ulcer. Review of R3's weekly skin checks, the assessments to identify new wounds, lacked evidence of consistent weekly completion with no documented refusals from R3 on the following dates: December 2023, there were no skin checks documented. January 2024 - one skin check documented as completed on 1/9/24. February 2024 - one skin check documented as completed on 2/29/24. March 2024 - no skin checks documented. A refusal for a skin check was documented on 3/30/24 in the progress notes. April 2024 - one skin check documented as completed on 4/24/22. A refusal for a skin check was documented on 4/22/24 in the progress notes. 1/1/24 8:00 PM - A progress note in R3's clinical record documented, "Late Entry: Resident is refusing to go for a consult regarding wound/abscess on her back. Antibiotics ordered. Resident lays all day on her back in a sitting/lying position. Sleeps on her side at night. Provider is aware." 1/24/24 - Braden Scale assessment for predicting pressure ulcer risk was completed for R3 and documented the resident as a "17" at risk	F 686		

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F 686	Continued From page 18 for pressure ulcer development. The most recent Braden scale assessment completed for R3 prior was 12/12/22. 2/29/24 2:01 PM - A progress note in R3's clinical record documented that R3 refused to allow staff to evaluate pressure ulcer wounds. Review of R3's wound evaluations for the pressure ulcer to her mid-back lacked evidence of weekly wound evaluations documenting staging, size and characteristics of the wound during from the evaluation dated 3/8/24 with the next wound evaluation dated 3/28/24, 4/4/24 then 5/10/24. There was no change in stage of the wounds between the assessments. During an interview on 5/20/24 at 12:51 PM, R3 confirmed the presence of pressure ulcers and stated, "I'm thin and was prone to them before I got here. I don't like to turn, I can't see my phone that well in certain positions but I let them turn me at night." When asked if staff complete weekly skin checks or evaluations of her wounds, R3 stated, They just ask and I tell them if I have something." During an interview on 5/20/24 at 1:11 PM, E6 (RN) and interim wound care nurse at the facility confirmed the absence of consistent wound checks and wound evaluations. E6 stated, "I got here [hired] around the 26th of last month and I have been trying to get everyone caught up and up to date. I do know she often refuses." During an interview on 5/20/24 at 1:53 PM, E7 (RN) and unit manager on R3's unit was asked how involved is she in ensuring that weekly skin checks and wound evaluation are completed for	F 686		

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F 686	Continued From page 19	F 686		

residents. E7 responded, "I'm very involved. I didn't realize they weren't complete, they should probably be marked as refusals."

During an interview on 5/21/24 at 12:10 PM E4 (Interim ADON) stated, "She refuses treatments. If she refuses that, then staff assumes she is refusing everything wound-related." When asked if an evaluation or skin check is not specifically documented, how would staff know to approach resident, E4 stated, "I see what your saying."

3. Review of R5's clinical record revealed:

12/19/23 - R5 was admitted to the facility with multiple diagnoses including quadriplegia and a pressure ulcers to the left shin, right middle knee, left shoulder, and buttocks.

12/19/23 - Wound evaluations of the aforementioned wounds, containing details regarding size, stage, and characteristics of the wounds present on admission were completed for R5.

12/20/23 - A care plan was created for R5 related to skin breakdown. Care plan interventions included weekly skin check by licensed nurse, turn and reposition every two hours, preventative skin care, off/load float heels, pressure redistribution devices to mattress and chair.

12/26/23 - An admission MDS documented R5 was at risk for pressure ulcers and had unhealed pressure ulcers, two Stage 2 (PU) and two Stage 4 (PU). Pressure redistribution devices were implemented. R5 was also assessed as dependent for rolling, and always incontinent of bowel.

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F 686	Continued From page 20 12/27/23 - Wound evaluations for R5's pressure ulcers to the left shin, right middle knee documented the areas as resolved. 1/18/24 - E3 (LPN) documented in a progress note, "Skin status evaluation: pressure ulcer/injury open area reported by CNA to this writer-open area located right outer, near the posterior knee. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback A. Recommendations: cleanse area wound cleaner, bacitracin and dressing. Review of R5's clinical record lacked evidence of a wound assesment that documented size or characteristics of this wound. 1/28/24 - A change of condition note documented that R5 had a new Stage II pressure ulcer to the right outer side of the knee. 1/28/24 - A wound evaluation was completed for R5 that documented, "New, in-house acquired pressure ulcer." 1/29/24 - R5's care plan for skin breakdown was updated to include a new skin breakdown to the right outer knee. Review of R5's wound evaluations for the pressure ulcers to the right knee, left shoulder and buttocks lacked evidence of weekly wound evaluations documenting staging, size and characteristics of the wound between the following dates: 3/14/24 wound evaluation completed, next evaluation completed 4/9/24. The three pressure areas did not worsen as evidenced by same staging and similar size.	F 686		

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F 686	Continued From page 21 March 2024 - Review of R5's weekly skin check assessments lacked evidence of completion of assessments to identify new wounds with the exception of one weekly skin check completed on 3/15/24. 3/25/24 - A care plan was intiated for R5 regarding resistant to care related to difficulty adjusting to facility. 4/15/24 - A Braden Scale assessment for predicting pressure ulcer risk was completed for R5 and documented the resident as a "12", high risk for pressure ulcer development. 5/1/24, 5/10/24, and 5/13/24 - The facility conducted employee training regarding skin check frequency and accuracy. During an interview on 5/21/24 at 1:03 PM, E4 (Interim ADON) confirmed the findings. E4 stated, "We identified it and are doing education". Findings were reviewed during the exit conference on 5/22/24 at 2:00 PM with E1 (NHA), E2 (DON).	F 686		