DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 25, 2026

Administrator
Good Samaritan Society - Windom
705 SIXTH STREET
WINDOM, MN 56101

Re: Reinspection Results
Event ID: 1DFF5E-H2

Dear Administrator:

On March 17, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 25, 2026

Administrator
Good Samaritan Society - Windom
705 SIXTH STREET
WINDOM, MN 56101

RE: CCN: 245558
Cycle Start Date: January 27, 2026

Dear Administrator:

On February 11, 2026, we notified you a remedy was imposed. On March 19, 2026 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 18, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective February 26, 2026 be discontinued as of March 18, 2026. (42 CFR 488.417 (b))

In our letter of February 11, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 27, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Rzke-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

February 11, 2026

Administrator
Good Samaritan Society - Windom
705 SIXTH STREET
WINDOM, MN 56101

RE: CCN: 677840200
Cycle Start Date: January 27, 2026

Dear Administrator:

On January 27, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 27, 2026, the situation of immediate jeopardy to potential health and safety cited at F686 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 26, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 26, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 26, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 27, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Windom is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 27, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office

3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 27, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 11, 2026

Administrator
Good Samaritan Society - Windom
705 SIXTH STREET
WINDOM, MN 56101

Re: State Nursing Home Licensing Orders
Event ID: 1DFF5E-H1

Dear Administrator:

The above facility survey was completed on January 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 1/16/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/26/26, and 1/27/26, an abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F686 when R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relief interventions to prevent further deterioration. The IJ began on 12/31/25, and the immediacy was removed on 1/27/26. The above findings constituted substandard quality of care, and an extended survey was conducted on 1/23/26. The following complaints were reviewed: H55583526C (2717316), H55582343C (2701954), and H55583526C (2715989) with deficiencies issued at: F550, F580, F657, F686, F791, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		02/25/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access	F0550	F550- Dignity What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	02/25/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0550 SS = D	Continued from page 1 to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide dignity 2 of 3 residents (R5, R6) who were reviewed for dignity. Findings include: R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, and dementia. R5's quarterly MDS dated 10/30/25, identified R5 had moderate cognitive impairment, no behaviors, used a walker and wheelchair; needed moderate assistance with	F0550	Continued from page 1 Facility /immediately /place R5's catheter in a dignity bag and secured in a clean manner. /Facility leadership staff ensured R6's care was provided with dignity and privacy. / How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents /with foley catheters and those that /require /staff /assistance /with /cares /have the potential to be affected by deficient practice. DNS or designee /identified /all residents with catheters, ensured each resident has a /dignity /bag /intact. / What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, all nursing staff will be reeducated, by DNS or designee, /to /ensure all residents with catheters have a dignity cover in /place and /providing privacy and dignity with personal /cares. / How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To /monitor /performance and ensure ongoing compliance, DNS or designee will complete weekly observations of 10% of residents /with catheters to ensure dignity covers /are in place /and secured in a clean manner. /DNS or designee will complete weekly observations of 10% of residents who require /assistance /with cares to ensure privacy and dignity is provided during cares. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0550 SS = D	Continued from page 2 dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations. R5's care plan dated 10/27/25, identified self-care deficits. Interventions included R5 could not walk, used mechanical lift for transfers, and required 1-2 staff to assist with toileting needs. R5's progress note dated 1/2/26, identified hospice nurse visited and placed a urinary catheter. During an observation and interview on 1/20/26 at 8:23 a.m., R5 was in his recliner chair. R5's urinary catheter collection bag was hanging on a garbage can next to recliner without a dignity cover. Registered nurse (RN)-A was in room and stated urinecollection bags need to be covered, facility uses dignity bags. "I don't like that it is on a trash can either". RN-A provided education to nursing assistant (NA)-A that urine collection bags cannot hang from garbage cans and a dignity bag must be provided to R5. During an observation and interview on 1/22/26 at 9:00 a.m., R5 was lying in bed. catheter bag was on floor in wash basin with no dignity cover. Licensed practical nurse (LPN)-B stated R5 was supposed to have a cover on his catheter bag. LPN-B went to R5's closet, pulled out a dignity bag, applied to R5's urine collection bag. During an interview on 1/20/26 at 1:18 p.m., NA-A stated urine collection bags should be covered for dignity, same thing for hanging them on trash cans, if someone would walk by they could see the urine in the bag. During an interview on 1/20/26 at 10:44 a.m., clinical care lead registered nurse (CCLRN)-A stated urine collection bags should be covered for dignity and should not hang off garbage cans, there is a pocket on the other side of the recliner where it could have gone. R6 R6's face sheet dated 1/20/26, identified diagnoses of anxiety disorder. R6's care plan dated 1/12/26, identified self-care deficits that required two staff for bed mobility. During an observation on 1/20/26 at 8:05 a.m., NA-B exited R6's without shutting the door and the privacy curtain drawn leaving R6 sitting on the edge of the bed with a brief on, secured around waist, and her pants	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

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F0550 SS = D	Continued from page 3 pulled down to her knees while NA-C and NA-G provided support to keep R6 in the seated position. R6 was yelling “help!” During an interview on 1/20/26 at 10:34 a.m., NA-C and NA-G stated R6’s door should have been shut when she was sitting on the edge of her bed in a brief and pants at her knees. During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the door to be shut during cares. Sometimes, the door does not shut unless slammed and was unsure if the NA’s would have been able to get the curtain shut when performing cares on R6. DON expected covers on catheter bags. The facility purchased “a bunch” recently. DON was not sure if staff thought they were disposable, but they should not be thrown out unless ripped. The facility policy Resident Dignity revised 12/18/25, identified the IDT will assist all staff members in maintaining the dignity of every resident.	F0550		
F0580 SS = D	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); (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	F0580	F580- Notification of Changes What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Physician /and resident representative were /notified /of /R1s skin condition /and new treatments /by /DNS or designee. / How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with changes in skin condition and treatments have the potential to be affected by deficient practice. /The facility /identified /residents at risk /for /skin conditions, /as well as /those /with existing issues or /changes. /Physicians and resident representatives /were notified /of any new skin findings or treatment updates /by DNS or designee. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?	02/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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F0580 SS = D	Continued from page 4 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 interview and record review the facility failed to notify the physician and resident representative regarding changes to skin integrity and treatment orders for 1 of 3 residents (R1) reviewed for change in condition. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body). R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open	F0580	Continued from page 4 To ensure deficient practice will not recur, all nursing staff /will be /reeducated /regarding proper /physician and responsible party /notification /of /changes in /resident skin integrity and treatment changes. /Education was provided by /DNS or /Designee. / How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee will audit 10% of resident population who are at risk of change in condition to skin and potential changes in treatments /to ensure proper notifications /to MD and responsible parties. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

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F0580 SS = D	Continued from page 5 and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum and not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included: • R1's Wound Data Collection dated 12/12/25, identified coccyx. Dressing present and intact. No drainage on the dressing. • R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of shearing injury. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or "wet wipes." Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin	F0580		

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F0580 SS = D	Continued from page 6 prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A [emergency contact] stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. During an interview on 1/22/26 at 12:14 p.m. director of nursing (DON) stated the facility received a call from the clinic that FM-A was upset about R1's wound and that she had not been notified of the wounds. FM-A had found out about the wounds from R1's girlfriend. Facility records did not have FM-A listed as emergency contact. Nurses should notify physician with any changes of resident condition. The facility Notification of Change policy revise 12/12/25, identified the facility must immediately inform the resident, consult with physician and notify resident representative a need to alter treatment significantly-a need to discontinue or change an existing form of treatment or to commence a new form of treatment.	F0580		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F0657	F657- Care Plan Timing and Revision What corrective action will be accomplished for those residents found to have been affected by the deficient	02/25/2026

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F0657 SS = E	Continued from page 7 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to update the care plan for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum	F0657	Continued from page 7 practice? DNS or Designee updated R1's care plan to reflect current skin conditions including pressure ulcers and pressure ulceration interventions. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with pressure injuries or skin conditions have a potential to be affected by this deficient practice. Facility identified residents with pressure injuries or skin conditions and reviewed their care plans to ensure proper revisions are in place for identified residents. The audit and corrections were completed by DNS or designee. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, all licensed nurses received training on properly updating resident care plans to reflect current skin issues and interventions by Regional Clinical Services Director or designee. Facility initiated a new process of clinical oversight morning meetings occurring 7 days per week, where nursing leadership will ensure any skin condition changes are updated on resident care plans reflecting the current status of resident's condition. Nursing leadership was educated by Regional Clinical Services Director regarding the clinical oversight process. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee will audit 10% of residents with pressure ulcers or skin conditions, ensuring care plans reflect current status of resident condition. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations.	

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F0657 SS = E	Continued from page 8 assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed "…staging to be completed by an RN [registered nurse]….Important Note: "include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.", there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to avoid positioning on oxygen and indwelling urinary catheter tubing; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25. (however, updated on TAR 8/11/25). R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. R1 had new concerns of an ulceration to the urinary meatus	F0657	Continued from page 8 What is the date of completion? 2/25/2026	

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F0657 SS = E	Continued from page 9 (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage. R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the care plan to be followed and RN nurse leaders to update the care plan quarterly and with changes.	F0657		
F0686 SS = SQC-K	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.	F0686	F686- Treatment to Prevent/Heal Pressure Injuries What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents R1, /R2, R3, and R5 received comprehensive skin reassessments, and the physician was notified of any newly identified changes in condition. /New interventions were /initiated /and care plans were updated accordingly. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents at risk for skin integrity concerns have the potential to be affected by this deficient practice. /All /residents with a Braden Score of 18 or	02/25/2026

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F0686 SS = SQC-K	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to identify, comprehensively assess, monitor, and develop interventions to prevent/mitigate the risk of pressure ulcer development and/or deterioration for 4 of 4 residents (R1, R2, R3, R5). The facility's failure resulted in Immediate Jeopardy (IJ) for R1 when the facility failed to prevent and manage impaired skin integrity that progressed to bone and soft tissue infections which required hospitalization for treatment and management. The IJ began on 12/31/25 after R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relieving interventions to prevent further deterioration. The Administrator, director of nursing (DON), regional clinical services director, senior director, and clinical care lead registered nurse (CCLRN)-B were notified of the IJ on 1/22/26 at 1:34 p.m. The IJ was removed on 1/27/26 at 1:58 p.m., but non-compliance remained at the lower scope and severity level E, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. R1 R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet.	F0686	Continued from page 10 below received /a full skin assessment completed by /the /DNS /or /designee /. /Any changes in condition /were /promptly communicated to the physician, interventions and care plans /were /updated as needed. / What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure this deficient practice does not recur, the facility provided /education /to all licensed nursing staff on /policies and procedures related to Pressure ulcers; including comprehensive skin /inspections, daily and weekly observation and assessments, notification to family and providers, /dressing change techniques /including return demonstration, infection control during wound care, and other best /practice /expectations. Unlicensed nursing staff were provided education on /Monitoring skin and reporting changes /that they /observe /to a nurse. They were also provided with education on the importance of following /care planned interventions for skin integrity and /to find /the /care planned intervention on the Kardex. The facility /will /follow /policy /and procedure related to /wound /management. The system includes nursing leadership oversight of wound prevention, skin observations, /wound assessment /physician communication and care plan review, /with adjustments /to care plans /as needed. Wound progression will be /monitored /using a tracking tool /and /will be /utilized /and overseen by nursing leadership. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To /monitor /performance and ensure ongoing compliance, /the /DNS or /designee, /will audit completed skin observations by visualizing resident skin and reviewing documentation weekly, /for 10% of population weekly x4 /and /monthly x2. To /ensure competency of frontline /nursing staff /regarding /the /process /for wound management and wound care knowledge, (This includes routine monitoring, proper wound identification, physician notifications with /interventions /and care plan updates as needed.) the /DNS or designee will complete random	

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F0686 SS = SQC-K	Continued from page 11 R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed "…staging to be completed by an RN [registered nurse]….Important Note: "include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.", there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's Skin Observation dated 7/31/25, identified R1 had a bath and skin check was completed. The evaluation had no mention of the right heel wound as identified on 7/24/25. In review of R1's record between 7/24/25 through 8/3/25, the care plan was not revised to identify the heel wound and not revised until 8/4/25 with new pressure relieving interventions to prevent deterioration and new wound development. R1's progress note dated 8/1/25, identified R1 was transferred to the hospital. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to position oxygen and indwelling urinary catheter tubing appropriately; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's progress note dated 8/11/25, identified R1 returned from hospital. R1's Nursing Admit/Re-admit Data Collection dated 8/11/25, had the same instructions for documenting the wound as previous assessment dated 7/24/25. The assessment identified R1 had right heel wound with a description of dried blood area size of nickel, and sacrum slightly red. These areas were not measured, staged, or the surrounding skin condition identified. Despite the identification of new impaired skin	F0686	Continued from page 11 wound dressing change audits for 10% of population /of residents with wounds, /weekly x4 and monthly x2, /to /ensure proper wound dressing changes are /performed /with proper infection prevention protocols /being /followed. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

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F0686 SS = SQC-K	Continued from page 12 integrity on R1's sacrum and the existing heel wound, there was no indication R1's care plan was revised with new pressure relieving/prevention interventions to address R1's sacral redness. R1's Treatment Administration Record (TAR) dated 8/11/25, identified for the nurse to acknowledge every shift: heel lift boots while in bed for heel protection and pressure reduction. Assess bony prominences, turn and reposition every 2 hours, protect skin and keep clean and dry, moisture barrier for incontinence, use lift pad. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. There is a 1.5-centimeter (cm) x 1.5 cm eschar (dry, dark scab) wound that was present on readmission. Surrounding skin is slightly pink. Mepilex applied to wound and off-loading boots to both feet. Referral made to local wound center. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25 (however updated on TAR 8/11/25). R1's Wound Clinic Visit Report dated 8/19/25, identified the wound on R1's right heel as stage 3 pressure ulcer. Wound measured 1.0 cm x 1.2 cm x 0.2 cm depth. No tunneling or undermining (pocket or shelf beneath skin) noted. Small amount of serosanguineous drainage noted. Wound margin is distinct with the outline attached to wound base. No granulation (new tissue growth) within the wound bed. A large amount (67-100%) of necrotic tissue within the wound bed including eschar and adherent slough. No probe to bone. The wound was debrided (removal of dead, infected, or damaged tissue) of eschar tissue and was not tolerated well. New wound measurements were 1.0 cm x 1.2 cm x 0.3 cm depth. Treatment included cleanse with normal saline, apply Iodosorb ointment to wound bed, avoid getting on surrounding skin. Cover with gauze sponge and tape. Prevalon boot at ALL times. Other non-wound condition instructions included buttocks looks okay, no need for Mepilex unless there is a concern, than may apply. In review of R1's record, despite the direction for R1 to have Prevalon boot (brand of off-loading boot) there was no indication the care plan was revised until 10/30/25 (however was on the TAR 8/11/26). Review of R1's wound clinic notes in conjunction with RN Wound Assessments and Skin Observations between 8/20/25 through 9/3/25, did not identify any impaired skin integrity to R1's buttocks/sacral/coccyx regions and or perineal areas.	F0686		

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F0686 SS = SQC-K	Continued from page 13 R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. Faxed physician regarding new pressure sore found on R1's right buttock. R1's record did not include a comprehensive assessment of R1's pressure ulcer to right buttock. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. Measured 0.8 cm x 0.4 cm x 0.2 cm depth. New orders for Santyl ointment in wound bed. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Measured 1.5 cm x 0.7 cm x 0.1 cm depth. Medium amount of serous (watery discharge) noted. Wound margin is flat and intact. No granulation within the wound bed and small amount of necrotic tissue within the wound bed. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage. R1's Skin Observation dated 9/12/25, indicated new wound development; left buttock-open area with current treatment of a Mepilex to area and right buttock open area with current treatment as barrier cream to area. In review of R1's record there was no indication these areas were comprehensively assessed nor evident a comprehensive assessment was completed for a turning and repositioning program, nor the care plan was revised with pressure relieving/prevention measures. R1's wound clinic notes, RN Wound Assessments and Skin Observations records were reviewed between 9/10/25 through 11/7/25. The Wound Clinic notes during this period identified on 9/10/25 a new wound on R1's urinary meatus stage 3 pressure ulcer which was comprehensively assessed and was documented as healed on 9/25/25; associated interventions for this wound included avoidance of briefs and use of undergarment	F0686		

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F0686 SS = SQC-K	Continued from page 14 pads only, which was recommended on 9/18/25 and reiterated on 10/2/25, at which time R1 was documented as wearing a brief despite prior recommendations. The left and right buttock skin impairments identified on Skin Observation form on 9/12/25 were not addressed by the wound clinic until 10/17/25, when the wound clinic determined the presence of partial thickness shearing injury; the shearing injury was subsequently documented as healed on 10/24/25. The right heel pressure ulcer was comprehensively assessed by the wound clinic beginning 9/18/25, with ongoing monitoring and treatment recommendations including strict offloading, and was documented as healed on 11/7/25. In contrast, the facility's RN Wound Assessments, progress notes, and Skin Observations did not include ongoing comprehensive assessments of R1's buttock wounds identified on 9/4/25 and 9/12/25 nor identify the urinary meatus pressure ulcer prior to wound clinic identification on 9/10/25 and reflected inconsistent wound identification with variable assessment details. R1's quarterly Braden Scale for Predicting Pressure Score Risk dated 10/30/25, identified R1 was at moderate risk for pressure ulcers. The assessment included an intervention guide, for moderate risk which suggested interventions of: frequent turning with a planned schedule, use foam wedges for thirty degree lateral positioning, pressure reduction support surfaces, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear*if other major risk factors present, advance to next level of risk. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. R1's Wound Clinic Visit Report dated 11/7/25, identified R1 was discharged from wound center today. R1's Skin Observation dated 11/11/25, identified no skin conditions observed. R1's interdisciplinary team (IDT) progress note dated 11/12/25, identified IDT met to review resident status. Followed by outside wound care services (sic-discharged	F0686		

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F0686 SS = SQC-K	Continued from page 15 on 11/7/25). R1 is to be up in chair for about two hours around mealtimes, “compliant, often refuses.” Diabetic boost taken for wound healing. New wounds seen on bottom and back, he can reposition himself but does not, a lot of the time. Monitoring these wounds. He needs much re-education on why these two new wounds are not healing (lack of repositioning, not getting out of bed.) mepilex on. these wounds are worsening. Using skin barrier to these areas. It is felt the buttock wound is due to the shearing, not pressure. He also has a wound on the penis where the catheter comes out. Silicone cream being used and ABD pads. In review of R1’s IDT progress notes from 9/30/25-1/14/26, the information and word structure remained almost identical. According to the Wound Clinic notes R1’s buttock wounds were healed on 10/24/25 and based on the R1’s skin records after 10/25/24 that identified coccyx wound/buttock skin impairment it could not be ascertained if the IDT notes were redundant since 9/30/25 or the wounds on and after 11/12/25 were “new” wounds. R1’s IDT progress note dated 11/18/25, was verbatim from progress note on 11/12/25 with no new information identified. R1’s progress note dated 11/18/25, identified R1 would not get out of bed this shift, nor would he take a bath. R1’s Skin Observation dated 11/20/25, identified shearing on left and right buttocks. No comprehensive assessment and/or additional information was included. R1’s care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1’s faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in	F0686		

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F0686 SS = SQC-K	Continued from page 16 groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's IDT progress note dated 11/26/25, was verbatim when compared to IDT progress notes dated 11/12/25 and 11/18/25 which included "R1 is to be up in chair for about two hours around mealtimes, "compliant, often refuses" During an interview on 1/22/26 at 8:51 a.m., NA-D stated a resident could refuse cares three times before they told the nurse. NA-D had worked with R1 since admission and R1 rarely refused cares. When R1 refused care, NA-D would go back later and R1 would always accept the cares offered. R1's record was reviewed which included Skin Observations, Wound Data Collections, and progress notes between 11/8/25 through 12/30/26. The skin observations identified inconsistent identification of the presence and location of wound (coccyx vs right and/or left buttocks) with no comprehensive assessment of the impaired skin integrity when identified. Skin Observation dated 12/5/25 identified pressure sore to coccyx, Observation on 12/12/26 identified no skin impairments, Observations dated 12/19/25, 12/29/25, and 12/30/25 described wound(s) on buttocks as shearing. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum but not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included:R1's Wound Data Collection dated 12/12/25, identified "coccyx." Dressing present and intact. No drainage on the dressing.R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of	F0686		

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F0686 SS = SQC-K	Continued from page 17 shearing injury or other wounds. R1's IDT progress note dated 12/24/25, was verbatim compared to IDT progress notes dated 11/12/25 and 11/18/25, and 11/26/25 with no new information added. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or wet wipes. Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/27/25, identified coccyx. Dressing present and intact. No drainage on dressing. Pink skin around dressing. Cleansed with wound cleanser, applied ABD pad, secured with tape. R1's Wound Data Collection dated 12/29/25, identified a new wound on R1's left lateral foot that measured 1.2 cm x 1.0 cm x 0.1 cm depth. Tan in color. Applied skin prep and covered with Mepilex. No other information was included. R1's Skin Observation dated 12/29/25, identified left and right buttock shearing. Cleansed area and covered with ABD pads secured with tape. Applied zinc oxide to reddened areas that were not open. R1's Skin Observation dated 12/30/25, right and left buttock shearing. Mepilex and ABD to areas. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. Nursing order dated 12/31/25-1/8/26 directed clean buttock area with soap and water or wet wipes. Cover each buttock with ABD pad and secure outer edges with tape. Apply zinc oxide to other areas that are red but not open daily.	F0686		

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F0686 SS = SQC-K	Continued from page 18 Skin Observations dated 1/2/26, 1/3/26, and 1/6/26 reflected variable identification of skin integrity. On 1/2/26, no skin conditions were observed. On 1/3/26, a small dark pressure area measuring 1.0 cm x 1.0 cm was identified on the left heel/lateral area, and skin prep and Mepilex were applied. On 1/6/26, no additional skin concerns were identified, and documentation noted ongoing daily treatment to the buttocks. During an interview on 1/20/26 at 2:40 p.m. with NA-C and NA-B present, nursing assistant (NA)-C stated R1 had the wounds on his buttocks prior to September. The buttocks had gotten progressively worse from the size of a nickel to the size of a quarter. NA-C was unable to articulate a time frame, for when the buttocks looked worse, but it was somewhere from two weeks to a month and a half ago. NA-B stated R1 refused to turn and reposition however, if staff re-approached when he refused to get out of bed that seemed to work. R1 would sometimes pull the wedge cushion out that helped him stay on his side when in bed. If R1 went to his recliner or wheelchair he would want to go back to bed after about 20 minutes. R1’s Wound Data Collection dated 1/7/26, initial data collection for left buttock wound, type of wound was not included. The wound measured 8.0 cm x 6.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 25% slough and 75% eschar. Minimum sanguineous drainage with no odor present. Wound edges were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1’s Wound Data Collection dated 1/7/26, initial data collection for right buttock wound, type of wound was not included. The wound measured 6.0 cm x 4.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 60% slough and 35% eschar. Moderate sanguineous drainage with no odor present. Wound margins were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1’s progress note dated 1/7/26 at 9:30 p.m., identified R1 stated he was “not feeling like himself”. Stated he was having chest/heart pain but mostly felt his heart hurt. Nitro administered and pain was 8/10 to begin and 2/10 after nitro given. R1’s progress note dated 1/8/26 at 10:12 a.m.,	F0686		

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F0686 SS = SQC-K	Continued from page 19 identified physician was notified for R1 having “heart hurting” and “pain going down back on left side.” Had good results from nitro the evening before. Verbal order to go to emergency department. At 12:55 p.m., returned from emergency room with no changes made to medications after electrocardiogram and x-ray obtained. During an interview on 1/20/26 at 2:46 p.m., RN-B stated she last worked with R1 on 1/7/26 and 1/8/26. When she changed the dressing on 1/8/26, there was not an odor to the wound, but had felt there had been an odor prior. The wound was red, moist, and the skin around was pink. There was an additional small wound just below the one that was the original pressure ulcer on the left side. RN-B informed clinical care lead RN (CCLRN)-B the left buttock was worse, it had spread and was bleeding; the right buttock was only reddened skin. RN-B did not work again until after R1 had been sent to the wound clinic on 1/13/26. On 1/21/26 at 10:09 a.m., RN-B stated CCLRN-B would always measure the wounds, sometimes do the wound care, notify the physician, and put the orders in the computer. Nurses would follow what the computer directed for orders. CCLRN-B was always the first person RN-B would go to with wound concerns as she was a wound care nurse prior to working at the facility. RN-B reviewed documentation on R1’s skin for December and January and noted the wounds had not been measured until 1/7/26. R1’s progress note dated 1/12/26 at 6:06 p.m., identified R1 complained of nausea. At 10:55 p.m., nausea was better but now complaints of headache. Medicated with as needed Tylenol. Has two appointments in the morning. R1’s progress note dated 1/13/26 at 1:08 p.m., identified wound clinic called and stated they sent R1 to the emergency department with fever, chills, and R1 would most likely be admitted. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. The wounds were classified as unstageable on right lateral foot, unstageable pressure ulcer to the gluteus, and stage 3 left ischium. The gluteus was very advanced and infected, so wound clinic sent R1 to the emergency department. CWNP-A saw R1 inpatient at the hospital from 1/14/26-1/17/26 and debrided the wound daily. The wound was to the bone	F0686		

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F0686 SS = SQC-K	Continued from page 20 when CWNP-A last saw it on 1/17/26. R1 was diagnosed with osteomyelitis, cellulitis, and soft tissue infection. Emergency department was suspicious of one but unable to officially diagnose until after MRI and MRI showed it went to the bone. R1 could die from these infections. R1's care plan was revised on 1/16/26 after R1 was admitted to the hospital on 1/13/26. The care plan identified R1 often refused repositioning and refused to get out of bed. Interventions included to educate R1/family of the possible outcomes of not complying with repositioning. Attempt non-pharmacological interventions including re-approach and report to nurse if refused a second time. During an interview on 1/22/26 at 10:42 am LPN-A stated R1 moved in bed with staff help. R1 was able to help by turning a little bit on his top half but he needed assistance of two people to get him on his side and staff performed most of the work. R1 was not on a turning and repositioning schedule, and staff would do cares in the morning and evening. Staff encouraged R1 to move to his recliner for meals but he would refuse a lot. Nurses were to chart when he refused. R1's hospital History and Physical records dated 1/17/26, indicated R1 was admitted to the hospital on 1/13/26 for a sacral decubitus ulcer and osteomyelitis of pelvis. MRI of pelvis with and without contrast was completed and showed osteomyelitis of the proximal coccygeal segment (bone infection near the tailbone) with likely anteriorly dislocated middle coccygeal segment (section tail bone shifted forward-can happen with long standing pressure, infection, or tissue breakdown in the area). Cellulitis within right pelvic sidewall and right medial buttocks (infection in nearby soft tissues of the pelvis and buttock area). R1 reported his girlfriend noticed the wound on approximately 1/10/26 and according to documentation facility had noted a sacral wound for approximately two weeks. R1 reported a couple of wounds to his heels which he had previously received treatment. There is a 2.5 cm x 2.5 cm lesion on lateral aspect of right foot with no significant erythema or discharge. Records indicated on 1/20/26 R1 remained in the hospital for ongoing treatment. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior to R1 being	F0686		

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F0686 SS = SQC-K	Continued from page 21 sent to the wound clinic. R1 remained in the hospital with cellulitis and osteomyelitis, he had debridement's, a wound vacuum to his buttock, possible sepsis and kidney failure. R1 could die "it is an avoidable wound they didn't tend to." During a follow-up interview on 1/22/26 at 10:05 a.m., CCLRN-B stated shearing was not a form of pressure. Interventions for R1 were in the care plan, but R1 refused to get out of bed. He was supposed to be up for meals. R1 could reposition himself and turn himself side to side in bed. R1 had a pressure-relieving mattress but if he wanted something that had more pressure relief, like an air mattress, it was up to R1 to contact the social worker or his case manager. Staff would reposition R1 to the wheelchair or recliner and that would distribute pressure in a different area. CCLRN-B had instructed R1 to move and get off his bottom various times. Pressure would be distributed to a different area if he got up in his wheelchair or recliner (did not articulate how long R1 could sit) and did not stay in his bed. R1 did go to a psychiatrist appointment in December 2025, but no interventions or suggestions for the care plan to help R1 with not refusing cares were discussed. R1's bottom was black and blue, always looked discolored and darker, and then it would heal. That was always something that was monitored. If skin was breaking down, a Mepilex would be appropriate but the facility did not have a large enough Mepilex, possibly related to payor concerns, so an ABD pad was used. Sometimes the mepilex and/or ABD were used just to protect the skin on his bottom. Nursing staff would always look for signs and symptoms of infection but CCLRN-B was unable to find documentation to that effect. CCLRN-B stated it would depend on the injury or what it looked like, she would monitor for a day or two, add orders in the medical record based off her experience from working at the wound clinic for three years. Typically, would communicate with physician when a wound changed and most of the time the physician would give a referral for the wound clinic. CCLRN-B acknowledged cleansing the buttock wounds with soap and water or wet wipes was not a standing order, but was unable to articulate the clinical rationale, physician authorization, or evidence-based standard supporting this practice. CCLRN-B stated she began the treatment of using hydrofera blue on R1's buttocks prior to getting orders from a physician. R1's hospital After Visit Summary dated 1/23/26, identified new orders for Intravenous medications ceftriaxone 50 milliliters every 24 hours, and daptomycin 600 milligrams for bone and joint infection;	F0686		

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F0686 SS = SQC-K	Continued from page 22 metronidazole 500 milligrams three times a day by mouth for osteomyelitis. During an observation and interview on 1/23/26 at 2:41 p.m., R1 returned to the facility from hospital around noon. R1 stated the facility had not provided education prior to hospitalization on the risks of not repositioning. “They about killed me; I have never been that sick.” R1 would like an air mattress on the bed but the facility told R1 an air mattress would make the wounds worse. R1 was positioned on his back in bed, and two wedge cushions were lying in the recliner. R1 had heel boots on bilateral heels and stated there was a wedge under his back. R1 stated he was supposed to be turned every two hours, and it had been past two hours. R1 would turn on his side if the staff came and helped him. R1 did not say if he ever refused position changes. During an observation on 1/26/26 at 9:02 a.m., R1 was sitting in a recliner in his room. Heel boots in place and air mattress on bed. During an interview on 1/26/26 at 10:15 a.m., RN-B could not find orders in R1’s medical record to change R1’s dressings, even though R1 returned to the facility on 1/23/26. RN-B alerted DON, RN-D, and DON-B. During an interview on 1/26/26 at 10:43 a.m., R1 was in bed, laying on his back. R1 stated staff had not done anything with his heels all weekend. Staff put the air mattress on his bed on 1/25/26 and staff would only put the wedges in if he told them too. During an observation and interview on 1/26/26 at 10:58 a.m., CCLRN-B and DON-B went to R1’s room to complete dressing changes. CCLRN-B stated the left lateral foot wound had been a blister prior to hospitalization, was “pretty much healed,” “looks really good, slightly open” and was not a pressure ulcer, but a diabetic wound. DON-B identified the area as partial thickness, barely open, pink, healthy tissue, slightly pink around wound with some edema, raised but that could be the bone that was raised. CCLRN-B painted the entire wound and surrounding tissue with betadine and stated the wound was not open on 1/23/26 when assessed. CCLRN-B stated the left heel was blanchable, normal pink colored skin. DON-B advised CCLRN-B to follow the current wound treatment order and update the physician on progress. Toenails on left foot were observed pressing into adjacent toes, creating indentations in the skin. Upon inquiry, CCLRN-B stated she was unaware of these skin conditions until identified during the observation. Gauze was placed between the toes to	F0686		

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F0686 SS = SQC-K	Continued from page 23 relieve pressure and CCLRN-B stated she would trim the toenails later. CCLRN-B stated prior to hospitalization the area on the right lateral side of the foot was a blister. DON-B stated the area was large, circular and dark colored inside and questioned if it was an unstageable pressure ulcer. DON-B stated it should be labeled as unstageable so the floor nurses would keep a better eye on it. DON-B did not see any blanching and that would be the other red flag for the area. CCLRN-B stated that was the weird thing, he got both of the blisters while wearing his heel boots. Measured the darkened area at 1.5 cm x 2.5 cm and noted a small open area at the top of the blister that measured 0.3 cm x 0.2 cm x 0.1 cm depth. CCLRN-B observed the right heel and stated it was blanchable, pink in color, and appeared healed. DON-B observed the right heel and stated it should be staged as a suspected deep tissue injury as it was slightly blue in color and unblanchable. R1 attempted to turn to his right side by himself and was unable to make the position change. Four briefs, a disposable chux pad, and a turn sheet were observed underneath R1. DON-B instructed CCLRN-B that excessive layers increase pressure and should be minimized. CCLRN-B described the left side wound as granulated with dry skin but would not identify a stage. DON-B examined the area and identified epithelialized, non-blanchable tissue, consistent with a healing stage 3 pressure ulcer, as the wound clinic had staged it at stage 3. CCLRN-B had applied adhesive foam over the wound to protect it from the wound vacuum; DON-B instructed that adhesives should not be placed on the wound and that Mepilex should be used instead. The wound vacuum tubing was positioned along the upper thigh with suction not applied directly to the wound. Upon removal of the dressing, the wound was observed to be actively bleeding. CCLRN-B stated she believed the wound was a stage 4 pressure ulcer and began cutting the wound vacuum foam into a narrow strip. DON-B stopped CCLRN-B and instructed that the foam must be cut to match the wound size, placed as one piece, and that suction should be applied directly to the foam at the wound site. Additional areas of impaired skin integrity were identified during the observation, including a red, raised area on the posterior thigh and a red area under the buttock crease, which CCLRN-B stated she was unaware of until identified during the observation. DON-B directed pressure-relief measures and initiation of data collection. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated physicians are notified of wounds on residents and nine out of ten times the physician would provide a referral for the residents to be seen by the wound	F0686		

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F0686 SS = SQC-K	Continued from page 24 clinic. Wound clinic would have weekly appointments with a resident until the wound was healed. Wound clinic would direct resident care including repositioning, non-weight bearing, air mattress, shoes, or whatever they would recommend. Wound clinic does not send dictation after appointments but will send orders and list important things the facility needs to do for residents. Facility would still complete weekly wound assessments with measurements while resident was followed at wound clinic. Nursing Admission/Readmission would be completed by CCLRN-B or DON. Wounds are assessed every day in some form, but measurements are done once a week. Any RN can do the measurements. CCLRN-B was unaware if audits were completed on comprehensive wound assessments. With R1, it was hard, sometimes it was shearing, and sometimes it would break into wounds. Staff would use barrier cream when they were not open. That is why the facility has Skin Observations and Wound Assessments, and only under Wound Assessments measurements would be included. Assessments should show that a wound is healing but R1's buttocks have always been an issue. CCLRN-B reviewed R1's medical record and identified on 12/29/25, it was charted shearing on right and left buttock, no measurement, cleansed, ABD and zinc applied to reddened areas. CCLRN-B stated measurements would only be done if there was a wound present; an assessment with measurements had been completed on 1/7/26 but was having a hard time finding other assessments that included measurements. R1 was able to position himself in bed. R1 would get explosive and angry at times and when R1 would refuse cares, NA's were educated to reapproach later. IDT, wound team, and physician were aware of R1's non-compliance. During an interview on 1/21/26 at 10:48 a.m., DON stated she was new to her position and started in September. DON was unaware of all the rules that needed to be followed for this corporation. DON had been unaware the facility had User Defined Assessments (UDA)'s for wounds that nurses were to fill out daily. DON began by making cheat sheets for the nurses with steps to make sure things are getting done appropriately and re-educated on the UDA's. All the nurses were learning together. Prompts to chart the UDA's were added in the TAR. On 1/16/25, IDT met and reviewed R1's medical record. While reviewing, DON wondered why R1 had not been on an air mattress prior to hospitalization but was not sure if he needed one and would have to evaluate the need after he returned from the hospital. IDT decided on 1/16/26, that both CCLRN-A and CCLRN- B would complete Weekly RN Assessments for wounds together. It began on 1/16/26, and we decided to continue doing it on Wednesdays to	F0686		

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F0686 SS = SQC-K	Continued from page 25 coincide with our weekly IDT meetings so any new information could be brought to the meeting. Also discussed how best the nurses could communicate important information to IDT and if they could put specific headers on the emails. Infection Preventionist (IP)-A runs the weekly IDT meeting and adds the progress note to resident charts. Nurse consultant had also done a chart audit and noted that education needed to be provided to IP-A on what the IDT progress note consisted of and that it could not be just copied and pasted from a previous note. DON reviewed R1's chart and determined the last physician order she could find for R1's bottom was from after his appointment with wound care on 11/7/25. Nurses can use their own judgement and add orders in the system prior to getting an order from a physician, that must have been what CCLRN-B did for R1's wound treatments. The IJ that began on 12/31/25, was removed on 1/27/26 at 1:58 p.m., when it was determined and verified the facility implemented the following: -R1 was assessed and care plan interventions updated to align with assessments and provider orders. completed 1/27/26. -charge nurses responsible for day-to-day Wound Assessments/data collection tools. Completed 1/25/26. -CCLRN's responsible for weekly wound care assessment, along with root cause analyzed by IDT weekly. -care plan development starts with admitting nurse. -care plan reviews done by MDS and CCLRN's quarterly and with any changes. -all residents with current skin issues reassessed on 1/22/26. All current wounds were reviewed, including history of wounds and are stable or healed with appropriate interventions in place. Care plans reviewed, and/or updated to ensure appropriate interventions are in place. Completed 1/27/26. -notification to physicians with current skin issues. Completed 1/26/27. -nursing staff educated on care plan, notification of change, skin assessment, pressure ulcer prevention, and documentation. Completed 1/25/26. -licensed nursing staff educated on documentation including required assessments, documentation guidelines, common wound etiologies and types,	F0686		

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F0686 SS = SQC-K	Continued from page 26 recognizing and staging wounds, best practices in wound treatment, nursing care, changes in condition, requirements of timely provider and family notification, and steps for staff to take when changes in condition occur. Completed 1/25/26. -NA's educated on care plans, skin assessment pressure ulcer prevention and documentation, documentation requirements including importance of daily skin observation and reporting any abnormal findings to a licensed nurse, instruction to find repositioning schedules on Kardex, change of condition and examples of change of condition. Completed 1/25/26. R3 R3's face sheet dated 1/20/26, identified diagnoses on 12/19/25, abrasion left lesser toe(s), generalized edema, unsteadiness on feet, and unspecified open wound of left lesser toe without damage to the nail. On 12/23/25, incomplete paraplegia, pressure ulcer of other site stage 2. On 12/30/25, non-pressure chronic ulcer of other part of the left foot with fat layer exposed. On 1/13/26, pressure ulcer of right heel unstageable, and non-presssure chronic ulcer of other part of left foot limited to breakdown of skin. R3's progress note dated 12/19/25, identified R3 admitted to facility due to wounds on left toes. R3's Nursing Admit/Re-Admit Data Collection dated 12/19/25, identified R3 had weak lower extremity movement, numbness/tingling identified for feet. Edema to left lower extremity and unable to palpate pedal pulse to left foot. Wounds described as left toes. The great toe and second toe have bandages in place. The 3rd-5th toes have dark spots noted at the tips of the toes. R3 had a history of healed pressure ulcers. No further other wound characteristics that wound include but not limited to type of wounds and measurements. R3's Braden Scale for Predicting Pressure Sore Risk dated 12/19/25, identified a score of 17, which was mild risk for pressure ulcer development. Braden Scale Reference Tool identified an Intervention Guide for mild risk (15-18): frequent turning, maximal remobilization, pressure-reduction support surfaces if bed or chair bound, protect heels, manage moisture, manage nutrition, manage friction and shear *if other major risk factors present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) advance to next level of risk. R3's care plan dated 12/19/25, identified potential for impairment to skin integrity related to being chair bound, and poor circulation evidenced by R3 stating	F0686		

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F0686 SS = SQC-K	Continued from page 27 that he has had pressure sores before. Interventions included provide pressure relieving mattress and pillows or heel protectors as needed. If needed apply heel protectors on at bedtime, off during the day. R3's physician orders dated 12/19/25, identified ankle foot orthoses (AFO) shoe brace on in AM, off at bedtime for foot drop, bilateral heels treatment: remove compression stockings, apply moisturizing lotion to heels at bedtime, check that foam boots are on heels and pillows under calves every night, compression socks on in AM, off at bedtime. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated her and DON completed all admissions at facility. She did R3's nursing admission, but CCLRN-A was the clinical care lead for R3. On admission, left great toe, second toe, third, fourth, and fifth toe had dark spots on them. R3 was referred to wound clinic. "Wherever he came from, he was seeing a wound clinic and we thought to just continue that locally". CCLRN-B was unable to find measurements for heels. CCLRN-B was unable to articulate if R3 admitted to facility with heel wound or if it was acquired after admission. R3's Skin Assessment dated 1/4/26, stated heels healing nicely but did not see any measurements. CCLRN-A would be better to talk to about R3. R3's Wound Clinic Visit Report dated 12/20/25, identified R3 came to clinic for left 2nd toe ulcer. Wound identified as unclassifiable. Measured 2.0 cm x 0.6 cm x 0.1 cm. ulcer base is 100% eschar. Loose eschar debrided as it was putting pressure on the ulcer base creating indentation revealing pink base. No tunnelling or undermining. Scant serous drainage. Periwound dry and intact. No erythema or warmth. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply iodosorb to wound bed, avoid getting on surrounding skin, sterile gauze sponge to cover. Betadine to small scabs on other toes of left foot. In review of R3's care plan/treatment order there was no indication the care plan revised and/or order transcribed into the facility's physician/nursing orders electronic health record system to identify may shower with protection but do not get dressings wet. R3's Skin Observation dated 12/21/25, identified no skin conditions observed. R3's admission MDS dated 12/23/25, identified R3 was cognitively intact, no behaviors or rejection of care,	F0686		

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F0686 SS = SQC-K	Continued from page 28 used a wheelchair for mobility, dependent for lower body dressing and putting on/taking off footwear, touching assistance to roll left to right, and transfer. R3 has a pressure ulcer, is at risk of developing pressure ulcers, has one or more unhealed pressure ulcers identified as two stage 2 pressure ulcers present on admission. Skin and ulcer treatments included pressure reducing device for chair and bed, pressure ulcer care, no turning/repositioning program, no nutrition/hydration, and no applications of dressing to feet were marked. R3's Wound RN Assessment dated 12/23/25, identified left foot great toe pressure ulcer stage 2 present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound RN Assessment dated 12/23/25, identified stage 2 pressure ulcer to second toe left foot present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound Data Collection dated 12/23/25, identified second toe left foot measured 0.8 cm x 1.0 cm x 0.1 cm. Dressing completed. The assessment did not identify the type of wound and no other characteristics were included. R3's Wound Data Collection dated 12/25/25, identified left second toe. Wound margins intact, pink. The assessment did not identify type of wound, no measurements, and no other wound characteristics. Treatment: left 4th toe: cleanse with wound cleanser, paint with betadine and cover with non-bordered foam dressing, secure with tape, change daily and as needed. Left foot (all toes): cleanse with wound cleanser, paint each toe with betadine, do daily at hour of sleep. R3's Wound Data Collection dated 12/26/25-12/28/25, and	F0686		

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F0686 SS = SQC-K	Continued from page 29 12/31/25, identified left second toe scabbed area. Wound margins intact, pink. No other wound characteristic were included. R3's Skin Observation dated 12/28/25, identified no skin conditions observed. R3's care plan dated,1/1/26, identified "potential" for pressure ulcer development related to impaired mobility and incontinence evidenced by poor Braden Scale. On 1/1/26, a focus of Admitted with stage 2 pressure ulcer on left great toe and second toe of left foot related to disease process of paraplegia and impaired mobility. New interventions added since care plan dated 12/19/25 included provide pressure redistributing mattress on bed and cushion in manual wheelchair, and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R3's Skin Observation dated 1/4/26, identified heels are healing nicely, follows wound weekly, currently no dressing to toe areas-no open areas at present. The observation did not include type of wound(s) and measurements nor additional wound characteristics. Furthermore in review of R1's record there was no previous assessment and no prior mention that R3 had wound(s) on his heels. R3's Wound Clinic Visit Report dated 1/6/26, identified R3 returned to clinic for left 2nd toe unclassified ulcer. Measured 0.3 cm x 0.6 cm x 0.1 cm. ulcer base is 100% dry eschar. Periwound dry and intact. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply betadine to area of eschar to wound bed, sterile gauze to cover. R3's record lacked orders to shower with protection and not get dressings we. R3's Wound RN Assessment dated 1/8/26, identified left toe(s) wound "non-pressure" The assessment did not specify which toe the wound was on. Healing process evidenced by area decreasing in size, no signs of infection noted at this time. Modifications to interventions included support surfaces and wound treatment. Measurement 0.5 x 0.5 cm scabbed area on toes on left foot. R3's Wound RN Assessment dated 1/8/26, identified left toes non-pressure wound. Area decreasing in size. No signs of infection noted at this time. 0.5 cm x 0.5 cm scabbed area on toes on left foot. R3's Wound Data Collection dated 1/1/26-1/14/26,	F0686		

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F0686 SS = SQC-K	Continued from page 30 identified left second toe wounds are covered. 1/2/26 scabbed area on toe is covered. 1/5/26 scabbed area on toe is covered. 1/7/26 wound is covered. 1/10/26 wound is closed. No bleeding or drainage noted. No dressing applied to area. 1/11/26 scabbed area. 1/12/26 nothing marked. 1/13/26 scabbed area noted.1/14/26 scabbed area on left second toe. R3's Wound Clinic Visit Report dated 1/13/26, identified R3 returned to clinic with left 2nd toe ulcer, right heel ulcer, and left great toe ulcer. Left 2nd toe currently classified as full thickness without exposed support structures. Wound margin is flat and intact, large pink granulation within wound bed. This wound is healed. Left great toe stage 3 pressure ulcer measured 0.1 cm x 0.1 cm x 0.1 cm. no tunneling or undermining noted. medium amount of serous drainage. Wound margin is distinct with the outline attached to wound base. Small amount of pink granulation within the wound bed, no necrotic tissue in wound bed. Unstageable pressure ulcer on right calcaneus (heel) measured 1.0 cm x 1.0 cm x 0.1 cm depth. No tunnelling or undermining, no drainage. Wound margin is flat and intact, no granulation within wound bed. Large amount of necrotic tissue within the wound bed including eschar. Plan: may shower with protection but do not get dressings wet. Prevalon boots to both feet when in bed. left great toe and 2nd toe cleanse with normal saline, apply betadine, cover with sterile gauze. Right heel cleanse with normal saline, apply betadine, cover with sterile gauze. The treatment was added to the physician orders in the treatment administration record (TAR), however, the record did not identify to shower with protection and not get dressings wet. In review of R1's record between 1/4/26 and 1/14/26, there were no comprehensive wound assessments completed between the assessment on 1/4/26 and the wound clinic assessment on 1/14/26. Additionally, despite the Skin Observation on 1/4/26 that indicated R3 had a wound to his "heels" and the wound clinic's identification of an unstageable pressure ulcer to R3's right heel, it was not evident R3's care plan was revised to address the pressure ulcer to R3's right heel or the shower instructions. R3's Skin Observation dated 1/14/26, identified treatment and monitoring to bilateral lower extremities ongoing. No other information documented including wound type. R3's IDT progress note dated 1/14/26, identified addendum to IDT note. Resident also has wounds to his feet for which he is seeing wound clinic. Right heel	F0686		

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F0686 SS = SQC-K	Continued from page 31 wound is painted with iodine and wrapped in gauze, left big toe and second toe have wounds. Monitoring. No other information documented including wound type. R3's Wound RN Assessment dated 1/15/26, identified left toe(s) wound non-pressure. Healing process evidenced by covered with new skin and are decreasing in size. No other information documented including wound type. R3's Wound RN Assessment dated 1/15/26, identified left toes non-pressure wound. Covered with new skin and decreasing in size. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/16/26, identified left toes very small areas of eschar noted on all toes, largest area measures 0.3 cm x 0.3 cm; smallest unable to measure; scabbed over-no drainage noted. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/17/26, identified left toes area covered on left great toe and 2nd digit, 3rd and 4th digit have areas that are covered in betadine, and no dressing over them. No complaints. No other information documented including wound type. R3's Wound Data Collection dated 1/18/26, identified left toes cleansed with betadine applied to scabbed areas and covered with gauze. No pain or discomfort. No other information documented including wound type and which toe(s). R3's Wound Clinic Visit Report dated 1/20/26, identified R3 returned to clinic for follow-up treatment to left great and 2nd toes, right heel ulcer. Left second toe full thickness wound, that was classified as healed on 1/13/26, measured 0.1 cm x 0.1 cm x 0.1 cm. large amount of necrotic tissue within the wound bed including eschar. No granulation in wound bed. stage 3 pressure ulcer on left great toe measured 0.1 cm x 0.1 cm x 0.1 cm. small amount of serosanguineous drainage. Large amount of necrotic tissue in wound bed including eschar. No granulation within the wound bed. unstageable pressure ulcer to right heel measured 1.0 cm x 1.0 cm x 0.1 cm depth. No drainage, no granulation within the wound bed. Large amount of necrotic tissue within the wound bed including eschar. Continue with current treatment to all wounds. During a phone interview on 1/21/26 at 9:43 a.m., CWNP-A stated R3 began at wound clinic on 12/30/25 with a left foot second toe ulcer; 1/6/26, R3 was again seen	F0686		

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F0686 SS = SQC-K	Continued from page 32 for the left foot second toe. On 1/13/26, left second toe healed, new pressure ulcer right heel, and left great toe. On 1/20/26, bilateral foot ulcers are dry and stable and left second toe and great toe measured 0.1 cm x 0.1 cm x 0.1 cm depth. Right heel pressure ulcer measure 1.0 cm x 1.0 cm. Review of medical record, the facility did not report the new ulcers to wound clinic and wounds were discovered between the 1/6/26 and 1/13/26 visit by wound clinic. R3's Wound Data Collection dated 1/20/26, identified left great toe eschar noted. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified wound name calcaneus right heel. Eschar noted. No drainage, denies pain. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified left second toe. Eschar noted on top of toe. Treatment done at wound clinic. No other information documented. R3's Wound Data Collection dated 1/22/25, identified right heel pressure ulcer measured 1.5 cm x 2.0 cm with no depth. 100% epithelized tissue to wound bed. Physician notified. No other information documented. R3's Wound Data Collection dated 1/22/25, identified left foot great toe pressure ulcer measured 0.3 cm x 0.5 cm with no depth. Left toes dark area. 100% eschar to wound bed. Modifications to interventions included support surfaces and wound management. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/22/25, identified left foot 2nd toe pressure ulcer. Left toes darkened area measured 0.6 cm x 0.7 cm, no depth. 100% eschar. Modifications to interventions included support surfaces and wound treatment. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/27/26, identified right heel no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink. No further information documented.	F0686		

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F0686 SS = SQC-K	Continued from page 33 R3's Wound Data Collection dated 1/27/26, identified left great toe no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink. No further information documented. R3's Wound Data Collection dated 1/27/26, identified left second toe scabbed, no open wounds noted, no drainage or bleeding, no pain. No further information documented. During an observation and interview on 1/20/26 at 7:54 a.m., R3 stated he had wounds on his toes and heels, nothing special he has to do for the wounds, "they" keep up with dressings. Stated he was going to an appointment at the wound clinic today. R3 was in a wheelchair, AFO, regular socks, and soft shoes on feet. Had a foot cradle on the end of his bed. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated NA's observe skin daily, nurses do weekly assessments during bathing. CCLRN-A and B complete the weekly RN Wound Assessments. Risk for pressure injury is determined by an individual's Braden score, mobility, how a resident transfers, and activity level. All residents are so unique, it is hard to say what model to follow. CCLRN-A did not clarify what model was meant. Interventions would change as needed if something came up. During a follow-up interview on 1/22/26 at 11:00 a.m., CCLRN-A stated R3 wore the bootie heel protectors, but was not sure if he had them since admission. He admitted with a stage 2 pressure ulcer of the left great toe and another toe. Did not admit with the right heel. R3 does have a foot cradle on his bed and that is not in his care plan. CCLRN-A stated the facility was working on better communication with the physician about sending weekly wound updates. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's quarterly MDS dated 10/30/25, identified R5 had moderate cognitive impairment, moderate hearing difficulty, usually understood, no behaviors, used a walker and wheelchair; needed moderate assistance with dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations; was at risk of developing pressure ulcers, did not have a pressure ulcer, had a pressure relieving device on bed	F0686		

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F0686 SS = SQC-K	Continued from page 34 and chair, application of nonsurgical dressing and ointments to places other than feet. R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. R5's physician order dated 12/8/25 directed for bilateral heel wound treatment: remove old dressings, cleanse with normal saline, apply Medi honey to open areas, cover with non-adherent telfa dressing, wrap with cast padding. Change every three days and as needed for excess drainage. Although the physician order that identified R1 had bilateral heel wounds, R5's record between 12/8/26 and 1/2/22 did not include any comprehensive assessments or documented monitoring of R5's heel wounds. R5's progress note dated 1/2/26, identified hospice nurse visited and placed catheter due to increased swelling to the scrotum and difficulties getting to the bathroom. Also having increased pain to left foot/leg. No further mention of location of pain and/or etiology. R5's progress note dated 1/2/26 at 11:11 p.m., identified R5 expressed pain when moving left lower extremity or raising the foot of recliner. Left lower leg dressing remained dry and intact, right lower extremity dressing changed once. Condition declining. R5's progress note dated 1/3/26, identified presence of edema about below his armpit level. Dressing to right lower extremity changed as scheduled for weeping clear fluids. R5's late entry progress note dated 1/5/26 at 11:47 a.m., identified new dressing orders obtained Unna boot (calamine/zinc roll to bilateral lower legs, followed by kerramax-extra absorbent dressing to right leg wound and areas of drainage, then coflex wrap as top layer. Change daily and as needed if drainage through	F0686		

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F0686 SS = SQC-K	Continued from page 35 dressing. Does complain of mainly left leg pain. R5's record reviewed between 1/5/26 through 1/26/26 identified R1 had extensive wounds that were not classified; however the record identified R1 had very edematous legs that were weeping. R5's physician ordered treatment that was dated 12/28/25 for R5's heels was discontinued on 1/6/26. R5's record did not identify another treatment order for the heels nor why the order was discontinued. In addition, based on the R5's record it could not be ascertained if the heel wounds had resolved. R5's physician order dated 1/7/26-1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "lower legs" and not feet or heels. R5's late entry progress note dated 1/7/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off, not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds. Monitoring. In review of R5's record between 12/28/25 through 1/14/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's late entry progress note dated 1/14/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Some	F0686		

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F0686 SS = SQC-K	Continued from page 36 progress seen to legs with initiation of una boot. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off, not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds plus the catheter. He also has a foley catheter now. Monitoring. In review of R5's record between 1/14/26 through 1/20/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's physician order dated 1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "legs" and not feet or heels. R5's progress note dated 1/17/26 at 2:40 p.m., identified dressings stayed dry this shift. At 4:08 p.m., legs were dry bilaterally with dressings intact. During an observation and interview on 1/20/26 at 8:23 a.m., R5 was on the commode and being transferred to a high-back wheelchair with a foam cushion on the seat and heel protectors on his feet. A dressing was on the right side of his bottom. When R1 was lifted off the commode there were small drops of blood on the commode The dressing was not changed, and NA-A was not able to ascertain where the blood came from. R5 yelled out in pain when staff wiped him with wet wipes he and was placed in the wheelchair. CCLRN-A stated R5 had sores on his legs, new one on scrotum, and a Mepilex on his bottom. CCLRN-A removed heel protectors and stated the heel protectors were soaked through with fluid from R5's legs. CCLRN-A described the right heel as an open area, black in the middle, on the bottom of the heel. When observing R5's right heel, the skin was also white consistent with maceration. CCLRN-A stated the skin is dry looking on his feet. When observing R5's left heel the skin was also white consistent with maceration with a small black spot consistent with eschar in the middle. When CCLRN cleaned the left heel wound blood was on the gauze but "the wound was not actively	F0686		

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F0686 SS = SQC-K	Continued from page 37 bleeding". Bilateral legs and feet were very edematous, R5 lightly placed his hand on his leg, removed it and the imprint of his hand remained for more than 2 minutes. CCLRN-A stated he was not the greatest at staging wounds. Since the heel protectors were soaked already, CCLRN-A did not think they would be a viable option for R5 to put back on. On 1/16/26, the Interdisciplinary Team (IDT) discussed switching things up and both CCLRN's would do wound care together to get better descriptions of wounds, not tie up the NA's, and keep the wound assessments consistent. A fair number of residents go to the wound clinic for treatments. In review of R5's record between 12/8/26 through 1/21/26, there was no indication R1 had impaired skin integrity to his right buttock nor was there a physician order for the Mepilex that was on R5's bottom during the observation on 1/20/26 at 8:23 a.m. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated R5 had a regular pressure relieving mattress on bed. R5 rarely went to bed because he would complain of shortness of breath, so he was always in recliner but did not use or have a pressure relieving cushion for the recliner. R5 would get up to reposition for meals into the high back wheelchair and then go back to the recliner. CCLRN-A explained a resident's risk for pressure ulcers was based off the Braden Score, mobility, how residents transfer, activity level-everything goes into determining it. If there were concerns identified when the assessments were completed, then the residents would be closely monitored and precautions put into place to reduce the risk. and if seeing concerns on some of those assessments either watch closely or precautions put in place. "Everyone is so unique, it is hard to say which model to follow." During an observation on 1/20/26 at 11:49 a.m., R5 was in his wheelchair, facing the fishtank, with his eyes closed. During an observation on 1/20/26 at 1:14 p.m., R5 was in his wheelchair in front of a table, with the fishtank on his left side, with his eyes closed. R5's progress note dated 1/20/26 at 4:29 p.m., identified R5 scooted down in recliner to the point the chair tipped forward and was resting on recliner part of chair. Will attempt trial of placing cushion from wheelchair into recliner to see if that will prevent R5 from scooting down in chair and placing too much weight on front of chair and tipping it forward. In review, R5's care plan was not revised to include the cushion	F0686		

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F0686 SS = SQC-K	Continued from page 38 to the recliner until 1/22/26, two days later. During an observation and interview on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A stated she received a call on 1/21/26 that R5's bottom was getting worse. LPN-B stated the facility was using a sacral Mepilex for treatment to the bottom, after leaving the room "to check the orders". LPN-B returned to R5's room and stated the order was for calmoseptine and sacral dressing to site. HN-A stated if the wound was not open, a Mepilex would be fine to put on but if it was open she would reach out to the physician for orders. LPN-B got dry wipes from drawer and wet them in sink to cleanse wound. HN-A stated there were open spots on both sides of R5's bottom and would classify them as stage 2 pressure ulcers. R5 winced and attempted to move away in pain when cleansing wounds. LPN-B stated the facility was using calmoseptine as a barrier cream to R5's bottom and read the bottle that stated it protects, soothes, and promotes healing skin. Applied to wound bed and surrounding skin. Placed a sacral Mepilex over wounds. Neither nurse was able to articulate how long R5 had the wounds on his buttocks. R5's care plan dated 1/22/26, identified an update of actual skin impairment to include open area to lower left rear leg on 1/19/26, open areas to right lower leg rear, left heel, right heel, left buttocks, and right buttocks. Interventions for skin impairment were updated to include turn and reposition in bed or chair every 2-3 hours, weekly skin observation by licensed nurse, check brief every 2-3 hours, provide cushion to recliner and wheelchair. In review of R1's record there was no indication of comprehensive assessment was completed to determine R5's skin tolerance to pressure over time, it could not be ascertained how the 2-3 hour repositioning scheduled was determined appropriate or sufficient to prevent further deterioration and/or new ulcer development. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to right heel that measured 3.0 cm x 2.5 cm x 0.1 cm depth. 100% eschar and surrounding skin intact and pink. Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to left heel that measured 4.0 cm x 3.5 cm x 0.1 cm depth. 100% eschar to wound bed. Surrounding skin pink and intact.	F0686		

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F0686 SS = SQC-K	Continued from page 39 Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed R5's Wound Data Collection and RN Assessment dated 1/22/26, identified pressure ulcer right buttock, did not identify a stage, measured 4.0 cm x 2.0 cm x 0.1 cm depth. 90% granulation tissue and 10% slough in wound bed. Minimum amount of drainage with 'other' selected as color and slight bleeding noted. Wound margins are intact and pink. Treatment was barrier cream applied and Mepilex placed. R5's Wound Data Collection dated 1/22/26, identified left buttock open area measured 5.0 cm x 4.5 cm x 0.1 cm depth. 100% granulation tissue in wound bed. Wound margins intact and pink. Barrier cream and Mepilex applied. During an interview on 1/22/26 at 11:00 a.m., CCLRN-A stated he had a note under his door on 1/21/26 from 1/20/26 that stated R5's bottom was open. Prior, it had only been red and the Mepilex was on for protection. CCLRN-A notified hospice on 1/21/26. Facility has been working on repositioning R5 every 2-3 hours. Staff were getting him up into the wheelchair for meals because he had been eating in his room. We began elevating his feet off ground with recliner which had mixed results as R5 can run buttons himself so he will put the reclining part back down. The facility worked with family and hospice to get him to go to his bed with his bottom starting to break down. For the moment, CCLRN-A had staff moving the foam, which was a little piece of foam, nothing significant, from his wheelchair to recliner, and will look for something better. CCLRN-A wanted to ask hospice about getting an air mattress and whatever else is necessary for feet. CCLRN-A tried the heel protectors, but they got soaked with fluid, so staff were directed to try a pillow to protect from moisture for the moment. The dressings to R5's legs have changed in the number of times they were changed each day and now they have started weeping again, R5's circulation has gotten really bad at this point, stuff has started opening back up on the calves.- During an observation on 1/23/26 at 10:17 a.m., R5 was at a table by the fishtank eating breakfast. During an observation on 1/26/26 at 10:38 a.m., R5 was laying in bed, no air mattress on bed, right foot is almost off the end of the bed. A follow-up email dated 1/27/26 at 1:52 p.m., DON	F0686		

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F0686 SS = SQC-K	Continued from page 40 stated she reviewed with hospice and an air mattress was ordered. R2 R2's face sheet dated 1/20/26, identified diagnoses of hemiplegia and hemiparesis. R2's quarterly MDS dated 10/24/25, identified R2 had moderate cognitive impairment, no behaviors, and had minimal difficulty with hearing but was able to understand and be understood. R1 was dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 had no pressure injuries and was not at risk of developing them. Treatments included pressure reducing device for chair and bed. R2's skin integrity care plan dated 1/28/25, identified R2 had potential impairment to skin integrity related to fragile skin on tailbone area, right hip, and lateral aspect right foot. Interventions dated 1/28/25 included Mepilex to tailbone/right foot area for protection as needed, monitor tailbone area and right hip for skin changes. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to health care provider, weekly skin observation by licensed nurse, and blue prevalon boot to right foot when in bed, assist to reposition every two hours or if observed leaning, pressure reduction mattress and waffle cushion in tilt/recline wheelchair, notify nurse immediately of any new areas of skin breakdown. R2's Skin Observation dated 1/3/26, identified right heel-outer right aspect of heel has "about" a 1.0 cm x 2.0 cm spongy, dark pressure area. Skin prep and mepilex applied. No further description was documented, not evident the care plan was revised with immediate pressure relieving interventions to prevent and/or reduce the risk of deterioration. Additionally, the physician notification was not completed until three days later on 1/6/26. R2's Wound Data Collection dated 1/6/26, initial data collection for lateral right heel that measured 0.75 cm x 1.5 cm. wound margins intact and pink. Looks like a bruise, slightly fluid filled, covered with Mepilex. R2's Wound RN Assessment was inconsistent with Data Collection. This document identified the impaired skin integrity as suspected deep tissue injury (not a bruise) and included interventions for repositioning/turning, support surfaces, friction/shear	F0686		

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F0686 SS = SQC-K	Continued from page 41 management, wound treatment. Continue with current treatment plan, and physician notified regarding wound status. R2's progress note dated 1/6/26, identified a fax was sent to physician regarding a suspected deep tissue injury on right lateral heel. Mepilex covering area for protection. R2 does not know how it happened and does not have any pain when asked about it. Asked for any additional interventions. Will continue to monitor. R2's Braden Scale for Predicting Pressure Score Risk dated 1/6/26, identified a score of 10. The Braden Scale Reference Tool for use in conjunction with Braden scale included an Intervention Guide: High Risk (score of 10-12) which included: frequent turning with a planned schedule, supplement with small shifts in position, pressure reduction support surface, use foam wedges for thirty degree lateral positioning, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. In review of R2's record between 1/3/26 through 1/14/26, there was no indication the care plan was revised to identify the suspected deep tissue injury and the interventions that were identified on the 1/6/26 assessments. R2's Skin Observation dated 1/7/26, identified no skin issues observed. R2's progress note dated 1/8/26, identified physician returned fax with orders to continue with mepilex and attempt to off-load pressure. In review of R2's record despite the physician ordered intervention there was no indication the care plan was revised to include the intervention to off-load pressure. R2's annual MDS dated 1/9/26, identified R2 had minimal difficulty with hearing but was able to understand and be understood, had moderate cognitive impairment, no behaviors, dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 has a pressure ulcer and is at risk of developing pressure ulcers. Pressure ulcer is identified as unstageable presenting as deep tissue injury. Treatments included pressure reducing devices for chairs, bed, and pressure ulcer care. R2 was not on a turning/repositioning program, no nutrition/hydration interventions to manage skin problems.	F0686		

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F0686 SS = SQC-K	Continued from page 42 R2's Wound Data Collection dated 1/13/26, identified right heel-mepilex in place. No measurements recorded. Surrounding tissue is pink and intact. Continues to be a dark, spongy, pressure area. R2's Skin Observation dated 1/14/26, identified right heel-lateral right heel. Faxed physician regarding status of bruised looking area. Looking less bruised and more pink/purple, lighter in the middle. Did note a pinpoint area in the middle of the bruised area but no drainage noted. R2's progress note dated 1/14/26, identified IDT met and reviewed the spot on right lateral heel. Sort of a pink/blue area, depends on positioning. It is not open or draining. Discussed possibility of evaluation at wound clinic and R2 shook her head "no". Daughter will be consulted. Monitoring. R2's ADL care plan dated 1/15/26, identified R2 had right sided weakness and required assistance with ADLs. Interventions included assist of two staff to position up in bed, one staff to turn side to side, two staff for transfers and toileting hygiene. The care plan included a focus area of deep tissue injury to right heel dated 1/15/26 with corresponding interventions included educate resident/family as to causes of skin breakdown including: transfer/positioning requirements, importance of taking care during ambulation/mobility, good nutrition and frequent repositioning. Provide pressure redistributing mattress on bed and cushion in scoot wheelchair, offload heels when in bed and chair. R2's Skin Observation dated 1/16/26, identified right heel-bruise. Covered with mepilex and put on an off-loading boot. Has an appointment at wound clinic on 1/20/26. No further wound characteristics were documented. R2's progress note dated 1/19/26, identified CCLRN-B notified daughter the "bruising" on R2's right heel was more reddish purple now compared to the black/blue before. The area is not soft and R2 does not complain of pain. Daughter requested to cancel wound clinic appointment. R2's Skin Observation dated 1/19/26, identified right heel-right lateral heel. Skin prep to heel and covered with mepilex, protective boot applied. R2 had no complaints of pain. Bruise area is less blueish/black and more purplish noting the center is fading in color. It is not soft to the touch. Has a piece of dry skin peeling off. No further wound characteristics were documented.	F0686		

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F0686 SS = SQC-K	Continued from page 43 During an observation on 1/20/26 at 10:25 a.m., R2 was in her room, sitting in a wheelchair with a pillow positioned on her right side. R2 leaned to the right with her right shoulder almost touching the armrest, right foot was on the floor with a heel protector on foot, not on foot pedal, left leg was crossed over right leg. During an interview on 1/22/26 at 10:05 a.m., CCLRN-B stated occupational therapy (OT) had evaluated R2 various times for right side lean. CCLRN-B indicated she was not familiar with R2's wounds or care because the director of nursing (DON) took was took over management of her care. During an interview on 1/22/26 at 10:51 a.m., NA-D stated R2 was repositioned every two hours. R2 liked to be on the right side. Staff attempted to put a pillow on the right side and one between the knees, along with the heel protector on the right foot. R2 tried to take the heel protector off but it was there to help the area not get worse. NA-D felt when R2 was in the wheelchair her heels would not touch the floor, so she was not at risk for pressure. Staff move R2 back and forth from wheelchair to recliner for position changes. R2 has a waffle cushion staff move back and forth from recliner to wheelchair. During an observation on 1/22/26 at 10:50 a.m., R2 was sitting in wheelchair in her room, leaning to right, arms bent and positioned with hands by neck on left side, heel protector on right heel, left leg crossed over right leg at knee. During an observation and interview on 1/23/26 at 11:44 a.m., R2 was sitting in a new wheelchair with a footboard attached at the foot pedals. Grippy socks on her feet, no heel protector on her right heel. Left leg crossed over the right leg at her knee. Mepilex on right heel. Mechanical lift sling was behind her in the wheelchair. Heel protector was on the recliner. Pressure relieving cushion in chair. R2 stated she likes to cross her legs. During an observation and interview on 1/23/26 at 11:48 a.m., DON came to R2's room. R2 stated she did not want to wear the heel protector and DON explained she had a sore on her right heel and the heel protector helped to cushion and protect it. R2 was okay with having heel protector applied. Examined left and right knees; skin is blanchable, no redness. DON stated mechanical lift sheet is tucked on the side of her legs, and behind her, not under her legs. DON stated she had not been	F0686		

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F0686 SS = SQC-K	Continued from page 44 aware of the information at the bottom of Braden Scale until 1/22/26, and R2's score put her at high risk for pressure related injuries. R2's Wound Data Collection dated 1/23/26, identified right outer heel, initial data collection, scabbed area. Measured 1.7 cm x 1.7 cm. Upon assessment scab sloughed off and underlying tissue with no open area, skin pink, warm, and blanchable. R2's care plan dated 1/23/26, was updated to include supplement added for wound healing, crosses her legs when up in chair and bed at times, heel boots bilateral feet at all times, and mepilex covering bruised area on right lateral foot, assist to reposition twice a shift if R2 is in bed, recliner, wheelchair, or if observed leaning, resident can be non-compliant and does refuse to have staff apply at times, consult therapy for repositioning needs. During an observation on 1/26/26 at 9:02 a.m., R2 was in commons area by nurses station. Heel protectors on both heels, nothing between knees. During an observation on 1/26/26 at 10:43 a.m., R2 was lying in bed, heel protectors on both feet. The facility Pressure Ulcers policy reviewed 2/17/25, identified to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when necessary. Based on residents comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individuals clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Residents will receive appropriate assessments and services to promote and maintain skin integrity. If a residents clinical condition makes compromise of skin integrity clinically unavoidable, this information will be documented in the medical record. The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements revised 12/8/25, identified all residents will be identified for their risk of developing pressure ulcers using the Braden Scale for Predicting Pressure Sore Risk. Those residents determined at risk will have the Braden Scale completed weekly for the first four weeks following admission. RN will complete Braden Scale quarterly or	F0686		

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F0686 SS = SQC-K	Continued from page 45 when the resident has a change of condition that could affect risk of developing pressure ulcer. All residents will have a comprehensive skin inspection by a licensed nurse on admission/readmission to identify any skin issues present. A comprehensive assessment, which includes the Resident Assessment Instrument (RAI), will be completed by the licensed nurse evaluation the residents risk factors, skin condition, and nature of the pressure to which the resident may be subjected. A systematic skin inspection will be made daily by the NA's assigned to the residents at risk for skin breakdown. The NA is responsible to report findings to the licensed nurse. If a pressure ulcer is identified, cleanse the area prior to observations. RN's should record the type of wound and degree of tissue damage on the Wound RN Assessment (i.e. for a pressure ulcer, record the stage). The licensed nurse records the location of the area, measurements, and ulcer/wound characteristics on the Wound Data Collection. Notify physician of the ulcer and residents condition to obtain orders fro a treatment. Notify resident and/or family/representative of pressure ulcers, orders, and planned interventions. Dietary is notified by an alert that occurs when Wound Data Collection is signed and locked. IDT should determine any modifications that are necessary to a residents plan of care. Interventions should focus on physical, mental and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with resident goals. When a pressure ulcer is present, complete the Wound Data Collection daily, documentation should include the following: evaluation of the ulcer, evaluation of the status of the dressing, status of area surrounding the ulcer, presence of possible complication, whether pain is present. If the ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within 2-4 weeks. The pressure ulcer should be assessed/evaluated weekly and documented on the Wound RN Assessment.	F0686		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791	F791 Routine Emergency Dental What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1 /has received a comprehensive oral assessment. /Administrative /Assistant scheduled an appointment for R1 /to see the dentist. How will other residents, having the potential to be	02/25/2026

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F0791 SS = D	Continued from page 46 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review the facility failed to assist 1 of 3 residents (R1) who requested to be seen by the dentist. Findings include: R1's face sheet dated 1/20/26, identified diagnoses of paraplegia (paralysis of legs and lower body), type 2 diabetes,	F0791	Continued from page 46 affected by the same deficient practice, be identified? All residents have the potential to be affected by deficient practice. All residents were reviewed for the need for dental services. Administrative Assistant or designee has made a dental referral for all residents in need of dental services. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, nursing staff /were /re-educated /by /DNS or designee /regarding /proper notifications and procedures for dental /referrals. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee, will audit completed Dental Assessments for 10% of the population by visualizing residents oral/dental area, ensuring proper documentation, and referrals are made as needed. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. What is the date of completion? 2/25/2026	

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F0791 SS = D	Continued from page 47 R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, and no obvious or likely cavities or broken natural teeth. R1's Nursing Admit/Re-admit Data collection dated 8/11/25, identified R1 had no dentures or bridges, no natural teeth or tooth fragments, obvious or likely cavity or broken natural teeth. Additional comments identified R1 would like to pursue some dental care. During an interview on 1/23/26 at 2:41 p.m., R1 stated no one at the facility ever worked with him to make a dental appointment. R1 stated he had told clinical care leader registered nurse (CCLRN)-B at some point. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated she had completed R1's Nursing Admit/Re-admit Data. CCLRN-B stated county case workers manages R1 and it would be them or director of nursing (DON) that would have to approve a dental appointment, "It's not like they can just go in town here, it is a process" CCLRN-B could not articulate the process for a resident to get a dentist appointment if they requested. CCLRN-B was not sure who started the process to get R1 a dental appointment as he requested. CCLRN-B reviewed R1's record and was unable to find documentation that would identify any attempts to set up a dental visit. The facility Dental and Oral Care, Dental Health Assessment, Dental Services policy reviewed 4/6/25, identified the location provides or obtains from an outside source routine and 24-hour emergency dental services that meet professional standards and principles. Residents are assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures	F0791		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	F880 Infection Prevention and Control What corrective action will be accomplished for those residents found to have been affected by the deficient practice? IDT reviewed infection control concerns noted for R1 and R5. The same education provided to staff, as a part of our systemic changes below, will correct issue for noted residents.	02/25/2026

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F0880 SS = D	Continued from page 48 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 48 How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by deficient practice. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure practice does not recur the facility conducted an ad hoc QAPI meeting to review Infection Control Concerns and to analyze root causes for issues, including wound dressing changes, cross contamination, dirty to clean tasks, proper glove use, peri care, enhanced barrier precautions, and hand hygiene. Education was provided by DNS or designee to nursing staff regarding infection control during wound treatments regarding infection control practices, including cross contamination, dirty to clean tasks, proper glove use, peri care, catheter care, and sanitizing between glove changes. Location will provide hospice agency noted, with EBP education. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and sustained compliance, the Director of Nursing (DNS) or designee will conduct direct observation audits of infection control practices on a random sample of at least 10% of the resident population. Observations will include, but are not limited to, wound care procedures, prevention of cross contamination, adherence to clean-to-dirty task sequencing, appropriate glove use, peri-care, enhanced barrier precautions (EBP), catheter care, and proper hand hygiene. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. What is the date of completion? 2/25/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	705 SIXTH STREET , WINDOM, Minnesota, 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 49 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control practices for 2 of 3 residents (R1, R5) reviewed for infection control. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. During an observation and interview on 1/26/26 at 10:58 a.m., director of nursing (DON)-B and clinical care leader registered nurse (CCLRN)-B went to R1's room. Both sanitized hands, applied gowns and gloves and entered room. CCLRN-B moved R1's bed, locked the brakes on the bed, used the remote for the bed and raised the bed. Area for wound supplies was not disinfected prior to placing supplies. CCLRN-B then removed heel boot and DON-B removed dressing on lateral left foot. CCLRN-B painted wound with betadine. DON-B directed CCLRN-B to	F0880		

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F0880 SS = D	Continued from page 50 remove gloves and sanitize hands. CCLRN-B applied clean dressing. CCLRN-B removed left heel dressing, applied betadine to heel and toes. CCLRN-B opened gauze package, and placed gauze between toes. Both removed gloves and sanitized hands. Removed boot and dressings to right lateral foot and heel. CCLRN-B changed gloves but did not sanitize hands. CCLRN-B applied betadine to heel, opened and put on new mepilex. Removed gloves and dated mepilex. Both sanitized hands. Rolled to right side and CCLRN-B removed dressing on left buttock, removed gloves, sanitized and applied new gloves. CCLRN-B applied a mepilex to area. CCLRN-B began removing dressing to wound vacuum site. CCLRN-B grabbed the suction machine and moved it, removed gloves and put new gloves on without sanitizing hands. CCLRN-B cleaning blood that is flowing from wound onto mepilex dressing on left buttock. DON-B came to the other side of the bed and assessed the wound, went to the other side of the bed, and handed CCLRN-B the sterile wound dressing in package. CCLRN-B removed gloves, sanitized, put on new gloves. CCLRN-B removed ointment lid, put ointment on q-tip, applied to wound bed, put lid on ointment, took out black foam and drape from the package, began cutting the foam, placed foam in wound, removed foam from wound, gave DON-B the unused foam, threw away the one that was in the wound, took the foam from DON-B, began trimming it, put hand in gauze package and removed a handful and began sponging the blood that was dripping from wound, got more gauze from the package of gauze, put the foam on wound. CCLRN-B then removed gloves, sanitized, applied new gloves. CCLRN-B applying drape but it was sticking to both of their gloves. Applied drape, cut a slit in the drape for the suction to be applied. The suction tubing had fallen on the floor and secretions from inside the tube were coming out onto the floor. CCLRN-B removed the canister from the suction machine and threw it in the garbage. CCLRN-B stated there was drainage at the bottom of the drape and needed to put more drape on. CCLRN-B removed the suction, placed new drape and cut a new slit for the suction. CCLRN-B grabbed more gauze from the package and alcohol wipes to wipe the mepilex next to wound vacuum site that had blood on it. CCLRN-B moved the remote control that was behind R1’s back, grabbed the dirty wound supplies from the bed, threw in trashcan, removed gloves. Applied gloves without sanitizing and wiped the scissors with an alcohol wipe. DON-B removed gloves, sanitized and applied new gloves. CCLRN-B removed gloves, applied new gloves and went to R1’s supplies and got him a new colostomy bag as his had fallen off while rolling. DON-B cleaned the blood from the floor, and advised CCLRN-B that the gauze package would need to be thrown away due to contamination from dirty gloves. Both removed gloves,	F0880		

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F0880 SS = D	Continued from page 51 gown, and sanitized when leaving room. RN-B entered the room wearing gloves but not a gown. RN-B removed Intravenous (IV) medication from R1's IV site, wiped the site, flushed IV with solution, removed gloves and left room. RN-B did not sanitize hands or change gloves after removing medication and did not wear a gown while performing these cares on R1. DON-B stated there is more work that needs to be done with infection control and wound care. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. During an observation on 1/20/26 at 8:23 a.m., R5 was in his recliner. RN-A is in room, waiting for assistance. Both CCLRN-A and NA-A entered room to assist. RN-A advised both to apply gown and gloves before assisting R5 with cares. CCLRN-A and NA-A placed a mechanical lift sling behind R5 and transferred him to the commode. NA-A placed a brief on wheelchair, got wipes and cleaned bowels. NA-A kept the same gloves on, removed sling straps from machine, manipulated R5's legs to removed the sling, attached brief, moving catheter bag around with both hands, touching catheter tubing, grabbed foot pedals, sat R5 up in wheelchair, took a blanket from R5's bed, placed it on him, moved hair from her mouth, put catheter holder on R5's leg, moved mechanical lift from in front of R5, took garbage, left room, returned with same gloves on, moved mechanical lift to hallway, moved commode to end of bed, moved to side of bed, picked up a pillow from the floor, put it on the bed, went to R5's bathroom, opened garbage bag, put bag in trashcan, opened catheter cover, lifted blanket on R5, removed straps to catheter cover, got on knees, touched catheter tubing, wheelchair, readjusted blanket on R5, untied gown from	F0880		

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F0880 SS = D	Continued from page 52 neck area, removed gloves, sanitized hands. During an observation on 1/20/26 at 9:09 a.m., CCLRN-A began wound care on R5's legs wearing a gown and gloves. Removed snacks from a plastic chair in room and sat in chair. Removed heel protectors from feet and stated they were soaked in bodily fluids. Removed dressings from left leg. Using the same gloves, CCLRN-A washed wounds with normal saline, washed heel, dropped gauze on floor, picked up gauze, washed back of leg wound. Removed gloves and applied a new pair. Opened dressing and put on the chair he had previously occupied, without disinfecting the chair. Wrapped leg with dressing. Removed dressings on right leg. Removed gloves, sanitized, applied new gloves. Wiped top wound with gauze pad, folded pad, wiped another wound, took another gauze from package and continued to wipe leg, removed gloves, sanitized, replaced gloves. Wrapped leg with dressing, removed gloves and sanitized hands. During an observation on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A went to R5's room to assess wounds on buttocks. HN-A wore gloves but no gown when obtaining R5's vital signs. Licensed practical nurse (LPN)-B came in room with medications and fed them to R5 without a gown or gloves on. Both nurses applied gown and gloves. Rolled R5 towards the window, removed dressing to buttocks. LPN-A went to R5's drawer, removed dry wipes, went to bathroom and wet them with water from the sink, washed buttocks. Both nurses touched R5's buttocks. LPN-A applied cream to buttocks and placed dressing over wound. HN-A moved wound care supplies from overbed table. LPN-A got a catheter cover and placed on R5's catheter. Neither nurse removed gloves and sanitized hands between touching clean and dirty surfaces. During an interview on 1/20/26 at 1:18 p.m., NA-A stated gloves should be changed if soiled, when doing a different task, after wiping a resident, should not go in hall with gloves on. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated it was definitely an infection control issues with wearing dirty gloves. During an interview on 1/22/6 at 12:14 p.m., director of nursing (DON) stated following enhanced barrier precautions and infection control was confusing.	F0880		

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F0000	INITIAL COMMENTS On 1/16/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/26/26, and 1/27/26, an abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F686 when R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relief interventions to prevent further deterioration. The IJ began on 12/31/25, and the immediacy was removed on 1/27/26. The above findings constituted substandard quality of care, and an extended survey was conducted on 1/23/26. The following complaints were reviewed: H55583526C (2717316), H55582343C (2701954), and H55583526C (2715989) with deficiencies issued at: F550, F580, F657, F686, F791, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		02/25/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access	F0550	F550- Dignity What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	02/25/2026

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 reverse for further 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.

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

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F0550 SS = D	Continued from page 1 to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide dignity 2 of 3 residents (R5, R6) who were reviewed for dignity. Findings include: R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, and dementia. R5's quarterly MDS dated 10/30/25, identified R5 had moderate cognitive impairment, no behaviors, used a walker and wheelchair; needed moderate assistance with	F0550	Continued from page 1 Facility /immediately /place R5's catheter in a dignity bag and secured in a clean manner. /Facility leadership staff ensured R6's care was provided with dignity and privacy. / How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents /with foley catheters and those that /require /staff /assistance /with /cares /have the potential to be affected by deficient practice. DNS or designee /identified /all residents with catheters, ensured each resident has a /dignity /bag /intact. / What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, all nursing staff will be reeducated, by DNS or designee, /to /ensure all residents with catheters have a dignity cover in /place and /providing privacy and dignity with personal /cares. / How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To /monitor /performance and ensure ongoing compliance, DNS or designee will complete weekly observations of 10% of residents /with catheters to ensure dignity covers /are in place /and secured in a clean manner. /DNS or designee will complete weekly observations of 10% of residents who require /assistance /with cares to ensure privacy and dignity is provided during cares. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

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F0550 SS = D	Continued from page 2 dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations. R5's care plan dated 10/27/25, identified self-care deficits. Interventions included R5 could not walk, used mechanical lift for transfers, and required 1-2 staff to assist with toileting needs. R5's progress note dated 1/2/26, identified hospice nurse visited and placed a urinary catheter. During an observation and interview on 1/20/26 at 8:23 a.m., R5 was in his recliner chair. R5's urinary catheter collection bag was hanging on a garbage can next to recliner without a dignity cover. Registered nurse (RN)-A was in room and stated urinecollection bags need to be covered, facility uses dignity bags. "I don't like that it is on a trash can either". RN-A provided education to nursing assistant (NA)-A that urine collection bags cannot hang from garbage cans and a dignity bag must be provided to R5. During an observation and interview on 1/22/26 at 9:00 a.m., R5 was lying in bed. catheter bag was on floor in wash basin with no dignity cover. Licensed practical nurse (LPN)-B stated R5 was supposed to have a cover on his catheter bag. LPN-B went to R5's closet, pulled out a dignity bag, applied to R5's urine collection bag. During an interview on 1/20/26 at 1:18 p.m., NA-A stated urine collection bags should be covered for dignity, same thing for hanging them on trash cans, if someone would walk by they could see the urine in the bag. During an interview on 1/20/26 at 10:44 a.m., clinical care lead registered nurse (CCLRN)-A stated urine collection bags should be covered for dignity and should not hang off garbage cans, there is a pocket on the other side of the recliner where it could have gone. R6 R6's face sheet dated 1/20/26, identified diagnoses of anxiety disorder. R6's care plan dated 1/12/26, identified self-care deficits that required two staff for bed mobility. During an observation on 1/20/26 at 8:05 a.m., NA-B exited R6's without shutting the door and the privacy curtain drawn leaving R6 sitting on the edge of the bed with a brief on, secured around waist, and her pants	F0550		

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F0550 SS = D	Continued from page 3 pulled down to her knees while NA-C and NA-G provided support to keep R6 in the seated position. R6 was yelling “help!” During an interview on 1/20/26 at 10:34 a.m., NA-C and NA-G stated R6’s door should have been shut when she was sitting on the edge of her bed in a brief and pants at her knees. During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the door to be shut during cares. Sometimes, the door does not shut unless slammed and was unsure if the NA’s would have been able to get the curtain shut when performing cares on R6. DON expected covers on catheter bags. The facility purchased “a bunch” recently. DON was not sure if staff thought they were disposable, but they should not be thrown out unless ripped. The facility policy Resident Dignity revised 12/18/25, identified the IDT will assist all staff members in maintaining the dignity of every resident.	F0550		
F0580 SS = D	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); (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	F0580	F580- Notification of Changes What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Physician /and resident representative were /notified /of /R1s skin condition /and new treatments /by /DNS or designee. / How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with changes in skin condition and treatments have the potential to be affected by deficient practice. /The facility /identified /residents at risk /for /skin conditions, /as well as /those /with existing issues or /changes. /Physicians and resident representatives /were notified /of any new skin findings or treatment updates /by DNS or designee. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?	02/25/2026

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F0580 SS = D	Continued from page 4 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 interview and record review the facility failed to notify the physician and resident representative regarding changes to skin integrity and treatment orders for 1 of 3 residents (R1) reviewed for change in condition. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body). R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open	F0580	Continued from page 4 To ensure deficient practice will not recur, all nursing staff /will be /reeducated /regarding proper /physician and responsible party /notification /of /changes in /resident skin integrity and treatment changes. /Education was provided by /DNS or /Designee. / How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee will audit 10% of resident population who are at risk of change in condition to skin and potential changes in treatments /to ensure proper notifications /to MD and responsible parties. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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F0580 SS = D	Continued from page 5 and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum and not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included: • R1's Wound Data Collection dated 12/12/25, identified coccyx. Dressing present and intact. No drainage on the dressing. • R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of shearing injury. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or "wet wipes." Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin	F0580		

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F0580 SS = D	Continued from page 6 prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A [emergency contact] stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. During an interview on 1/22/26 at 12:14 p.m. director of nursing (DON) stated the facility received a call from the clinic that FM-A was upset about R1's wound and that she had not been notified of the wounds. FM-A had found out about the wounds from R1's girlfriend. Facility records did not have FM-A listed as emergency contact. Nurses should notify physician with any changes of resident condition. The facility Notification of Change policy revise 12/12/25, identified the facility must immediately inform the resident, consult with physician and notify resident representative a need to alter treatment significantly-a need to discontinue or change an existing form of treatment or to commence a new form of treatment.	F0580		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F0657	F657- Care Plan Timing and Revision What corrective action will be accomplished for those residents found to have been affected by the deficient	02/25/2026

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F0657 SS = E	Continued from page 7 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to update the care plan for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum	F0657	Continued from page 7 practice? DNS or Designee updated R1's care plan to reflect current skin conditions including pressure ulcers and pressure ulceration interventions. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents with pressure injuries or skin conditions have a potential to be affected by this deficient practice. Facility identified residents with pressure injuries or skin conditions and reviewed their care plans to ensure proper revisions are in place for identified residents. The audit and corrections were completed by DNS or designee. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, all licensed nurses received training on properly updating resident care plans to reflect current skin issues and interventions by Regional Clinical Services Director or designee. Facility initiated a new process of clinical oversight morning meetings occurring 7 days per week, where nursing leadership will ensure any skin condition changes are updated on resident care plans reflecting the current status of resident's condition. Nursing leadership was educated by Regional Clinical Services Director regarding the clinical oversight process. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee will audit 10% of residents with pressure ulcers or skin conditions, ensuring care plans reflect current status of resident condition. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations.	

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F0657 SS = E	Continued from page 8 assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed "…staging to be completed by an RN [registered nurse]….Important Note: "include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.", there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to avoid positioning on oxygen and indwelling urinary catheter tubing; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25. (however, updated on TAR 8/11/25). R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. R1 had new concerns of an ulceration to the urinary meatus	F0657	Continued from page 8 What is the date of completion? 2/25/2026	

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F0657 SS = E	Continued from page 9 (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage. R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the care plan to be followed and RN nurse leaders to update the care plan quarterly and with changes.	F0657		
F0686 SS = SQC-K	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.	F0686	F686- Treatment to Prevent/Heal Pressure Injuries What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents R1, /R2, R3, and R5 received comprehensive skin reassessments, and the physician was notified of any newly identified changes in condition. /New interventions were /initiated /and care plans were updated accordingly. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents at risk for skin integrity concerns have the potential to be affected by this deficient practice. /All /residents with a Braden Score of 18 or	02/25/2026

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F0686 SS = SQC-K	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to identify, comprehensively assess, monitor, and develop interventions to prevent/mitigate the risk of pressure ulcer development and/or deterioration for 4 of 4 residents (R1, R2, R3, R5). The facility's failure resulted in Immediate Jeopardy (IJ) for R1 when the facility failed to prevent and manage impaired skin integrity that progressed to bone and soft tissue infections which required hospitalization for treatment and management. The IJ began on 12/31/25 after R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relieving interventions to prevent further deterioration. The Administrator, director of nursing (DON), regional clinical services director, senior director, and clinical care lead registered nurse (CCLRN)-B were notified of the IJ on 1/22/26 at 1:34 p.m. The IJ was removed on 1/27/26 at 1:58 p.m., but non-compliance remained at the lower scope and severity level E, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. R1 R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet.	F0686	Continued from page 10 below received /a full skin assessment completed by /the /DNS /or /designee /. /Any changes in condition /were /promptly communicated to the physician, interventions and care plans /were /updated as needed. / What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure this deficient practice does not recur, the facility provided /education /to all licensed nursing staff on /policies and procedures related to Pressure ulcers; including comprehensive skin /inspections, daily and weekly observation and assessments, notification to family and providers, /dressing change techniques /including return demonstration, infection control during wound care, and other best /practice /expectations. Unlicensed nursing staff were provided education on /Monitoring skin and reporting changes /that they /observe /to a nurse. They were also provided with education on the importance of following /care planned interventions for skin integrity and /to find /the /care planned intervention on the Kardex. The facility /will /follow /policy /and procedure related to /wound /management. The system includes nursing leadership oversight of wound prevention, skin observations, /wound assessment /physician communication and care plan review, /with adjustments /to care plans /as needed. Wound progression will be /monitored /using a tracking tool /and /will be /utilized /and overseen by nursing leadership. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To /monitor /performance and ensure ongoing compliance, /the /DNS or /designee, /will audit completed skin observations by visualizing resident skin and reviewing documentation weekly, /for 10% of population weekly x4 /and /monthly x2. To /ensure competency of frontline /nursing staff /regarding /the /process /for wound management and wound care knowledge, (This includes routine monitoring, proper wound identification, physician notifications with /interventions /and care plan updates as needed.) the /DNS or designee will complete random	

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F0686 SS = SQC-K	Continued from page 11 R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed "…staging to be completed by an RN [registered nurse]….Important Note: "include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.", there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's Skin Observation dated 7/31/25, identified R1 had a bath and skin check was completed. The evaluation had no mention of the right heel wound as identified on 7/24/25. In review of R1's record between 7/24/25 through 8/3/25, the care plan was not revised to identify the heel wound and not revised until 8/4/25 with new pressure relieving interventions to prevent deterioration and new wound development. R1's progress note dated 8/1/25, identified R1 was transferred to the hospital. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to position oxygen and indwelling urinary catheter tubing appropriately; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's progress note dated 8/11/25, identified R1 returned from hospital. R1's Nursing Admit/Re-admit Data Collection dated 8/11/25, had the same instructions for documenting the wound as previous assessment dated 7/24/25. The assessment identified R1 had right heel wound with a description of dried blood area size of nickel, and sacrum slightly red. These areas were not measured, staged, or the surrounding skin condition identified. Despite the identification of new impaired skin	F0686	Continued from page 11 wound dressing change audits for 10% of population /of residents with wounds, /weekly x4 and monthly x2, /to /ensure proper wound dressing changes are /performed /with proper infection prevention protocols /being /followed. Results from audits will be discussed at QAPI committee meetings for further recommendations. / What is the date of completion? 2/25/2026	

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F0686 SS = SQC-K	Continued from page 12 integrity on R1's sacrum and the existing heel wound, there was no indication R1's care plan was revised with new pressure relieving/prevention interventions to address R1's sacral redness. R1's Treatment Administration Record (TAR) dated 8/11/25, identified for the nurse to acknowledge every shift: heel lift boots while in bed for heel protection and pressure reduction. Assess bony prominences, turn and reposition every 2 hours, protect skin and keep clean and dry, moisture barrier for incontinence, use lift pad. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. There is a 1.5-centimeter (cm) x 1.5 cm eschar (dry, dark scab) wound that was present on readmission. Surrounding skin is slightly pink. Mepilex applied to wound and off-loading boots to both feet. Referral made to local wound center. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25 (however updated on TAR 8/11/25). R1's Wound Clinic Visit Report dated 8/19/25, identified the wound on R1's right heel as stage 3 pressure ulcer. Wound measured 1.0 cm x 1.2 cm x 0.2 cm depth. No tunneling or undermining (pocket or shelf beneath skin) noted. Small amount of serosanguineous drainage noted. Wound margin is distinct with the outline attached to wound base. No granulation (new tissue growth) within the wound bed. A large amount (67-100%) of necrotic tissue within the wound bed including eschar and adherent slough. No probe to bone. The wound was debrided (removal of dead, infected, or damaged tissue) of eschar tissue and was not tolerated well. New wound measurements were 1.0 cm x 1.2 cm x 0.3 cm depth. Treatment included cleanse with normal saline, apply Iodosorb ointment to wound bed, avoid getting on surrounding skin. Cover with gauze sponge and tape. Prevalon boot at ALL times. Other non-wound condition instructions included buttocks looks okay, no need for Mepilex unless there is a concern, than may apply. In review of R1's record, despite the direction for R1 to have Prevalon boot (brand of off-loading boot) there was no indication the care plan was revised until 10/30/25 (however was on the TAR 8/11/26). Review of R1's wound clinic notes in conjunction with RN Wound Assessments and Skin Observations between 8/20/25 through 9/3/25, did not identify any impaired skin integrity to R1's buttocks/sacral/coccyx regions and or perineal areas.	F0686		

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F0686 SS = SQC-K	Continued from page 13 R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. Faxed physician regarding new pressure sore found on R1's right buttock. R1's record did not include a comprehensive assessment of R1's pressure ulcer to right buttock. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. Measured 0.8 cm x 0.4 cm x 0.2 cm depth. New orders for Santyl ointment in wound bed. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Measured 1.5 cm x 0.7 cm x 0.1 cm depth. Medium amount of serous (watery discharge) noted. Wound margin is flat and intact. No granulation within the wound bed and small amount of necrotic tissue within the wound bed. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage. R1's Skin Observation dated 9/12/25, indicated new wound development; left buttock-open area with current treatment of a Mepilex to area and right buttock open area with current treatment as barrier cream to area. In review of R1's record there was no indication these areas were comprehensively assessed nor evident a comprehensive assessment was completed for a turning and repositioning program, nor the care plan was revised with pressure relieving/prevention measures. R1's wound clinic notes, RN Wound Assessments and Skin Observations records were reviewed between 9/10/25 through 11/7/25. The Wound Clinic notes during this period identified on 9/10/25 a new wound on R1's urinary meatus stage 3 pressure ulcer which was comprehensively assessed and was documented as healed on 9/25/25; associated interventions for this wound included avoidance of briefs and use of undergarment	F0686		

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F0686 SS = SQC-K	Continued from page 14 pads only, which was recommended on 9/18/25 and reiterated on 10/2/25, at which time R1 was documented as wearing a brief despite prior recommendations. The left and right buttock skin impairments identified on Skin Observation form on 9/12/25 were not addressed by the wound clinic until 10/17/25, when the wound clinic determined the presence of partial thickness shearing injury; the shearing injury was subsequently documented as healed on 10/24/25. The right heel pressure ulcer was comprehensively assessed by the wound clinic beginning 9/18/25, with ongoing monitoring and treatment recommendations including strict offloading, and was documented as healed on 11/7/25. In contrast, the facility's RN Wound Assessments, progress notes, and Skin Observations did not include ongoing comprehensive assessments of R1's buttock wounds identified on 9/4/25 and 9/12/25 nor identify the urinary meatus pressure ulcer prior to wound clinic identification on 9/10/25 and reflected inconsistent wound identification with variable assessment details. R1's quarterly Braden Scale for Predicting Pressure Score Risk dated 10/30/25, identified R1 was at moderate risk for pressure ulcers. The assessment included an intervention guide, for moderate risk which suggested interventions of: frequent turning with a planned schedule, use foam wedges for thirty degree lateral positioning, pressure reduction support surfaces, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear*if other major risk factors present, advance to next level of risk. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. R1's Wound Clinic Visit Report dated 11/7/25, identified R1 was discharged from wound center today. R1's Skin Observation dated 11/11/25, identified no skin conditions observed. R1's interdisciplinary team (IDT) progress note dated 11/12/25, identified IDT met to review resident status. Followed by outside wound care services (sic-discharged	F0686		

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F0686 SS = SQC-K	Continued from page 15 on 11/7/25). R1 is to be up in chair for about two hours around mealtimes, “compliant, often refuses.” Diabetic boost taken for wound healing. New wounds seen on bottom and back, he can reposition himself but does not, a lot of the time. Monitoring these wounds. He needs much re-education on why these two new wounds are not healing (lack of repositioning, not getting out of bed.) mepilex on. these wounds are worsening. Using skin barrier to these areas. It is felt the buttock wound is due to the shearing, not pressure. He also has a wound on the penis where the catheter comes out. Silicone cream being used and ABD pads. In review of R1’s IDT progress notes from 9/30/25-1/14/26, the information and word structure remained almost identical. According to the Wound Clinic notes R1’s buttock wounds were healed on 10/24/25 and based on the R1’s skin records after 10/25/24 that identified coccyx wound/buttock skin impairment it could not be ascertained if the IDT notes were redundant since 9/30/25 or the wounds on and after 11/12/25 were “new” wounds. R1’s IDT progress note dated 11/18/25, was verbatim from progress note on 11/12/25 with no new information identified. R1’s progress note dated 11/18/25, identified R1 would not get out of bed this shift, nor would he take a bath. R1’s Skin Observation dated 11/20/25, identified shearing on left and right buttocks. No comprehensive assessment and/or additional information was included. R1’s care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1’s faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in	F0686		

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F0686 SS = SQC-K	Continued from page 16 groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's IDT progress note dated 11/26/25, was verbatim when compared to IDT progress notes dated 11/12/25 and 11/18/25 which included "R1 is to be up in chair for about two hours around mealtimes, "compliant, often refuses" During an interview on 1/22/26 at 8:51 a.m., NA-D stated a resident could refuse cares three times before they told the nurse. NA-D had worked with R1 since admission and R1 rarely refused cares. When R1 refused care, NA-D would go back later and R1 would always accept the cares offered. R1's record was reviewed which included Skin Observations, Wound Data Collections, and progress notes between 11/8/25 through 12/30/26. The skin observations identified inconsistent identification of the presence and location of wound (coccyx vs right and/or left buttocks) with no comprehensive assessment of the impaired skin integrity when identified. Skin Observation dated 12/5/25 identified pressure sore to coccyx, Observation on 12/12/26 identified no skin impairments, Observations dated 12/19/25, 12/29/25, and 12/30/25 described wound(s) on buttocks as shearing. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum but not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included:R1's Wound Data Collection dated 12/12/25, identified "coccyx." Dressing present and intact. No drainage on the dressing.R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of	F0686		

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F0686 SS = SQC-K	Continued from page 17 shearing injury or other wounds. R1's IDT progress note dated 12/24/25, was verbatim compared to IDT progress notes dated 11/12/25 and 11/18/25, and 11/26/25 with no new information added. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or wet wipes. Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/27/25, identified coccyx. Dressing present and intact. No drainage on dressing. Pink skin around dressing. Cleansed with wound cleanser, applied ABD pad, secured with tape. R1's Wound Data Collection dated 12/29/25, identified a new wound on R1's left lateral foot that measured 1.2 cm x 1.0 cm x 0.1 cm depth. Tan in color. Applied skin prep and covered with Mepilex. No other information was included. R1's Skin Observation dated 12/29/25, identified left and right buttock shearing. Cleansed area and covered with ABD pads secured with tape. Applied zinc oxide to reddened areas that were not open. R1's Skin Observation dated 12/30/25, right and left buttock shearing. Mepilex and ABD to areas. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. Nursing order dated 12/31/25-1/8/26 directed clean buttock area with soap and water or wet wipes. Cover each buttock with ABD pad and secure outer edges with tape. Apply zinc oxide to other areas that are red but not open daily.	F0686		

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F0686 SS = SQC-K	Continued from page 18 Skin Observations dated 1/2/26, 1/3/26, and 1/6/26 reflected variable identification of skin integrity. On 1/2/26, no skin conditions were observed. On 1/3/26, a small dark pressure area measuring 1.0 cm x 1.0 cm was identified on the left heel/lateral area, and skin prep and Mepilex were applied. On 1/6/26, no additional skin concerns were identified, and documentation noted ongoing daily treatment to the buttocks. During an interview on 1/20/26 at 2:40 p.m. with NA-C and NA-B present, nursing assistant (NA)-C stated R1 had the wounds on his buttocks prior to September. The buttocks had gotten progressively worse from the size of a nickel to the size of a quarter. NA-C was unable to articulate a time frame, for when the buttocks looked worse, but it was somewhere from two weeks to a month and a half ago. NA-B stated R1 refused to turn and reposition however, if staff re-approached when he refused to get out of bed that seemed to work. R1 would sometimes pull the wedge cushion out that helped him stay on his side when in bed. If R1 went to his recliner or wheelchair he would want to go back to bed after about 20 minutes. R1’s Wound Data Collection dated 1/7/26, initial data collection for left buttock wound, type of wound was not included. The wound measured 8.0 cm x 6.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 25% slough and 75% eschar. Minimum sanguineous drainage with no odor present. Wound edges were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1’s Wound Data Collection dated 1/7/26, initial data collection for right buttock wound, type of wound was not included. The wound measured 6.0 cm x 4.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 60% slough and 35% eschar. Moderate sanguineous drainage with no odor present. Wound margins were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1’s progress note dated 1/7/26 at 9:30 p.m., identified R1 stated he was “not feeling like himself”. Stated he was having chest/heart pain but mostly felt his heart hurt. Nitro administered and pain was 8/10 to begin and 2/10 after nitro given. R1’s progress note dated 1/8/26 at 10:12 a.m.,	F0686		

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F0686 SS = SQC-K	Continued from page 19 identified physician was notified for R1 having “heart hurting” and “pain going down back on left side.” Had good results from nitro the evening before. Verbal order to go to emergency department. At 12:55 p.m., returned from emergency room with no changes made to medications after electrocardiogram and x-ray obtained. During an interview on 1/20/26 at 2:46 p.m., RN-B stated she last worked with R1 on 1/7/26 and 1/8/26. When she changed the dressing on 1/8/26, there was not an odor to the wound, but had felt there had been an odor prior. The wound was red, moist, and the skin around was pink. There was an additional small wound just below the one that was the original pressure ulcer on the left side. RN-B informed clinical care lead RN (CCLRN)-B the left buttock was worse, it had spread and was bleeding; the right buttock was only reddened skin. RN-B did not work again until after R1 had been sent to the wound clinic on 1/13/26. On 1/21/26 at 10:09 a.m., RN-B stated CCLRN-B would always measure the wounds, sometimes do the wound care, notify the physician, and put the orders in the computer. Nurses would follow what the computer directed for orders. CCLRN-B was always the first person RN-B would go to with wound concerns as she was a wound care nurse prior to working at the facility. RN-B reviewed documentation on R1’s skin for December and January and noted the wounds had not been measured until 1/7/26. R1’s progress note dated 1/12/26 at 6:06 p.m., identified R1 complained of nausea. At 10:55 p.m., nausea was better but now complaints of headache. Medicated with as needed Tylenol. Has two appointments in the morning. R1’s progress note dated 1/13/26 at 1:08 p.m., identified wound clinic called and stated they sent R1 to the emergency department with fever, chills, and R1 would most likely be admitted. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. The wounds were classified as unstageable on right lateral foot, unstageable pressure ulcer to the gluteus, and stage 3 left ischium. The gluteus was very advanced and infected, so wound clinic sent R1 to the emergency department. CWNP-A saw R1 inpatient at the hospital from 1/14/26-1/17/26 and debrided the wound daily. The wound was to the bone	F0686		

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F0686 SS = SQC-K	Continued from page 20 when CWNP-A last saw it on 1/17/26. R1 was diagnosed with osteomyelitis, cellulitis, and soft tissue infection. Emergency department was suspicious of one but unable to officially diagnose until after MRI and MRI showed it went to the bone. R1 could die from these infections. R1's care plan was revised on 1/16/26 after R1 was admitted to the hospital on 1/13/26. The care plan identified R1 often refused repositioning and refused to get out of bed. Interventions included to educate R1/family of the possible outcomes of not complying with repositioning. Attempt non-pharmacological interventions including re-approach and report to nurse if refused a second time. During an interview on 1/22/26 at 10:42 am LPN-A stated R1 moved in bed with staff help. R1 was able to help by turning a little bit on his top half but he needed assistance of two people to get him on his side and staff performed most of the work. R1 was not on a turning and repositioning schedule, and staff would do cares in the morning and evening. Staff encouraged R1 to move to his recliner for meals but he would refuse a lot. Nurses were to chart when he refused. R1's hospital History and Physical records dated 1/17/26, indicated R1 was admitted to the hospital on 1/13/26 for a sacral decubitus ulcer and osteomyelitis of pelvis. MRI of pelvis with and without contrast was completed and showed osteomyelitis of the proximal coccygeal segment (bone infection near the tailbone) with likely anteriorly dislocated middle coccygeal segment (section tail bone shifted forward-can happen with long standing pressure, infection, or tissue breakdown in the area). Cellulitis within right pelvic sidewall and right medial buttocks (infection in nearby soft tissues of the pelvis and buttock area). R1 reported his girlfriend noticed the wound on approximately 1/10/26 and according to documentation facility had noted a sacral wound for approximately two weeks. R1 reported a couple of wounds to his heels which he had previously received treatment. There is a 2.5 cm x 2.5 cm lesion on lateral aspect of right foot with no significant erythema or discharge. Records indicated on 1/20/26 R1 remained in the hospital for ongoing treatment. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior to R1 being	F0686		

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F0686 SS = SQC-K	Continued from page 21 sent to the wound clinic. R1 remained in the hospital with cellulitis and osteomyelitis, he had debridement's, a wound vacuum to his buttock, possible sepsis and kidney failure. R1 could die "it is an avoidable wound they didn't tend to." During a follow-up interview on 1/22/26 at 10:05 a.m., CCLRN-B stated shearing was not a form of pressure. Interventions for R1 were in the care plan, but R1 refused to get out of bed. He was supposed to be up for meals. R1 could reposition himself and turn himself side to side in bed. R1 had a pressure-relieving mattress but if he wanted something that had more pressure relief, like an air mattress, it was up to R1 to contact the social worker or his case manager. Staff would reposition R1 to the wheelchair or recliner and that would distribute pressure in a different area. CCLRN-B had instructed R1 to move and get off his bottom various times. Pressure would be distributed to a different area if he got up in his wheelchair or recliner (did not articulate how long R1 could sit) and did not stay in his bed. R1 did go to a psychiatrist appointment in December 2025, but no interventions or suggestions for the care plan to help R1 with not refusing cares were discussed. R1's bottom was black and blue, always looked discolored and darker, and then it would heal. That was always something that was monitored. If skin was breaking down, a Mepilex would be appropriate but the facility did not have a large enough Mepilex, possibly related to payor concerns, so an ABD pad was used. Sometimes the mepilex and/or ABD were used just to protect the skin on his bottom. Nursing staff would always look for signs and symptoms of infection but CCLRN-B was unable to find documentation to that effect. CCLRN-B stated it would depend on the injury or what it looked like, she would monitor for a day or two, add orders in the medical record based off her experience from working at the wound clinic for three years. Typically, would communicate with physician when a wound changed and most of the time the physician would give a referral for the wound clinic. CCLRN-B acknowledged cleansing the buttock wounds with soap and water or wet wipes was not a standing order, but was unable to articulate the clinical rationale, physician authorization, or evidence-based standard supporting this practice. CCLRN-B stated she began the treatment of using hydrofera blue on R1's buttocks prior to getting orders from a physician. R1's hospital After Visit Summary dated 1/23/26, identified new orders for Intravenous medications ceftriaxone 50 milliliters every 24 hours, and daptomycin 600 milligrams for bone and joint infection;	F0686		

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F0686 SS = SQC-K	Continued from page 22 metronidazole 500 milligrams three times a day by mouth for osteomyelitis. During an observation and interview on 1/23/26 at 2:41 p.m., R1 returned to the facility from hospital around noon. R1 stated the facility had not provided education prior to hospitalization on the risks of not repositioning. “They about killed me; I have never been that sick.” R1 would like an air mattress on the bed but the facility told R1 an air mattress would make the wounds worse. R1 was positioned on his back in bed, and two wedge cushions were lying in the recliner. R1 had heel boots on bilateral heels and stated there was a wedge under his back. R1 stated he was supposed to be turned every two hours, and it had been past two hours. R1 would turn on his side if the staff came and helped him. R1 did not say if he ever refused position changes. During an observation on 1/26/26 at 9:02 a.m., R1 was sitting in a recliner in his room. Heel boots in place and air mattress on bed. During an interview on 1/26/26 at 10:15 a.m., RN-B could not find orders in R1’s medical record to change R1’s dressings, even though R1 returned to the facility on 1/23/26. RN-B alerted DON, RN-D, and DON-B. During an interview on 1/26/26 at 10:43 a.m., R1 was in bed, laying on his back. R1 stated staff had not done anything with his heels all weekend. Staff put the air mattress on his bed on 1/25/26 and staff would only put the wedges in if he told them too. During an observation and interview on 1/26/26 at 10:58 a.m., CCLRN-B and DON-B went to R1’s room to complete dressing changes. CCLRN-B stated the left lateral foot wound had been a blister prior to hospitalization, was “pretty much healed,” “looks really good, slightly open” and was not a pressure ulcer, but a diabetic wound. DON-B identified the area as partial thickness, barely open, pink, healthy tissue, slightly pink around wound with some edema, raised but that could be the bone that was raised. CCLRN-B painted the entire wound and surrounding tissue with betadine and stated the wound was not open on 1/23/26 when assessed. CCLRN-B stated the left heel was blanchable, normal pink colored skin. DON-B advised CCLRN-B to follow the current wound treatment order and update the physician on progress. Toenails on left foot were observed pressing into adjacent toes, creating indentations in the skin. Upon inquiry, CCLRN-B stated she was unaware of these skin conditions until identified during the observation. Gauze was placed between the toes to	F0686		

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F0686 SS = SQC-K	Continued from page 23 relieve pressure and CCLRN-B stated she would trim the toenails later. CCLRN-B stated prior to hospitalization the area on the right lateral side of the foot was a blister. DON-B stated the area was large, circular and dark colored inside and questioned if it was an unstageable pressure ulcer. DON-B stated it should be labeled as unstageable so the floor nurses would keep a better eye on it. DON-B did not see any blanching and that would be the other red flag for the area. CCLRN-B stated that was the weird thing, he got both of the blisters while wearing his heel boots. Measured the darkened area at 1.5 cm x 2.5 cm and noted a small open area at the top of the blister that measured 0.3 cm x 0.2 cm x 0.1 cm depth. CCLRN-B observed the right heel and stated it was blanchable, pink in color, and appeared healed. DON-B observed the right heel and stated it should be staged as a suspected deep tissue injury as it was slightly blue in color and unblanchable. R1 attempted to turn to his right side by himself and was unable to make the position change. Four briefs, a disposable chux pad, and a turn sheet were observed underneath R1. DON-B instructed CCLRN-B that excessive layers increase pressure and should be minimized. CCLRN-B described the left side wound as granulated with dry skin but would not identify a stage. DON-B examined the area and identified epithelialized, non-blanchable tissue, consistent with a healing stage 3 pressure ulcer, as the wound clinic had staged it at stage 3. CCLRN-B had applied adhesive foam over the wound to protect it from the wound vacuum; DON-B instructed that adhesives should not be placed on the wound and that Mepilex should be used instead. The wound vacuum tubing was positioned along the upper thigh with suction not applied directly to the wound. Upon removal of the dressing, the wound was observed to be actively bleeding. CCLRN-B stated she believed the wound was a stage 4 pressure ulcer and began cutting the wound vacuum foam into a narrow strip. DON-B stopped CCLRN-B and instructed that the foam must be cut to match the wound size, placed as one piece, and that suction should be applied directly to the foam at the wound site. Additional areas of impaired skin integrity were identified during the observation, including a red, raised area on the posterior thigh and a red area under the buttock crease, which CCLRN-B stated she was unaware of until identified during the observation. DON-B directed pressure-relief measures and initiation of data collection. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated physicians are notified of wounds on residents and nine out of ten times the physician would provide a referral for the residents to be seen by the wound	F0686		

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F0686 SS = SQC-K	Continued from page 24 clinic. Wound clinic would have weekly appointments with a resident until the wound was healed. Wound clinic would direct resident care including repositioning, non-weight bearing, air mattress, shoes, or whatever they would recommend. Wound clinic does not send dictation after appointments but will send orders and list important things the facility needs to do for residents. Facility would still complete weekly wound assessments with measurements while resident was followed at wound clinic. Nursing Admission/Readmission would be completed by CCLRN-B or DON. Wounds are assessed every day in some form, but measurements are done once a week. Any RN can do the measurements. CCLRN-B was unaware if audits were completed on comprehensive wound assessments. With R1, it was hard, sometimes it was shearing, and sometimes it would break into wounds. Staff would use barrier cream when they were not open. That is why the facility has Skin Observations and Wound Assessments, and only under Wound Assessments measurements would be included. Assessments should show that a wound is healing but R1's buttocks have always been an issue. CCLRN-B reviewed R1's medical record and identified on 12/29/25, it was charted shearing on right and left buttock, no measurement, cleansed, ABD and zinc applied to reddened areas. CCLRN-B stated measurements would only be done if there was a wound present; an assessment with measurements had been completed on 1/7/26 but was having a hard time finding other assessments that included measurements. R1 was able to position himself in bed. R1 would get explosive and angry at times and when R1 would refuse cares, NA's were educated to reapproach later. IDT, wound team, and physician were aware of R1's non-compliance. During an interview on 1/21/26 at 10:48 a.m., DON stated she was new to her position and started in September. DON was unaware of all the rules that needed to be followed for this corporation. DON had been unaware the facility had User Defined Assessments (UDA)'s for wounds that nurses were to fill out daily. DON began by making cheat sheets for the nurses with steps to make sure things are getting done appropriately and re-educated on the UDA's. All the nurses were learning together. Prompts to chart the UDA's were added in the TAR. On 1/16/25, IDT met and reviewed R1's medical record. While reviewing, DON wondered why R1 had not been on an air mattress prior to hospitalization but was not sure if he needed one and would have to evaluate the need after he returned from the hospital. IDT decided on 1/16/26, that both CCLRN-A and CCLRN- B would complete Weekly RN Assessments for wounds together. It began on 1/16/26, and we decided to continue doing it on Wednesdays to	F0686		

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F0686 SS = SQC-K	Continued from page 25 coincide with our weekly IDT meetings so any new information could be brought to the meeting. Also discussed how best the nurses could communicate important information to IDT and if they could put specific headers on the emails. Infection Preventionist (IP)-A runs the weekly IDT meeting and adds the progress note to resident charts. Nurse consultant had also done a chart audit and noted that education needed to be provided to IP-A on what the IDT progress note consisted of and that it could not be just copied and pasted from a previous note. DON reviewed R1's chart and determined the last physician order she could find for R1's bottom was from after his appointment with wound care on 11/7/25. Nurses can use their own judgement and add orders in the system prior to getting an order from a physician, that must have been what CCLRN-B did for R1's wound treatments. The IJ that began on 12/31/25, was removed on 1/27/26 at 1:58 p.m., when it was determined and verified the facility implemented the following: -R1 was assessed and care plan interventions updated to align with assessments and provider orders. completed 1/27/26. -charge nurses responsible for day-to-day Wound Assessments/data collection tools. Completed 1/25/26. -CCLRN's responsible for weekly wound care assessment, along with root cause analyzed by IDT weekly. -care plan development starts with admitting nurse. -care plan reviews done by MDS and CCLRN's quarterly and with any changes. -all residents with current skin issues reassessed on 1/22/26. All current wounds were reviewed, including history of wounds and are stable or healed with appropriate interventions in place. Care plans reviewed, and/or updated to ensure appropriate interventions are in place. Completed 1/27/26. -notification to physicians with current skin issues. Completed 1/26/27. -nursing staff educated on care plan, notification of change, skin assessment, pressure ulcer prevention, and documentation. Completed 1/25/26. -licensed nursing staff educated on documentation including required assessments, documentation guidelines, common wound etiologies and types,	F0686		

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F0686 SS = SQC-K	Continued from page 26 recognizing and staging wounds, best practices in wound treatment, nursing care, changes in condition, requirements of timely provider and family notification, and steps for staff to take when changes in condition occur. Completed 1/25/26. -NA's educated on care plans, skin assessment pressure ulcer prevention and documentation, documentation requirements including importance of daily skin observation and reporting any abnormal findings to a licensed nurse, instruction to find repositioning schedules on Kardex, change of condition and examples of change of condition. Completed 1/25/26. R3 R3's face sheet dated 1/20/26, identified diagnoses on 12/19/25, abrasion left lesser toe(s), generalized edema, unsteadiness on feet, and unspecified open wound of left lesser toe without damage to the nail. On 12/23/25, incomplete paraplegia, pressure ulcer of other site stage 2. On 12/30/25, non-pressure chronic ulcer of other part of the left foot with fat layer exposed. On 1/13/26, pressure ulcer of right heel unstageable, and non-presssure chronic ulcer of other part of left foot limited to breakdown of skin. R3's progress note dated 12/19/25, identified R3 admitted to facility due to wounds on left toes. R3's Nursing Admit/Re-Admit Data Collection dated 12/19/25, identified R3 had weak lower extremity movement, numbness/tingling identified for feet. Edema to left lower extremity and unable to palpate pedal pulse to left foot. Wounds described as left toes. The great toe and second toe have bandages in place. The 3rd-5th toes have dark spots noted at the tips of the toes. R3 had a history of healed pressure ulcers. No further other wound characteristics that wound include but not limited to type of wounds and measurements. R3's Braden Scale for Predicting Pressure Sore Risk dated 12/19/25, identified a score of 17, which was mild risk for pressure ulcer development. Braden Scale Reference Tool identified an Intervention Guide for mild risk (15-18): frequent turning, maximal remobilization, pressure-reduction support surfaces if bed or chair bound, protect heels, manage moisture, manage nutrition, manage friction and shear *if other major risk factors present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) advance to next level of risk. R3's care plan dated 12/19/25, identified potential for impairment to skin integrity related to being chair bound, and poor circulation evidenced by R3 stating	F0686		

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F0686 SS = SQC-K	Continued from page 27 that he has had pressure sores before. Interventions included provide pressure relieving mattress and pillows or heel protectors as needed. If needed apply heel protectors on at bedtime, off during the day. R3's physician orders dated 12/19/25, identified ankle foot orthoses (AFO) shoe brace on in AM, off at bedtime for foot drop, bilateral heels treatment: remove compression stockings, apply moisturizing lotion to heels at bedtime, check that foam boots are on heels and pillows under calves every night, compression socks on in AM, off at bedtime. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated her and DON completed all admissions at facility. She did R3's nursing admission, but CCLRN-A was the clinical care lead for R3. On admission, left great toe, second toe, third, fourth, and fifth toe had dark spots on them. R3 was referred to wound clinic. "Wherever he came from, he was seeing a wound clinic and we thought to just continue that locally". CCLRN-B was unable to find measurements for heels. CCLRN-B was unable to articulate if R3 admitted to facility with heel wound or if it was acquired after admission. R3's Skin Assessment dated 1/4/26, stated heels healing nicely but did not see any measurements. CCLRN-A would be better to talk to about R3. R3's Wound Clinic Visit Report dated 12/20/25, identified R3 came to clinic for left 2nd toe ulcer. Wound identified as unclassifiable. Measured 2.0 cm x 0.6 cm x 0.1 cm. ulcer base is 100% eschar. Loose eschar debrided as it was putting pressure on the ulcer base creating indentation revealing pink base. No tunnelling or undermining. Scant serous drainage. Periwound dry and intact. No erythema or warmth. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply iodosorb to wound bed, avoid getting on surrounding skin, sterile gauze sponge to cover. Betadine to small scabs on other toes of left foot. In review of R3's care plan/treatment order there was no indication the care plan revised and/or order transcribed into the facility's physician/nursing orders electronic health record system to identify may shower with protection but do not get dressings wet. R3's Skin Observation dated 12/21/25, identified no skin conditions observed. R3's admission MDS dated 12/23/25, identified R3 was cognitively intact, no behaviors or rejection of care,	F0686		

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F0686 SS = SQC-K	Continued from page 28 used a wheelchair for mobility, dependent for lower body dressing and putting on/taking off footwear, touching assistance to roll left to right, and transfer. R3 has a pressure ulcer, is at risk of developing pressure ulcers, has one or more unhealed pressure ulcers identified as two stage 2 pressure ulcers present on admission. Skin and ulcer treatments included pressure reducing device for chair and bed, pressure ulcer care, no turning/repositioning program, no nutrition/hydration, and no applications of dressing to feet were marked. R3's Wound RN Assessment dated 12/23/25, identified left foot great toe pressure ulcer stage 2 present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound RN Assessment dated 12/23/25, identified stage 2 pressure ulcer to second toe left foot present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound Data Collection dated 12/23/25, identified second toe left foot measured 0.8 cm x 1.0 cm x 0.1 cm. Dressing completed. The assessment did not identify the type of wound and no other characteristics were included. R3's Wound Data Collection dated 12/25/25, identified left second toe. Wound margins intact, pink. The assessment did not identify type of wound, no measurements, and no other wound characteristics. Treatment: left 4th toe: cleanse with wound cleanser, paint with betadine and cover with non-bordered foam dressing, secure with tape, change daily and as needed. Left foot (all toes): cleanse with wound cleanser, paint each toe with betadine, do daily at hour of sleep. R3's Wound Data Collection dated 12/26/25-12/28/25, and	F0686		

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F0686 SS = SQC-K	Continued from page 29 12/31/25, identified left second toe scabbed area. Wound margins intact, pink. No other wound characteristic were included. R3's Skin Observation dated 12/28/25, identified no skin conditions observed. R3's care plan dated,1/1/26, identified "potential" for pressure ulcer development related to impaired mobility and incontinence evidenced by poor Braden Scale. On 1/1/26, a focus of Admitted with stage 2 pressure ulcer on left great toe and second toe of left foot related to disease process of paraplegia and impaired mobility. New interventions added since care plan dated 12/19/25 included provide pressure redistributing mattress on bed and cushion in manual wheelchair, and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R3's Skin Observation dated 1/4/26, identified heels are healing nicely, follows wound weekly, currently no dressing to toe areas-no open areas at present. The observation did not include type of wound(s) and measurements nor additional wound characteristics. Furthermore in review of R1's record there was no previous assessment and no prior mention that R3 had wound(s) on his heels. R3's Wound Clinic Visit Report dated 1/6/26, identified R3 returned to clinic for left 2nd toe unclassified ulcer. Measured 0.3 cm x 0.6 cm x 0.1 cm. ulcer base is 100% dry eschar. Periwound dry and intact. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply betadine to area of eschar to wound bed, sterile gauze to cover. R3's record lacked orders to shower with protection and not get dressings we. R3's Wound RN Assessment dated 1/8/26, identified left toe(s) wound "non-pressure" The assessment did not specify which toe the wound was on. Healing process evidenced by area decreasing in size, no signs of infection noted at this time. Modifications to interventions included support surfaces and wound treatment. Measurement 0.5 x 0.5 cm scabbed area on toes on left foot. R3's Wound RN Assessment dated 1/8/26, identified left toes non-pressure wound. Area decreasing in size. No signs of infection noted at this time. 0.5 cm x 0.5 cm scabbed area on toes on left foot. R3's Wound Data Collection dated 1/1/26-1/14/26,	F0686		

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F0686 SS = SQC-K	Continued from page 30 identified left second toe wounds are covered. 1/2/26 scabbed area on toe is covered. 1/5/26 scabbed area on toe is covered. 1/7/26 wound is covered. 1/10/26 wound is closed. No bleeding or drainage noted. No dressing applied to area. 1/11/26 scabbed area. 1/12/26 nothing marked. 1/13/26 scabbed area noted.1/14/26 scabbed area on left second toe. R3's Wound Clinic Visit Report dated 1/13/26, identified R3 returned to clinic with left 2nd toe ulcer, right heel ulcer, and left great toe ulcer. Left 2nd toe currently classified as full thickness without exposed support structures. Wound margin is flat and intact, large pink granulation within wound bed. This wound is healed. Left great toe stage 3 pressure ulcer measured 0.1 cm x 0.1 cm x 0.1 cm. no tunneling or undermining noted. medium amount of serous drainage. Wound margin is distinct with the outline attached to wound base. Small amount of pink granulation within the wound bed, no necrotic tissue in wound bed. Unstageable pressure ulcer on right calcaneus (heel) measured 1.0 cm x 1.0 cm x 0.1 cm depth. No tunnelling or undermining, no drainage. Wound margin is flat and intact, no granulation within wound bed. Large amount of necrotic tissue within the wound bed including eschar. Plan: may shower with protection but do not get dressings wet. Prevalon boots to both feet when in bed. left great toe and 2nd toe cleanse with normal saline, apply betadine, cover with sterile gauze. Right heel cleanse with normal saline, apply betadine, cover with sterile gauze. The treatment was added to the physician orders in the treatment administration record (TAR), however, the record did not identify to shower with protection and not get dressings wet. In review of R1's record between 1/4/26 and 1/14/26, there were no comprehensive wound assessments completed between the assessment on 1/4/26 and the wound clinic assessment on 1/14/26. Additionally, despite the Skin Observation on 1/4/26 that indicated R3 had a wound to his "heels" and the wound clinic's identification of an unstageable pressure ulcer to R3's right heel, it was not evident R3's care plan was revised to address the pressure ulcer to R3's right heel or the shower instructions. R3's Skin Observation dated 1/14/26, identified treatment and monitoring to bilateral lower extremities ongoing. No other information documented including wound type. R3's IDT progress note dated 1/14/26, identified addendum to IDT note. Resident also has wounds to his feet for which he is seeing wound clinic. Right heel	F0686		

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F0686 SS = SQC-K	Continued from page 31 wound is painted with iodine and wrapped in gauze, left big toe and second toe have wounds. Monitoring. No other information documented including wound type. R3's Wound RN Assessment dated 1/15/26, identified left toe(s) wound non-pressure. Healing process evidenced by covered with new skin and are decreasing in size. No other information documented including wound type. R3's Wound RN Assessment dated 1/15/26, identified left toes non-pressure wound. Covered with new skin and decreasing in size. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/16/26, identified left toes very small areas of eschar noted on all toes, largest area measures 0.3 cm x 0.3 cm; smallest unable to measure; scabbed over-no drainage noted. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/17/26, identified left toes area covered on left great toe and 2nd digit, 3rd and 4th digit have areas that are covered in betadine, and no dressing over them. No complaints. No other information documented including wound type. R3's Wound Data Collection dated 1/18/26, identified left toes cleansed with betadine applied to scabbed areas and covered with gauze. No pain or discomfort. No other information documented including wound type and which toe(s). R3's Wound Clinic Visit Report dated 1/20/26, identified R3 returned to clinic for follow-up treatment to left great and 2nd toes, right heel ulcer. Left second toe full thickness wound, that was classified as healed on 1/13/26, measured 0.1 cm x 0.1 cm x 0.1 cm. large amount of necrotic tissue within the wound bed including eschar. No granulation in wound bed. stage 3 pressure ulcer on left great toe measured 0.1 cm x 0.1 cm x 0.1 cm. small amount of serosanguineous drainage. Large amount of necrotic tissue in wound bed including eschar. No granulation within the wound bed. unstageable pressure ulcer to right heel measured 1.0 cm x 1.0 cm x 0.1 cm depth. No drainage, no granulation within the wound bed. Large amount of necrotic tissue within the wound bed including eschar. Continue with current treatment to all wounds. During a phone interview on 1/21/26 at 9:43 a.m., CWNP-A stated R3 began at wound clinic on 12/30/25 with a left foot second toe ulcer; 1/6/26, R3 was again seen	F0686		

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F0686 SS = SQC-K	Continued from page 32 for the left foot second toe. On 1/13/26, left second toe healed, new pressure ulcer right heel, and left great toe. On 1/20/26, bilateral foot ulcers are dry and stable and left second toe and great toe measured 0.1 cm x 0.1 cm x 0.1 cm depth. Right heel pressure ulcer measure 1.0 cm x 1.0 cm. Review of medical record, the facility did not report the new ulcers to wound clinic and wounds were discovered between the 1/6/26 and 1/13/26 visit by wound clinic. R3's Wound Data Collection dated 1/20/26, identified left great toe eschar noted. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified wound name calcaneus right heel. Eschar noted. No drainage, denies pain. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified left second toe. Eschar noted on top of toe. Treatment done at wound clinic. No other information documented. R3's Wound Data Collection dated 1/22/25, identified right heel pressure ulcer measured 1.5 cm x 2.0 cm with no depth. 100% epithelized tissue to wound bed. Physician notified. No other information documented. R3's Wound Data Collection dated 1/22/25, identified left foot great toe pressure ulcer measured 0.3 cm x 0.5 cm with no depth. Left toes dark area. 100% eschar to wound bed. Modifications to interventions included support surfaces and wound management. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/22/25, identified left foot 2nd toe pressure ulcer. Left toes darkened area measured 0.6 cm x 0.7 cm, no depth. 100% eschar. Modifications to interventions included support surfaces and wound treatment. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/27/26, identified right heel no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink. No further information documented.	F0686		

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F0686 SS = SQC-K	Continued from page 33 R3's Wound Data Collection dated 1/27/26, identified left great toe no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink. No further information documented. R3's Wound Data Collection dated 1/27/26, identified left second toe scabbed, no open wounds noted, no drainage or bleeding, no pain. No further information documented. During an observation and interview on 1/20/26 at 7:54 a.m., R3 stated he had wounds on his toes and heels, nothing special he has to do for the wounds, "they" keep up with dressings. Stated he was going to an appointment at the wound clinic today. R3 was in a wheelchair, AFO, regular socks, and soft shoes on feet. Had a foot cradle on the end of his bed. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated NA's observe skin daily, nurses do weekly assessments during bathing. CCLRN-A and B complete the weekly RN Wound Assessments. Risk for pressure injury is determined by an individual's Braden score, mobility, how a resident transfers, and activity level. All residents are so unique, it is hard to say what model to follow. CCLRN-A did not clarify what model was meant. Interventions would change as needed if something came up. During a follow-up interview on 1/22/26 at 11:00 a.m., CCLRN-A stated R3 wore the bootie heel protectors, but was not sure if he had them since admission. He admitted with a stage 2 pressure ulcer of the left great toe and another toe. Did not admit with the right heel. R3 does have a foot cradle on his bed and that is not in his care plan. CCLRN-A stated the facility was working on better communication with the physician about sending weekly wound updates. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's quarterly MDS dated 10/30/25, identified R5 had moderate cognitive impairment, moderate hearing difficulty, usually understood, no behaviors, used a walker and wheelchair; needed moderate assistance with dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations; was at risk of developing pressure ulcers, did not have a pressure ulcer, had a pressure relieving device on bed	F0686		

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F0686 SS = SQC-K	Continued from page 34 and chair, application of nonsurgical dressing and ointments to places other than feet. R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. R5's physician order dated 12/8/25 directed for bilateral heel wound treatment: remove old dressings, cleanse with normal saline, apply Medi honey to open areas, cover with non-adherent telfa dressing, wrap with cast padding. Change every three days and as needed for excess drainage. Although the physician order that identified R1 had bilateral heel wounds, R5's record between 12/8/26 and 1/2/22 did not include any comprehensive assessments or documented monitoring of R5's heel wounds. R5's progress note dated 1/2/26, identified hospice nurse visited and placed catheter due to increased swelling to the scrotum and difficulties getting to the bathroom. Also having increased pain to left foot/leg. No further mention of location of pain and/or etiology. R5's progress note dated 1/2/26 at 11:11 p.m., identified R5 expressed pain when moving left lower extremity or raising the foot of recliner. Left lower leg dressing remained dry and intact, right lower extremity dressing changed once. Condition declining. R5's progress note dated 1/3/26, identified presence of edema about below his armpit level. Dressing to right lower extremity changed as scheduled for weeping clear fluids. R5's late entry progress note dated 1/5/26 at 11:47 a.m., identified new dressing orders obtained Unna boot (calamine/zinc roll to bilateral lower legs, followed by kerramax-extra absorbent dressing to right leg wound and areas of drainage, then coflex wrap as top layer. Change daily and as needed if drainage through	F0686		

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F0686 SS = SQC-K	Continued from page 35 dressing. Does complain of mainly left leg pain. R5's record reviewed between 1/5/26 through 1/26/26 identified R1 had extensive wounds that were not classified; however the record identified R1 had very edematous legs that were weeping. R5's physician ordered treatment that was dated 12/28/25 for R5's heels was discontinued on 1/6/26. R5's record did not identify another treatment order for the heels nor why the order was discontinued. In addition, based on the R5's record it could not be ascertained if the heel wounds had resolved. R5's physician order dated 1/7/26-1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "lower legs" and not feet or heels. R5's late entry progress note dated 1/7/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off, not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds. Monitoring. In review of R5's record between 12/28/25 through 1/14/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's late entry progress note dated 1/14/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Some	F0686		

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F0686 SS = SQC-K	Continued from page 36 progress seen to legs with initiation of una boot. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off, not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds plus the catheter. He also has a foley catheter now. Monitoring. In review of R5's record between 1/14/26 through 1/20/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's physician order dated 1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "legs" and not feet or heels. R5's progress note dated 1/17/26 at 2:40 p.m., identified dressings stayed dry this shift. At 4:08 p.m., legs were dry bilaterally with dressings intact. During an observation and interview on 1/20/26 at 8:23 a.m., R5 was on the commode and being transferred to a high-back wheelchair with a foam cushion on the seat and heel protectors on his feet. A dressing was on the right side of his bottom. When R1 was lifted off the commode there were small drops of blood on the commode The dressing was not changed, and NA-A was not able to ascertain where the blood came from. R5 yelled out in pain when staff wiped him with wet wipes he and was placed in the wheelchair. CCLRN-A stated R5 had sores on his legs, new one on scrotum, and a Mepilex on his bottom. CCLRN-A removed heel protectors and stated the heel protectors were soaked through with fluid from R5's legs. CCLRN-A described the right heel as an open area, black in the middle, on the bottom of the heel. When observing R5's right heel, the skin was also white consistent with maceration. CCLRN-A stated the skin is dry looking on his feet. When observing R5's left heel the skin was also white consistent with maceration with a small black spot consistent with eschar in the middle. When CCLRN cleaned the left heel wound blood was on the gauze but "the wound was not actively	F0686		

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F0686 SS = SQC-K	Continued from page 37 bleeding". Bilateral legs and feet were very edematous, R5 lightly placed his hand on his leg, removed it and the imprint of his hand remained for more than 2 minutes. CCLRN-A stated he was not the greatest at staging wounds. Since the heel protectors were soaked already, CCLRN-A did not think they would be a viable option for R5 to put back on. On 1/16/26, the Interdisciplinary Team (IDT) discussed switching things up and both CCLRN's would do wound care together to get better descriptions of wounds, not tie up the NA's, and keep the wound assessments consistent. A fair number of residents go to the wound clinic for treatments. In review of R5's record between 12/8/26 through 1/21/26, there was no indication R1 had impaired skin integrity to his right buttock nor was there a physician order for the Mepilex that was on R5's bottom during the observation on 1/20/26 at 8:23 a.m. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated R5 had a regular pressure relieving mattress on bed. R5 rarely went to bed because he would complain of shortness of breath, so he was always in recliner but did not use or have a pressure relieving cushion for the recliner. R5 would get up to reposition for meals into the high back wheelchair and then go back to the recliner. CCLRN-A explained a resident's risk for pressure ulcers was based off the Braden Score, mobility, how residents transfer, activity level-everything goes into determining it. If there were concerns identified when the assessments were completed, then the residents would be closely monitored and precautions put into place to reduce the risk. and if seeing concerns on some of those assessments either watch closely or precautions put in place. "Everyone is so unique, it is hard to say which model to follow." During an observation on 1/20/26 at 11:49 a.m., R5 was in his wheelchair, facing the fishtank, with his eyes closed. During an observation on 1/20/26 at 1:14 p.m., R5 was in his wheelchair in front of a table, with the fishtank on his left side, with his eyes closed. R5's progress note dated 1/20/26 at 4:29 p.m., identified R5 scooted down in recliner to the point the chair tipped forward and was resting on recliner part of chair. Will attempt trial of placing cushion from wheelchair into recliner to see if that will prevent R5 from scooting down in chair and placing too much weight on front of chair and tipping it forward. In review, R5's care plan was not revised to include the cushion	F0686		

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F0686 SS = SQC-K	Continued from page 38 to the recliner until 1/22/26, two days later. During an observation and interview on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A stated she received a call on 1/21/26 that R5's bottom was getting worse. LPN-B stated the facility was using a sacral Mepilex for treatment to the bottom, after leaving the room "to check the orders". LPN-B returned to R5's room and stated the order was for calmoseptine and sacral dressing to site. HN-A stated if the wound was not open, a Mepilex would be fine to put on but if it was open she would reach out to the physician for orders. LPN-B got dry wipes from drawer and wet them in sink to cleanse wound. HN-A stated there were open spots on both sides of R5's bottom and would classify them as stage 2 pressure ulcers. R5 winced and attempted to move away in pain when cleansing wounds. LPN-B stated the facility was using calmoseptine as a barrier cream to R5's bottom and read the bottle that stated it protects, soothes, and promotes healing skin. Applied to wound bed and surrounding skin. Placed a sacral Mepilex over wounds. Neither nurse was able to articulate how long R5 had the wounds on his buttocks. R5's care plan dated 1/22/26, identified an update of actual skin impairment to include open area to lower left rear leg on 1/19/26, open areas to right lower leg rear, left heel, right heel, left buttocks, and right buttocks. Interventions for skin impairment were updated to include turn and reposition in bed or chair every 2-3 hours, weekly skin observation by licensed nurse, check brief every 2-3 hours, provide cushion to recliner and wheelchair. In review of R1's record there was no indication of comprehensive assessment was completed to determine R5's skin tolerance to pressure over time, it could not be ascertained how the 2-3 hour repositioning scheduled was determined appropriate or sufficient to prevent further deterioration and/or new ulcer development. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to right heel that measured 3.0 cm x 2.5 cm x 0.1 cm depth. 100% eschar and surrounding skin intact and pink. Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to left heel that measured 4.0 cm x 3.5 cm x 0.1 cm depth. 100% eschar to wound bed. Surrounding skin pink and intact.	F0686		

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F0686 SS = SQC-K	Continued from page 39 Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed R5's Wound Data Collection and RN Assessment dated 1/22/26, identified pressure ulcer right buttock, did not identify a stage, measured 4.0 cm x 2.0 cm x 0.1 cm depth. 90% granulation tissue and 10% slough in wound bed. Minimum amount of drainage with 'other' selected as color and slight bleeding noted. Wound margins are intact and pink. Treatment was barrier cream applied and Mepilex placed. R5's Wound Data Collection dated 1/22/26, identified left buttock open area measured 5.0 cm x 4.5 cm x 0.1 cm depth. 100% granulation tissue in wound bed. Wound margins intact and pink. Barrier cream and Mepilex applied. During an interview on 1/22/26 at 11:00 a.m., CCLRN-A stated he had a note under his door on 1/21/26 from 1/20/26 that stated R5's bottom was open. Prior, it had only been red and the Mepilex was on for protection. CCLRN-A notified hospice on 1/21/26. Facility has been working on repositioning R5 every 2-3 hours. Staff were getting him up into the wheelchair for meals because he had been eating in his room. We began elevating his feet off ground with recliner which had mixed results as R5 can run buttons himself so he will put the reclining part back down. The facility worked with family and hospice to get him to go to his bed with his bottom starting to break down. For the moment, CCLRN-A had staff moving the foam, which was a little piece of foam, nothing significant, from his wheelchair to recliner, and will look for something better. CCLRN-A wanted to ask hospice about getting an air mattress and whatever else is necessary for feet. CCLRN-A tried the heel protectors, but they got soaked with fluid, so staff were directed to try a pillow to protect from moisture for the moment. The dressings to R5's legs have changed in the number of times they were changed each day and now they have started weeping again, R5's circulation has gotten really bad at this point, stuff has started opening back up on the calves.- During an observation on 1/23/26 at 10:17 a.m., R5 was at a table by the fishtank eating breakfast. During an observation on 1/26/26 at 10:38 a.m., R5 was laying in bed, no air mattress on bed, right foot is almost off the end of the bed. A follow-up email dated 1/27/26 at 1:52 p.m., DON	F0686		

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F0686 SS = SQC-K	Continued from page 40 stated she reviewed with hospice and an air mattress was ordered. R2 R2's face sheet dated 1/20/26, identified diagnoses of hemiplegia and hemiparesis. R2's quarterly MDS dated 10/24/25, identified R2 had moderate cognitive impairment, no behaviors, and had minimal difficulty with hearing but was able to understand and be understood. R1 was dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 had no pressure injuries and was not at risk of developing them. Treatments included pressure reducing device for chair and bed. R2's skin integrity care plan dated 1/28/25, identified R2 had potential impairment to skin integrity related to fragile skin on tailbone area, right hip, and lateral aspect right foot. Interventions dated 1/28/25 included Mepilex to tailbone/right foot area for protection as needed, monitor tailbone area and right hip for skin changes. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to health care provider, weekly skin observation by licensed nurse, and blue prevalon boot to right foot when in bed, assist to reposition every two hours or if observed leaning, pressure reduction mattress and waffle cushion in tilt/recline wheelchair, notify nurse immediately of any new areas of skin breakdown. R2's Skin Observation dated 1/3/26, identified right heel-outer right aspect of heel has "about" a 1.0 cm x 2.0 cm spongy, dark pressure area. Skin prep and mepilex applied. No further description was documented, not evident the care plan was revised with immediate pressure relieving interventions to prevent and/or reduce the risk of deterioration. Additionally, the physician notification was not completed until three days later on 1/6/26. R2's Wound Data Collection dated 1/6/26, initial data collection for lateral right heel that measured 0.75 cm x 1.5 cm. wound margins intact and pink. Looks like a bruise, slightly fluid filled, covered with Mepilex. R2's Wound RN Assessment was inconsistent with Data Collection. This document identified the impaired skin integrity as suspected deep tissue injury (not a bruise) and included interventions for repositioning/turning, support surfaces, friction/shear	F0686		

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F0686 SS = SQC-K	Continued from page 41 management, wound treatment. Continue with current treatment plan, and physician notified regarding wound status. R2's progress note dated 1/6/26, identified a fax was sent to physician regarding a suspected deep tissue injury on right lateral heel. Mepilex covering area for protection. R2 does not know how it happened and does not have any pain when asked about it. Asked for any additional interventions. Will continue to monitor. R2's Braden Scale for Predicting Pressure Score Risk dated 1/6/26, identified a score of 10. The Braden Scale Reference Tool for use in conjunction with Braden scale included an Intervention Guide: High Risk (score of 10-12) which included: frequent turning with a planned schedule, supplement with small shifts in position, pressure reduction support surface, use foam wedges for thirty degree lateral positioning, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. In review of R2's record between 1/3/26 through 1/14/26, there was no indication the care plan was revised to identify the suspected deep tissue injury and the interventions that were identified on the 1/6/26 assessments. R2's Skin Observation dated 1/7/26, identified no skin issues observed. R2's progress note dated 1/8/26, identified physician returned fax with orders to continue with mepilex and attempt to off-load pressure. In review of R2's record despite the physician ordered intervention there was no indication the care plan was revised to include the intervention to off-load pressure. R2's annual MDS dated 1/9/26, identified R2 had minimal difficulty with hearing but was able to understand and be understood, had moderate cognitive impairment, no behaviors, dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 has a pressure ulcer and is at risk of developing pressure ulcers. Pressure ulcer is identified as unstageable presenting as deep tissue injury. Treatments included pressure reducing devices for chairs, bed, and pressure ulcer care. R2 was not on a turning/repositioning program, no nutrition/hydration interventions to manage skin problems.	F0686		

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F0686 SS = SQC-K	Continued from page 42 R2's Wound Data Collection dated 1/13/26, identified right heel-mepilex in place. No measurements recorded. Surrounding tissue is pink and intact. Continues to be a dark, spongy, pressure area. R2's Skin Observation dated 1/14/26, identified right heel-lateral right heel. Faxed physician regarding status of bruised looking area. Looking less bruised and more pink/purple, lighter in the middle. Did note a pinpoint area in the middle of the bruised area but no drainage noted. R2's progress note dated 1/14/26, identified IDT met and reviewed the spot on right lateral heel. Sort of a pink/blue area, depends on positioning. It is not open or draining. Discussed possibility of evaluation at wound clinic and R2 shook her head "no". Daughter will be consulted. Monitoring. R2's ADL care plan dated 1/15/26, identified R2 had right sided weakness and required assistance with ADLs. Interventions included assist of two staff to position up in bed, one staff to turn side to side, two staff for transfers and toileting hygiene. The care plan included a focus area of deep tissue injury to right heel dated 1/15/26 with corresponding interventions included educate resident/family as to causes of skin breakdown including: transfer/positioning requirements, importance of taking care during ambulation/mobility, good nutrition and frequent repositioning. Provide pressure redistributing mattress on bed and cushion in scoot wheelchair, offload heels when in bed and chair. R2's Skin Observation dated 1/16/26, identified right heel-bruise. Covered with mepilex and put on an off-loading boot. Has an appointment at wound clinic on 1/20/26. No further wound characteristics were documented. R2's progress note dated 1/19/26, identified CCLRN-B notified daughter the "bruising" on R2's right heel was more reddish purple now compared to the black/blue before. The area is not soft and R2 does not complain of pain. Daughter requested to cancel wound clinic appointment. R2's Skin Observation dated 1/19/26, identified right heel-right lateral heel. Skin prep to heel and covered with mepilex, protective boot applied. R2 had no complaints of pain. Bruise area is less blueish/black and more purplish noting the center is fading in color. It is not soft to the touch. Has a piece of dry skin peeling off. No further wound characteristics were documented.	F0686		

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F0686 SS = SQC-K	Continued from page 43 During an observation on 1/20/26 at 10:25 a.m., R2 was in her room, sitting in a wheelchair with a pillow positioned on her right side. R2 leaned to the right with her right shoulder almost touching the armrest, right foot was on the floor with a heel protector on foot, not on foot pedal, left leg was crossed over right leg. During an interview on 1/22/26 at 10:05 a.m., CCLRN-B stated occupational therapy (OT) had evaluated R2 various times for right side lean. CCLRN-B indicated she was not familiar with R2's wounds or care because the director of nursing (DON) took was took over management of her care. During an interview on 1/22/26 at 10:51 a.m., NA-D stated R2 was repositioned every two hours. R2 liked to be on the right side. Staff attempted to put a pillow on the right side and one between the knees, along with the heel protector on the right foot. R2 tried to take the heel protector off but it was there to help the area not get worse. NA-D felt when R2 was in the wheelchair her heels would not touch the floor, so she was not at risk for pressure. Staff move R2 back and forth from wheelchair to recliner for position changes. R2 has a waffle cushion staff move back and forth from recliner to wheelchair. During an observation on 1/22/26 at 10:50 a.m., R2 was sitting in wheelchair in her room, leaning to right, arms bent and positioned with hands by neck on left side, heel protector on right heel, left leg crossed over right leg at knee. During an observation and interview on 1/23/26 at 11:44 a.m., R2 was sitting in a new wheelchair with a footboard attached at the foot pedals. Grippy socks on her feet, no heel protector on her right heel. Left leg crossed over the right leg at her knee. Mepilex on right heel. Mechanical lift sling was behind her in the wheelchair. Heel protector was on the recliner. Pressure relieving cushion in chair. R2 stated she likes to cross her legs. During an observation and interview on 1/23/26 at 11:48 a.m., DON came to R2's room. R2 stated she did not want to wear the heel protector and DON explained she had a sore on her right heel and the heel protector helped to cushion and protect it. R2 was okay with having heel protector applied. Examined left and right knees; skin is blanchable, no redness. DON stated mechanical lift sheet is tucked on the side of her legs, and behind her, not under her legs. DON stated she had not been	F0686		

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F0686 SS = SQC-K	Continued from page 44 aware of the information at the bottom of Braden Scale until 1/22/26, and R2's score put her at high risk for pressure related injuries. R2's Wound Data Collection dated 1/23/26, identified right outer heel, initial data collection, scabbed area. Measured 1.7 cm x 1.7 cm. Upon assessment scab sloughed off and underlying tissue with no open area, skin pink, warm, and blanchable. R2's care plan dated 1/23/26, was updated to include supplement added for wound healing, crosses her legs when up in chair and bed at times, heel boots bilateral feet at all times, and mepilex covering bruised area on right lateral foot, assist to reposition twice a shift if R2 is in bed, recliner, wheelchair, or if observed leaning, resident can be non-compliant and does refuse to have staff apply at times, consult therapy for repositioning needs. During an observation on 1/26/26 at 9:02 a.m., R2 was in commons area by nurses station. Heel protectors on both heels, nothing between knees. During an observation on 1/26/26 at 10:43 a.m., R2 was lying in bed, heel protectors on both feet. The facility Pressure Ulcers policy reviewed 2/17/25, identified to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when necessary. Based on residents comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individuals clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Residents will receive appropriate assessments and services to promote and maintain skin integrity. If a residents clinical condition makes compromise of skin integrity clinically unavoidable, this information will be documented in the medical record. The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements revised 12/8/25, identified all residents will be identified for their risk of developing pressure ulcers using the Braden Scale for Predicting Pressure Sore Risk. Those residents determined at risk will have the Braden Scale completed weekly for the first four weeks following admission. RN will complete Braden Scale quarterly or	F0686		

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F0686 SS = SQC-K	Continued from page 45 when the resident has a change of condition that could affect risk of developing pressure ulcer. All residents will have a comprehensive skin inspection by a licensed nurse on admission/readmission to identify any skin issues present. A comprehensive assessment, which includes the Resident Assessment Instrument (RAI), will be completed by the licensed nurse evaluation the residents risk factors, skin condition, and nature of the pressure to which the resident may be subjected. A systematic skin inspection will be made daily by the NA's assigned to the residents at risk for skin breakdown. The NA is responsible to report findings to the licensed nurse. If a pressure ulcer is identified, cleanse the area prior to observations. RN's should record the type of wound and degree of tissue damage on the Wound RN Assessment (i.e. for a pressure ulcer, record the stage). The licensed nurse records the location of the area, measurements, and ulcer/wound characteristics on the Wound Data Collection. Notify physician of the ulcer and residents condition to obtain orders fro a treatment. Notify resident and/or family/representative of pressure ulcers, orders, and planned interventions. Dietary is notified by an alert that occurs when Wound Data Collection is signed and locked. IDT should determine any modifications that are necessary to a residents plan of care. Interventions should focus on physical, mental and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with resident goals. When a pressure ulcer is present, complete the Wound Data Collection daily, documentation should include the following: evaluation of the ulcer, evaluation of the status of the dressing, status of area surrounding the ulcer, presence of possible complication, whether pain is present. If the ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within 2-4 weeks. The pressure ulcer should be assessed/evaluated weekly and documented on the Wound RN Assessment.	F0686		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791	F791 Routine Emergency Dental What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1 /has received a comprehensive oral assessment. /Administrative /Assistant scheduled an appointment for R1 /to see the dentist. How will other residents, having the potential to be	02/25/2026

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F0791 SS = D	Continued from page 46 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review the facility failed to assist 1 of 3 residents (R1) who requested to be seen by the dentist. Findings include: R1's face sheet dated 1/20/26, identified diagnoses of paraplegia (paralysis of legs and lower body), type 2 diabetes,	F0791	Continued from page 46 affected by the same deficient practice, be identified? All residents have the potential to be affected by deficient practice. All residents were reviewed for the need for dental services. Administrative Assistant or designee has made a dental referral for all residents in need of dental services. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure deficient practice will not recur, nursing staff /were /re-educated /by /DNS or designee /regarding /proper notifications and procedures for dental /referrals. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and ensure ongoing compliance, DNS or designee, will audit completed Dental Assessments for 10% of the population by visualizing residents oral/dental area, ensuring proper documentation, and referrals are made as needed. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. What is the date of completion? 2/25/2026	

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F0791 SS = D	Continued from page 47 R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, and no obvious or likely cavities or broken natural teeth. R1's Nursing Admit/Re-admit Data collection dated 8/11/25, identified R1 had no dentures or bridges, no natural teeth or tooth fragments, obvious or likely cavity or broken natural teeth. Additional comments identified R1 would like to pursue some dental care. During an interview on 1/23/26 at 2:41 p.m., R1 stated no one at the facility ever worked with him to make a dental appointment. R1 stated he had told clinical care leader registered nurse (CCLRN)-B at some point. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated she had completed R1's Nursing Admit/Re-admit Data. CCLRN-B stated county case workers manages R1 and it would be them or director of nursing (DON) that would have to approve a dental appointment, "It's not like they can just go in town here, it is a process" CCLRN-B could not articulate the process for a resident to get a dentist appointment if they requested. CCLRN-B was not sure who started the process to get R1 a dental appointment as he requested. CCLRN-B reviewed R1's record and was unable to find documentation that would identify any attempts to set up a dental visit. The facility Dental and Oral Care, Dental Health Assessment, Dental Services policy reviewed 4/6/25, identified the location provides or obtains from an outside source routine and 24-hour emergency dental services that meet professional standards and principles. Residents are assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures	F0791		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	F880 Infection Prevention and Control What corrective action will be accomplished for those residents found to have been affected by the deficient practice? IDT reviewed infection control concerns noted for R1 and R5. The same education provided to staff, as a part of our systemic changes below, will correct issue for noted residents.	02/25/2026

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F0880 SS = D	Continued from page 48 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 48 How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by deficient practice. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure practice does not recur the facility conducted an ad hoc QAPI meeting to review Infection Control Concerns and to analyze root causes for issues, including wound dressing changes, cross contamination, dirty to clean tasks, proper glove use, peri care, enhanced barrier precautions, and hand hygiene. Education was provided by DNS or designee to nursing staff regarding infection control during wound treatments regarding infection control practices, including cross contamination, dirty to clean tasks, proper glove use, peri care, catheter care, and sanitizing between glove changes. Location will provide hospice agency noted, with EBP education. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To monitor performance and sustained compliance, the Director of Nursing (DNS) or designee will conduct direct observation audits of infection control practices on a random sample of at least 10% of the resident population. Observations will include, but are not limited to, wound care procedures, prevention of cross contamination, adherence to clean-to-dirty task sequencing, appropriate glove use, peri-care, enhanced barrier precautions (EBP), catheter care, and proper hand hygiene. Audits will be completed weekly x4 and monthly x2. Results from audits will be discussed at QAPI committee meetings for further recommendations. What is the date of completion? 2/25/2026	

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F0880 SS = D	Continued from page 49 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control practices for 2 of 3 residents (R1, R5) reviewed for infection control. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. During an observation and interview on 1/26/26 at 10:58 a.m., director of nursing (DON)-B and clinical care leader registered nurse (CCLRN)-B went to R1's room. Both sanitized hands, applied gowns and gloves and entered room. CCLRN-B moved R1's bed, locked the brakes on the bed, used the remote for the bed and raised the bed. Area for wound supplies was not disinfected prior to placing supplies. CCLRN-B then removed heel boot and DON-B removed dressing on lateral left foot. CCLRN-B painted wound with betadine. DON-B directed CCLRN-B to	F0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 50 remove gloves and sanitize hands. CCLRN-B applied clean dressing. CCLRN-B removed left heel dressing, applied betadine to heel and toes. CCLRN-B opened gauze package, and placed gauze between toes. Both removed gloves and sanitized hands. Removed boot and dressings to right lateral foot and heel. CCLRN-B changed gloves but did not sanitize hands. CCLRN-B applied betadine to heel, opened and put on new mepilex. Removed gloves and dated mepilex. Both sanitized hands. Rolled to right side and CCLRN-B removed dressing on left buttock, removed gloves, sanitized and applied new gloves. CCLRN-B applied a mepilex to area. CCLRN-B began removing dressing to wound vacuum site. CCLRN-B grabbed the suction machine and moved it, removed gloves and put new gloves on without sanitizing hands. CCLRN-B cleaning blood that is flowing from wound onto mepilex dressing on left buttock. DON-B came to the other side of the bed and assessed the wound, went to the other side of the bed, and handed CCLRN-B the sterile wound dressing in package. CCLRN-B removed gloves, sanitized, put on new gloves. CCLRN-B removed ointment lid, put ointment on q-tip, applied to wound bed, put lid on ointment, took out black foam and drape from the package, began cutting the foam, placed foam in wound, removed foam from wound, gave DON-B the unused foam, threw away the one that was in the wound, took the foam from DON-B, began trimming it, put hand in gauze package and removed a handful and began sponging the blood that was dripping from wound, got more gauze from the package of gauze, put the foam on wound. CCLRN-B then removed gloves, sanitized, applied new gloves. CCLRN-B applying drape but it was sticking to both of their gloves. Applied drape, cut a slit in the drape for the suction to be applied. The suction tubing had fallen on the floor and secretions from inside the tube were coming out onto the floor. CCLRN-B removed the canister from the suction machine and threw it in the garbage. CCLRN-B stated there was drainage at the bottom of the drape and needed to put more drape on. CCLRN-B removed the suction, placed new drape and cut a new slit for the suction. CCLRN-B grabbed more gauze from the package and alcohol wipes to wipe the mepilex next to wound vacuum site that had blood on it. CCLRN-B moved the remote control that was behind R1's back, grabbed the dirty wound supplies from the bed, threw in trashcan, removed gloves. Applied gloves without sanitizing and wiped the scissors with an alcohol wipe. DON-B removed gloves, sanitized and applied new gloves. CCLRN-B removed gloves, applied new gloves and went to R1's supplies and got him a new colostomy bag as his had fallen off while rolling. DON-B cleaned the blood from the floor, and advised CCLRN-B that the gauze package would need to be thrown away due to contamination from dirty gloves. Both removed gloves,	F0880		

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Good Samaritan Society - Windom	705 SIXTH STREET , WINDOM, Minnesota, 56101

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F0880 SS = D	Continued from page 51 gown, and sanitized when leaving room. RN-B entered the room wearing gloves but not a gown. RN-B removed Intravenous (IV) medication from R1's IV site, wiped the site, flushed IV with solution, removed gloves and left room. RN-B did not sanitize hands or change gloves after removing medication and did not wear a gown while performing these cares on R1. DON-B stated there is more work that needs to be done with infection control and wound care. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. During an observation on 1/20/26 at 8:23 a.m., R5 was in his recliner. RN-A is in room, waiting for assistance. Both CCLRN-A and NA-A entered room to assist. RN-A advised both to apply gown and gloves before assisting R5 with cares. CCLRN-A and NA-A placed a mechanical lift sling behind R5 and transferred him to the commode. NA-A placed a brief on wheelchair, got wipes and cleaned bowels. NA-A kept the same gloves on, removed sling straps from machine, manipulated R5's legs to removed the sling, attached brief, moving catheter bag around with both hands, touching catheter tubing, grabbed foot pedals, sat R5 up in wheelchair, took a blanket from R5's bed, placed it on him, moved hair from her mouth, put catheter holder on R5's leg, moved mechanical lift from in front of R5, took garbage, left room, returned with same gloves on, moved mechanical lift to hallway, moved commode to end of bed, moved to side of bed, picked up a pillow from the floor, put it on the bed, went to R5's bathroom, opened garbage bag, put bag in trashcan, opened catheter cover, lifted blanket on R5, removed straps to catheter cover, got on knees, touched catheter tubing, wheelchair, readjusted blanket on R5, untied gown from	F0880		

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F0880 SS = D	Continued from page 52 neck area, removed gloves, sanitized hands. During an observation on 1/20/26 at 9:09 a.m., CCLRN-A began wound care on R5's legs wearing a gown and gloves. Removed snacks from a plastic chair in room and sat in chair. Removed heel protectors from feet and stated they were soaked in bodily fluids. Removed dressings from left leg. Using the same gloves, CCLRN-A washed wounds with normal saline, washed heel, dropped gauze on floor, picked up gauze, washed back of leg wound. Removed gloves and applied a new pair. Opened dressing and put on the chair he had previously occupied, without disinfecting the chair. Wrapped leg with dressing. Removed dressings on right leg. Removed gloves, sanitized, applied new gloves. Wiped top wound with gauze pad, folded pad, wiped another wound, took another gauze from package and continued to wipe leg, removed gloves, sanitized, replaced gloves. Wrapped leg with dressing, removed gloves and sanitized hands. During an observation on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A went to R5's room to assess wounds on buttocks. HN-A wore gloves but no gown when obtaining R5's vital signs. Licensed practical nurse (LPN)-B came in room with medications and fed them to R5 without a gown or gloves on. Both nurses applied gown and gloves. Rolled R5 towards the window, removed dressing to buttocks. LPN-A went to R5's drawer, removed dry wipes, went to bathroom and wet them with water from the sink, washed buttocks. Both nurses touched R5's buttocks. LPN-A applied cream to buttocks and placed dressing over wound. HN-A moved wound care supplies from overbed table. LPN-A got a catheter cover and placed on R5's catheter. Neither nurse removed gloves and sanitized hands between touching clean and dirty surfaces. During an interview on 1/20/26 at 1:18 p.m., NA-A stated gloves should be changed if soiled, when doing a different task, after wiping a resident, should not go in hall with gloves on. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated it was definitely an infection control issues with wearing dirty gloves. During an interview on 1/22/6 at 12:14 p.m., director of nursing (DON) stated following enhanced barrier precautions and infection control was confusing.	F0880		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/16/26, 1/20/26, 1/21/26, 1/22/26, 1/23/26, 1/26/26, and 1/27/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		02/25/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H55583526C (2717316), H55582343C (2701954), and H55583526C (2715989) with licensing orders issued at: 20260, 20265, 20555, 20830, and 20900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20260	Outside Resources CFR(s): MN Rule 4658.0075 If a nursing home does not employ a qualified professional person to furnish a specific service to be provided by the nursing home, the nursing home must have that service furnished to residents under a written agreement with a person or agency outside the nursing home. The written agreement must specify that	20260	corrected	02/25/2026

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20260	Continued from page 2 the service meets professional standards and principles that apply to professionals providing services in a nursing home, and that the service meets the same standards as required by this chapter. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review the facility failed to assist 1 of 3 residents (R1) who requested to be seen by the dentist. Findings include: R1's face sheet dated 1/20/26, identified diagnoses of paraplegia (paralysis of legs and lower body), type 2 diabetes, R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, and no obvious or likely cavities or broken natural teeth. R1's Nursing Admit/Re-admit Data collection dated 8/11/25, identified R1 had no dentures or bridges, no natural teeth or tooth fragments, obvious or likely cavity or broken natural teeth. Additional comments identified R1 would like to pursue some dental care. During an interview on 1/23/26 at 2:41 p.m., R1 stated no one at the facility ever worked with him to make a dental appointment. R1 stated he had told clinical care leader registered nurse (CCLRN)-B at some point. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated she had completed R1's Nursing Admit/Re-admit Data. CCLRN-B stated county case workers manages R1 and it would be them or director of nursing (DON) that would have to approve a dental appointment, "It's not like they can just go in town here, it is a process" CCLRN-B could not articulate the process for a resident to get a dentist appointment if they requested. CCLRN-B was not sure who started the process to get R1 a dental appointment as he requested. CCLRN-B reviewed R1's record and was unable to find documentation that would identify any attempts to set up a dental visit. The facility Dental and Oral Care, Dental Health Assessment, Dental Services policy reviewed 4/6/25, identified the location provides or obtains from an outside source routine and 24-hour emergency dental services that meet professional standards and principles. Residents are assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of	20260		

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20260	Continued from page 3 lost or damaged dentures SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	20260		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20265	Corrected	02/25/2026

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20265	Continued from page 4 Based on interview and record review the facility failed to notify the physician and resident representative regarding changes to skin integrity and treatment orders for 1 of 3 residents (R1) reviewed for change in condition. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body). R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum and not buttocks as described in the Skin Observations. Wound Data collections during this period were not	20265		

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20265	Continued from page 5 comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included: • R1's Wound Data Collection dated 12/12/25, identified coccyx. Dressing present and intact. No drainage on the dressing. • R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of shearing injury. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or "wet wipes." Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A [emergency contact] stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a	20265		

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20265	Continued from page 6 week prior. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. During an interview on 1/22/26 at 12:14 p.m. director of nursing (DON) stated the facility received a call from the clinic that FM-A was upset about R1's wound and that she had not been notified of the wounds. FM-A had found out about the wounds from R1's girlfriend. Facility records did not have FM-A listed as emergency contact. Nurses should notify physician with any changes of resident condition. The facility Notification of Change policy revise 12/12/25, identified the facility must immediately inform the resident, consult with physician and notify resident representative a need to alter treatment significantly-a need to discontinue or change an existing form of treatment or to commence a new form of treatment. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures related to notification of change in resident health status and who to notify. The Director of Nursing (or designee) should conduct measurable audits on residents health records to verify that change in health status is being completed and bring to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20265		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an	20555	corrected	02/25/2026

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20555	Continued from page 7 interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to update the care plan for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1’s face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1’s admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. R1’s Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed “…staging to be completed by an RN [registered nurse]….Important Note: “include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.”, there was no further information documented. R1’s care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. The care plan identified R1 required extensive assistance of one staff to turn from side to	20555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

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20555	Continued from page 8 side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to avoid positioning on oxygen and indwelling urinary catheter tubing; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25. (however, updated on TAR 8/11/25). R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. This wound was classified as stage 3 pressure ulcer at 3 o'clock. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage.	20555		

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20555	Continued from page 9 R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. During an interview on 1/22/26 at 12:14 p.m., director of nursing (DON) stated she expected the care plan to be followed and RN nurse leaders to update the care plan quarterly and with changes. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop a system to ensure a care plan is developed and updated to reflect each residents current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20555		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control practices for 2 of 3 residents (R1, R5) reviewed for infection control. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On	20830	corrected	02/25/2026

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20830	Continued from page 10 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. During an observation and interview on 1/26/26 at 10:58 a.m., director of nursing (DON)-B and clinical care leader registered nurse (CCLRN)-B went to R1's room. Both sanitized hands, applied gowns and gloves and entered room. CCLRN-B moved R1's bed, locked the brakes on the bed, used the remote for the bed and raised the bed. Area for wound supplies was not disinfected prior to placing supplies. CCLRN-B then removed heel boot and DON-B removed dressing on lateral left foot. CCLRN-B painted wound with betadine. DON-B directed CCLRN-B to remove gloves and sanitize hands. CCLRN-B applied clean dressing. CCLRN-B removed left heel dressing, applied betadine to heel and toes. CCLRN-B opened gauze package, and placed gauze between toes. Both removed gloves and sanitized hands. Removed boot and dressings to right lateral foot and heel. CCLRN-B changed gloves but did not sanitize hands. CCLRN-B applied betadine to heel, opened and put on new mepilex. Removed gloves and dated mepilex. Both sanitized hands. Rolled to right side and CCLRN-B removed dressing on left buttock, removed gloves, sanitized and applied new gloves. CCLRN-B applied a mepilex to area. CCLRN-B began removing dressing to wound vacuum site. CCLRN-B grabbed the suction machine and moved it, removed gloves and put new gloves on without sanitizing hands. CCLRN-B cleaning blood that is flowing from wound onto mepilex dressing on left buttock. DON-B came to the other side of the bed and assessed the wound, went to the other side of the bed, and handed CCLRN-B the sterile wound dressing in package. CCLRN-B removed gloves, sanitized, put on new gloves. CCLRN-B removed ointment lid, put ointment on q-tip, applied to wound bed, put lid on ointment, took out black foam and drape from the package, began cutting the foam, placed foam in wound,	20830		

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20830	Continued from page 11 removed foam from wound, gave DON-B the unused foam, threw away the one that was in the wound, took the foam from DON-B, began trimming it, put hand in gauze package and removed a handful and began sponging the blood that was dripping from wound, got more gauze from the package of gauze, put the foam on wound. CCLRN-B then removed gloves, sanitized, applied new gloves. CCLRN-B applying drape but it was sticking to both of their gloves. Applied drape, cut a slit in the drape for the suction to be applied. The suction tubing had fallen on the floor and secretions from inside the tube were coming out onto the floor. CCLRN-B removed the canister from the suction machine and threw it in the garbage. CCLRN-B stated there was drainage at the bottom of the drape and needed to put more drape on. CCLRN-B removed the suction, placed new drape and cut a new slit for the suction. CCLRN-B grabbed more gauze from the package and alcohol wipes to wipe the mepilex next to wound vacuum site that had blood on it. CCLRN-B moved the remote control that was behind R1's back, grabbed the dirty wound supplies from the bed, threw in trashcan, removed gloves. Applied gloves without sanitizing and wiped the scissors with an alcohol wipe. DON-B removed gloves, sanitized and applied new gloves. CCLRN-B removed gloves, applied new gloves and went to R1's supplies and got him a new colostomy bag as his had fallen off while rolling. DON-B cleaned the blood from the floor, and advised CCLRN-B that the gauze package would need to be thrown away due to contamination from dirty gloves. Both removed gloves, gown, and sanitized when leaving room. RN-B entered the room wearing gloves but not a gown. RN-B removed Intravenous (IV) medication from R1's IV site, wiped the site, flushed IV with solution, removed gloves and left room. RN-B did not sanitize hands or change gloves after removing medication and did not wear a gown while performing these cares on R1. DON-B stated there is more work that needs to be done with infection control and wound care. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's care plan dated 8/4/25, identified potential for pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin	20830		

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20830	Continued from page 12 breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. During an observation on 1/20/26 at 8:23 a.m., R5 was in his recliner. RN-A is in room, waiting for assistance. Both CCLRN-A and NA-A entered room to assist. RN-A advised both to apply gown and gloves before assisting R5 with cares. CCLRN-A and NA-A placed a mechanical lift sling behind R5 and transferred him to the commode. NA-A placed a brief on wheelchair, got wipes and cleaned bowels. NA-A kept the same gloves on, removed sling straps from machine, manipulated R5's legs to removed the sling, attached brief, moving catheter bag around with both hands, touching catheter tubing, grabbed foot pedals, sat R5 up in wheelchair, took a blanket from R5's bed, placed it on him, moved hair from her mouth, put catheter holder on R5's leg, moved mechanical lift from in front of R5, took garbage, left room, returned with same gloves on, moved mechanical lift to hallway, moved commode to end of bed, moved to side of bed, picked up a pillow from the floor, put it on the bed, went to R5's bathroom, opened garbage bag, put bag in trashcan, opened catheter cover, lifted blanket on R5, removed straps to catheter cover, got on knees, touched catheter tubing, wheelchair, readjusted blanket on R5, untied gown from neck area, removed gloves, sanitized hands. During an observation on 1/20/26 at 9:09 a.m., CCLRN-A began wound care on R5's legs wearing a gown and gloves. Removed snacks from a plastic chair in room and sat in chair. Removed heel protectors from feet and stated they were soaked in bodily fluids. Removed dressings from left leg. Using the same gloves, CCLRN-A washed wounds with normal saline, washed heel, dropped gauze on floor, picked up gauze, washed back of leg wound. Removed gloves and applied a new pair. Opened dressing and put on the chair he had previously occupied, without disinfecting the chair. Wrapped leg with dressing. Removed dressings on right leg. Removed gloves, sanitized, applied new gloves. Wiped top wound with gauze pad, folded pad, wiped another wound, took another gauze from package and continued to wipe leg, removed gloves, sanitized, replaced gloves. Wrapped leg with dressing, removed gloves and sanitized hands.	20830		

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20830	Continued from page 13 During an observation on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A went to R5's room to assess wounds on buttocks. HN-A wore gloves but no gown when obtaining R5's vital signs. Licensed practical nurse (LPN)-B came in room with medications and fed them to R5 without a gown or gloves on. Both nurses applied gown and gloves. Rolled R5 towards the window, removed dressing to buttocks. LPN-A went to R5's drawer, removed dry wipes, went to bathroom and wet them with water from the sink, washed buttocks. Both nurses touched R5's buttocks. LPN-A applied cream to buttocks and placed dressing over wound. HN-A moved wound care supplies from overbed table. LPN-A got a catheter cover and placed on R5's catheter. Neither nurse removed gloves and sanitized hands between touching clean and dirty surfaces. During an interview on 1/20/26 at 1:18 p.m., NA-A stated gloves should be changed if soiled, when doing a different task, after wiping a resident, should not go in hall with gloves on. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated it was definitely an infection control issues with wearing dirty gloves. During an interview on 1/22/6 at 12:14 p.m., director of nursing (DON) stated following enhanced barrier precautions and infection control was confusing. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit and train staff on appropriate infection control practices during cares and when in contact precaution rooms. The DON or designee could do weekly/monthly audits to determine compliance and bring findings to Quality Assurance Performance Improvement (QAPI) meetings. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20830		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	20900	corrected	02/25/2026

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20900	Continued from page 14 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to identify, comprehensively assess, monitor, and develop interventions to prevent/mitigate the risk of pressure ulcer development and/or deterioration for 4 of 4 residents (R1, R2, R3, R5) The facilities failure resulted in Immediate Jeopardy (IJ) for R1 when the facility failed to prevent and manage impaired skin integrity that progressed to bone and soft tissue infections which required hospitalization for treatment and management. The IJ began on 12/31/25 after R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relief interventions to prevent further deterioration. The Administrator, director of nursing (DON), regional clinical services director, senior director, and clinical care lead registered nurse (CCLRN)-B were notified of the IJ on 1/22/26 at 1:34 p.m. The IJ was removed on 1/27/26 at 1:58 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R1Based on observation, interview, and document review the facility failed to identify, comprehensively assess, monitor, and develop interventions to prevent/mitigate the risk of pressure ulcer development and/or deterioration for 4 of 4 residents (R1, R2, R3, R5). The facility's failure resulted in Immediate Jeopardy (IJ) for R1 when the facility failed to prevent and manage impaired skin integrity that progressed to bone and soft tissue infections which required hospitalization for treatment and	20900		

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20900	Continued from page 15 management. The IJ began on 12/31/25 after R1's existing buttock wound(s) were documented as black and blue tissue to the buttocks, with ongoing inconsistent identification of skin integrity and without completion of comprehensive wound assessments, physician notification, or implementation of effective treatment and pressure-relieving interventions to prevent further deterioration. The Administrator, director of nursing (DON), regional clinical services director, senior director, and clinical care lead registered nurse (CCLRN)-B /were notified of the IJ on 1/22/26 at 1:34 p.m. The IJ was removed on 1/27/26 at 1:58 p.m., but non-compliance remained at the lower scope and severity level E, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's face sheet dated 1/20/26, identified R1 admitted with diagnoses of paraplegia (paralysis of legs and lower body), pressure ulcer of right heel (diagnosis added 8/11/25), type 2 diabetes, and obesity. On 1/13/26, diagnoses of pressure ulcer of other site, pressure ulcer of unspecified, pressure ulcer of left buttock were included. R1's admission Minimum Data Set (MDS) dated 8/8/25, identified R1 had no cognitive impairments, no rejection of care, had an indwelling catheter and ostomy, had impairment on both sides of lower extremities, dependent for lower body care, maximum assistance to roll left and right, and dependent to transfer from surfaces. R1 was at risk of developing pressure ulcers/injuries but did not have any pressure ulcers and no open lesions. Treatments included pressure-reducing devices for chair and bed. R1 was not on a turning and reposition program, no nutrition or hydration interventions, and no dressing or treatments to feet. R1's Nursing Admit/Re-admit Data Collection dated 7/24/25, identified R1 had a right heel wound. Despite the instructions on the form that directed "…staging to be completed by an RN [registered nurse]….Important Note: "include the type of skin observation (blanchable or non-blanchable), size, color, odor or discharge in the description.", there was no further information documented. R1's care plan dated 7/25/25, did not identify a skin integrity focus nor identified R1 had a wound on his right heel. /The care plan identified R1 required extensive assistance of one staff to turn from side to side. R1 was able to assist by using the grab bars located on both sides of the bed. Dependent on two staff to transfer between surfaces using the mechanical lift. R1's Skin Observation dated 7/31/25, identified R1 had a bath and skin check was completed. The evaluation had no mention of the right heel wound as identified on 7/24/25. In review of R1's record between 7/24/25 through 8/3/25, the care plan	20900		

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20900	Continued from page 16 was not revised to identify the heel wound and not revised until 8/4/25 with new pressure relieving interventions to prevent deterioration and new wound development. R1's progress note dated 8/1/25, identified R1 was transferred to the hospital. R1's care plan dated 8/4/25, identified R1 had "potential" for pressure ulcer development related to dehydration, disease process, history of ulcers, and immobility. Interventions directed staff to avoid positioning on oxygen and indwelling urinary catheter tubing; Provide pressure redistributing mattress on bed and cushion on manual wheelchair; and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R1's progress note dated 8/11/25, identified R1 returned from hospital. R1's Nursing Admit/Re-admit Data Collection dated 8/11/25, had the same instructions for documenting the wound as previous assessment dated 7/24/25. The assessment identified R1 had right heel wound with a description of dried blood area size of nickel, and sacrum slightly red. These areas were not measured, staged, or the surrounding skin condition identified. Despite the identification of new impaired skin integrity on R1's sacrum and the existing heel wound, there was no indication R1's care plan was revised with new pressure relieving/prevention interventions to address R1's sacral redness. R1's Treatment Administration Record (TAR) dated 8/11/25, identified for the nurse to acknowledge every shift: heel lift boots while in bed for heel protection and pressure reduction. Assess bony prominences, turn and reposition every 2 hours, protect skin and keep clean and dry, moisture barrier for incontinence, use lift pad. R1's RN Wound Assessment dated 8/18/25, identified right heel unstageable pressure ulcer. There is a 1.5-centimeter (cm) x 1.5 cm eschar (dry, dark scab) wound that was present on readmission. Surrounding skin is slightly pink. Mepilex applied to wound and off-loading boots to both feet. /Referral made to local wound center. The wound assessment did not address the red sacrum identified on the 8/11/25 assessment and there was no indication the care plan was updated to reflect the off-loading boots until 10/30/25 (however updated on TAR 8/11/25). R1's Wound Clinic Visit Report dated 8/19/25, identified the wound on R1's right heel as stage 3 pressure ulcer. Wound measured 1.0 cm x 1.2 cm x 0.2 cm depth. No tunneling or undermining (pocket or shelf beneath skin) noted. Small amount of serosanguineous drainage noted. Wound margin is distinct with the outline attached to wound base. No granulation (new tissue growth) withing the wound bed. A large amount (67-100%) of necrotic tissue within the wound bed including eschar and	20900		

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20900	Continued from page 17 adherent slough. No probe to bone. The wound was debrided (removal of dead, infected, or damaged tissue) of eschar tissue and was not tolerated well. New wound measurements were 1.0 cm x 1.2 cm x 0.3 cm depth. Treatment included cleanse with normal saline, apply Iodosorb ointment to wound bed, avoid getting on surrounding skin. Cover with gauze sponge and tape. Prevalon boot at ALL times. /Other non-wound condition instructions included buttocks looks okay, no need for Mepilex unless there is a concern, than may apply. In review of R1's record, despite the direction for R1 to have Prevalon boot (brand of off-loading boot) there was no indication the care plan was revised until 10/30/25 (however was on the TAR 8/11/25). Review of R1's wound clinic notes in conjunction with RN Wound Assessments and Skin Observations between 8/20/25 through 9/3/25, did not identify any impaired skin integrity to R1's buttocks/sacral/coccyx regions and or perineal areas. R1's progress note dated 9/4/25, identified R1 had a new pressure sore to his right buttock. R1 had been refusing staff to get up in his chair at mealtimes per therapy. Explained the risks of not repositioning but R1 continued to refuse. Faxed physician regarding new pressure sore found on R1's right buttock. R1's record did not include a comprehensive assessment of R1's pressure ulcer to right buttock. R1's Wound Clinic Visit Report dated 9/10/25, identified the stage 3 pressure ulcer to right heel. Measured 0.8 cm x 0.4 cm x 0.2 cm depth. New orders for Santyl ointment in wound bed. R1 had new concerns of an ulceration to the urinary meatus (opening of the urethra) from his catheter. R1 reported he had reconstructive surgery to the area and had chronic issues with erosion (loss of epithelial tissue) of the glans (tip of penis) as a result of long-term catheter use. /This wound was classified as stage 3 pressure ulcer at 3 o'clock. Measured 1.5 cm x 0.7 cm x 0.1 cm depth. Medium amount of serous (watery discharge) noted. Wound margin is flat and intact. No granulation within the wound bed and small amount of necrotic tissue within the wound bed. Noted R1's incontinent brief was causing serious tension to the catheter that led to the breakdown. Repositioned the device that holds the catheter in place at the leg to the right leg. Brief removed in order to avoid further irritation to the skin and silicon barrier cream twice daily. /In review of R1's record there was no indication the care plan was revised to identify the presence of the new ulcer on the urinary meatus nor revised to address interventions pertaining to the urinary catheter placement and incontinent garment usage. R1's Skin Observation dated 9/12/25, indicated new wound development; left buttock-open area with current treatment of a Mepilex	20900		

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20900	Continued from page 18 to area and right buttock open area with current treatment as barrier cream to area. In review of R1's record there was no indication these areas were comprehensively assessed nor evident a comprehensive assessment was completed for a turning and repositioning program, nor evident the care plan was revised with pressure relieving/prevention measures. R1's wound clinic notes, RN Wound Assessments and Skin Observations records were reviewed between 9/10/25 through 11/7/25. The Wound Clinic notes during this period identified on 9/10/25 a new wound on R1's urinary meatus stage 3 pressure ulcer which was comprehensively assessed and was documented as healed on 9/25/25; associated interventions for this wound included avoidance of briefs and use of undergarment pads only, which was recommended on 9/18/25 and reiterated on 10/2/25, at which time R1 was documented as wearing a brief despite prior recommendations. The left and right buttock skin impairments identified on Skin Observation form on 9/12/25 were not addressed by the wound clinic until 10/17/25, when the wound clinic determined the presence of partial thickness shearing injury; the shearing injury was subsequently documented as healed on 10/24/25. The right heel pressure ulcer was comprehensively assessed by the wound clinic beginning 9/18/25, with ongoing monitoring and treatment recommendations including strict offloading, and was documented as healed on 11/7/25. In contrast, the facility's RN Wound Assessments, progress notes, and Skin Observations did not include ongoing comprehensive assessments of R1's buttock wounds identified on 9/4/25 and 9/12/25 nor identify the urinary meatus pressure ulcer prior to wound clinic identification on 9/10/25 and reflected inconsistent wound identification with variable assessment details. R1's quarterly Braden Scale for Predicting Pressure Score Risk dated 10/30/25, identified R1 was at moderate risk for pressure ulcers. The assessment included an intervention guide, for moderate risk which suggested interventions of: frequent turning with a planned schedule, use foam wedges for thirty degree lateral positioning, pressure reduction support surfaces, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear*if other major risk factors present, advance to next level of risk. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. R1's care plan dated 10/30/25, was revised to include use of heel boots/protective boots while in bed and received diabetic nutritional supplements twice daily for wound healing. The care plan did not address the wound clinic's directions for prevention/minimization of re-current pressure	20900		

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20900	Continued from page 19 injuries pertaining to the urinary catheter nor address interventions to prevention/minimization the risk of re-current shearing injuries to buttocks until 11/20/25. R1's Wound Clinic Visit Report dated 11/7/25, identified R1 was discharged from wound center today. R1's Skin Observation dated 11/11/25, identified no skin conditions observed. R1's interdisciplinary team (IDT) progress note dated 11/12/25, identified IDT met to review resident status. Followed by outside wound care services (sic-discharged on 11/7/25). R1 is to be up in chair for about two hours around mealtimes, "compliant, often refuses." Diabetic boost taken for wound healing. New wounds seen on bottom and back, he can reposition himself but does not, a lot of the time. Monitoring these wounds. He needs much re-education on why these two new wounds are not healing (lack of repositioning, not getting out of bed.) mepilex on. these wounds are worsening. Using skin barrier to these areas. It is felt the buttock wound is due to the shearing, not pressure. He also has a wound on the penis where the catheter comes out. Silicone cream being used and ABD pads. In review of R1's IDT progress notes from 9/30/25-1/14/26, the information and word structure remained almost identical. According to the Wound Clinic notes R1's buttock wounds were healed on 10/24/25 and based on the R1's skin records after 10/25/24 that identified coccyx wound/buttock skin impairment it could not be ascertained if the IDT notes were redundant since 9/30/25 or the wounds on and after 11/12/25 were "new" wounds. During an interview on 1/21/26 at 10:48 a.m., Infection Preventionist (IP)-A runs the weekly IDT meeting and adds the progress note to resident charts. Nurse consultant had also done a chart audit and noted that education needed to be provided to /IP-A on what the IDT progress note /consisted of and that it could not be just copied and pasted from a previous note. R1's IDT progress note dated 11/18/25, was verbatim from progress note on 11/12/25 with no new information identified. R1's progress note dated 11/18/25, identified R5 would not get out of bed this shift, nor would he take a bath. R1's Skin Observation dated 11/20/25, identified shearing on left and right buttocks. No comprehensive assessment and/or additional information was included. R1's care plan dated 11/20/25, identified R1 had shearing on his left and right buttock and is at risk for skin breakdown and shearing related to immobilization/chairbound/bedbound and used the total lift sling evidenced by open shearing areas on both left and right buttock. Interventions included to keep skin clean and dry. Use skin barrier cream to buttocks daily and protect these areas with a dressing	20900		

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20900	Continued from page 20 when open and draining. High risk for skin injury-use caution during transfers when using the sling being cautious to not quickly and forcefully place the sling under R1. Monitor for signs of shearing. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R1's faxed request to physician dated 11/21/25, identified FYI: R1 continued to have some shearing on buttocks off and on due to resident not wearing a brief as this causes other issues with skin breakdown in groin and penial area. Will continue to apply skin barrier cream to bottom when appropriate or cover with a coccyx mepilex if area is more open and drainage. Physician responded OK. R1's faxed request to physician dated 11/25/25, identified R1 was more depressed and refused to get out of bed which caused increased skin breakdown and open sores on his buttocks. Physician response was to get a psych consult. There was no indication R1's care plan was revised that addressed R1's refusals or repositioning program. R1's IDT progress note dated 11/26/25, was verbatim when compared to IDT progress notes dated 11/12/25 and 11/18/25 which included "R1 is to be up in chair for about two hours around mealtimes, "compliant, often refuses" During an interview on 1/22/26 at 8:51 a.m., NA-D stated a resident could refuse cares three times before they told the nurse. NA-D had worked with R1 since admission and R1 rarely refused cares. When R1 refused care, NA-D would go back later and R1 would always accept the cares offered. R1's record was reviewed which included Skin Observations, Wound Data Collections, and progress notes between 11/8/25 through 12/30/25. The skin observations identified inconsistent identification of the presence and location of wound (coccyx vs right and/or left buttocks) with no comprehensive assessment of the impaired skin integrity when identified. Skin Observation dated 12/5/25 identified pressure sore to coccyx, Observation on 12/12/25 identified no skin impairments, Observations dated 12/19/25, 12/29/25, and 12/30/25 described wound(s) on buttocks as shearing. R1's Wound Data Collections between 12/12/25 and 12/26/25 identified the area of impaired skin integrity was on R1's coccyx and/or coccyx/sacrum but not buttocks as described in the Skin Observations. Wound Data collections during this period were not comprehensive as none of these assessments included measurements nor included type of wound present. Examples from the record included: R1's Wound Data Collection dated 12/12/25, identified "coccyx." Dressing present and intact. No drainage on the dressing. R1's Wound Data Collection dated 12/16/25, identified wound location coccyx and the site was sacrum. Protective cream	20900		

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20900	Continued from page 21 applied after shower. Dressing present and intact. No drainage on dressing. R1's physician note dated 12/19/25, had no mention of shearing injury or other wounds. R1's IDT progress note dated 12/24/25, was verbatim compared to IDT progress notes dated 11/12/25 and 11/18/25, and 11/26/25 with no new information added. R1's nursing order dated 12/25/25-12/30/25, identified clean buttock area with soap and water or wet wipes. Apply a thin layer of zinc oxide to both buttock areas and cover each buttock with an ABD pad and secure the outer edge with tape daily. R1's Wound Data Collection dated 12/27/25, identified coccyx. Dressing present and intact. No drainage on dressing. Pink skin around dressing. Cleansed with wound cleanser, applied ABD pad, secured with tape. R1's Wound Data Collection dated 12/29/25, identified a new wound on R1's left lateral foot that measured 1.2 cm x 1.0 cm x 0.1 cm depth. Tan in color. Applied skin prep and covered with Mepilex. No other information was included. R1's Skin Observation dated 12/29/25, identified left and right buttock shearing. Cleansed area and covered with ABD pads secured with tape. Applied zinc oxide to reddened areas that were not open. R1's Skin Observation dated 12/30/25, right and left buttock shearing. Mepilex and ABD to areas. R1's Wound Data Collection dated 12/30/25, identified left buttock has shearing to area, right buttock has darkened area with redness surrounding it. Applied skin prep and covered with mepilex. R1's Skin Observation dated 12/31/25, identified right buttock shearing, left buttock shearing-black and blue tissue noted, left lateral foot-dried calloused area. Covered with ABD pads and secured with tape. Applied iodine to left lateral foot. In review of R1's records between 12/5/25 through 12/31/25, it was not evident the physician was notified of new wounds nor changes to treatment orders. Additionally, between 12/27/25 through 12/31/25 there was no indication R1's right and left buttock wounds and left lateral heel were comprehensively assessed. Nursing order dated 12/31/25-1/8/26 directed clean buttock area with soap and water or wet wipes. Cover each buttock with ABD pad and secure outer edges with tape. Apply zinc oxide to other areas that are red but not open daily. Skin Observations dated 1/2/26, 1/3/26, and 1/6/26 reflected variable identification of skin integrity. On 1/2/26, no skin conditions were observed. On 1/3/26, a small dark pressure area measuring 1.0 cm x 1.0 cm was identified on the left heel/lateral area, and skin prep and Mepilex were applied. On 1/6/26, no additional skin concerns were identified, and documentation noted ongoing daily treatment to the buttocks. During an interview on 1/20/26 at 2:40 p.m. with NA-C and NA-B present, nursing assistant (NA)-C	20900		

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20900	Continued from page 22 stated R1 had the wounds on his buttocks prior to September. The buttocks /had gotten progressively worse from the size of a nickel to the size of a quarter. NA-C was unable to articulate a time frame, for when the buttocks looked worse, but it was somewhere from two weeks to a month and a half ago. NA-B stated /R1 /refused to turn and reposition however, if staff re-approached when he refused to get out of bed that seemed to work. R1 /would /sometimes pull the wedge cushion out that helped him stay on his side when in bed. If /R1 /went to his recliner or wheelchair he would want to go back to bed after about 20 minutes. R1's Wound Data Collection dated 1/7/26, initial data collection for left buttock wound, type of wound was not included. The wound measured 8.0 cm x 6.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 25% slough and 75% eschar. Minimum sanguineous drainage with no odor present. Wound edges were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1's Wound Data Collection dated 1/7/26, initial data collection for right buttock wound, type of wound was not included. The wound measured 6.0 cm x 4.0 cm x 0.2 cm depth. Drainage present with a presence of possible complications described as eschar and slough present. Wound bed was 60% slough and 35% eschar. Moderate sanguineous drainage with no odor present. Wound margins were macerated and erythematous. Cleansed area with soap and water, covered with hydrofera blue, ABD pads secured with tape. R1's progress note dated 1/7/26 at 9:30 p.m., identified R1 stated he was "not feeling like himself". Stated he was having chest/heart pain but mostly felt his heart hurt. Nitro administered and pain was 8/10 to begin and 2/10 after nitro given. R1's progress note dated 1/8/26 at 10:12 a.m., identified physician was notified for R1 having "heart hurting" and "pain going down back on left side." Had good results from nitro the evening before. Verbal order to go to emergency department. At 12:55 p.m., returned from emergency room with no changes made to medications after electrocardiogram and x-ray obtained. During an interview on 1/20/26 at 2:46 p.m., RN-B stated she last worked with R1 on 1/7/26 and 1/8/26. When she changed the dressing on 1/8/26, there was not an odor to the wound, but had felt there had been an odor prior. The wound was red, moist, and the skin around was pink. There was an additional small wound just below the one that was the original pressure ulcer on the left side. RN-B informed clinical care lead RN (CCLRN)-B the left buttock was worse, it had spread and was bleeding; the right buttock was only reddened skin. RN-B did not work again until after R1	20900		

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20900	Continued from page 23 had been sent to the wound clinic on 1/13/26. On 1/21/26 at 10:09 a.m., RN-B stated CCLRN-B would always measure the wounds, sometimes do the wound care, notify the physician, and put the orders in the computer. Nurses would follow what the computer directed for orders. CCLRN-B was always the first person RN-B would go to with wound concerns as she was a wound care nurse prior to working at the facility. RN-B reviewed documentation on R1's skin for December and January and noted the wounds had not been measured until 1/7/26. R1's progress note dated 1/12/26 at 6:06 p.m., identified R1 complained of nausea. At 10:55 p.m., nausea was better but now complaints of headache. Medicated with as needed Tylenol. Has two appointments in the morning. R1's progress note dated 1/13/26 at 1:08 p.m., identified wound clinic called and stated they sent R1 to the emergency department with fever, chills, and R1 would most likely be admitted. During a phone interview on 1/20/26 at 1:41 p.m., certified wound nurse practitioner (CWNP)-A stated she knew R1 well and had followed his wound care from 8/19/25-11/7/25, when all wounds were healed. Wound clinic received a referral on 1/12/26 for pressure ulcer right lateral foot, left and right buttock pressure ulcers from facility. On 1/13/25, R1 came to the wound clinic. The wounds were classified as unstageable on right lateral foot, unstageable pressure ulcer to the gluteus, and stage 3 left ischium. The gluteus was very advanced and infected, so wound clinic sent R1 to the emergency department. CWNP-A saw R1 inpatient at the hospital from 1/14/26-1/17/26 and debrided the wound daily. The wound was to the bone when CWNP-A last saw it on 1/17/26. R1 was diagnosed with osteomyelitis, cellulitis, and soft tissue infection. Emergency department was suspicious of one but unable to officially diagnose until after MRI and MRI showed it went to the bone. R1 could die from these infections. R1's care plan was revised on 1/16/26 after R1 was admitted to the hospital on 1/13/26. The care plan identified R1 often refused repositioning and refused to get out of bed. Interventions included to educate R1/family of the possible outcomes of not complying with repositioning. Attempt non-pharmacological interventions including re-approach and report to nurse if refused a second time. During an interview on 1/22/26 at 10:42 am LPN-A stated R1 moved in bed with staff help. R1 was able to help by turning a little bit on his top half but he needed assistance of two people to get him on his side and staff performed most of the work. R1 was not on a turning and repositioning schedule, and staff would do cares in the morning and evening. Staff encouraged R1 to move to his recliner for meals but he would refuse a lot. Nurses were to chart when he refused. R1's	20900		

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20900	Continued from page 24 hospital History and Physical records dated 1/17/26, indicated R1 was admitted to the hospital on 1/13/25 for a sacral decubitus ulcer and osteomyelitis of pelvis. MRI of pelvis with and without contrast was completed and showed osteomyelitis of the proximal coccygeal segment (bone infection near the tailbone) with likely anteriorly dislocated middle coccygeal segment (section tail bone shifted forward-can happen with long standing pressure, infection, or tissue breakdown in the area). Cellulitis within right pelvic sidewall and right medial buttocks (infection in nearby soft tissues of the pelvis and buttock area). R1 reported his girlfriend noticed the wound on approximately 1/10/26 and according to documentation facility had noted a sacral wound for approximately two weeks. R1 reported a couple of wounds to his heels which he had previously received treatment. There is a 2.5 cm x 2.5 cm lesion on lateral aspect of right foot with no significant erythema or discharge. Records indicated on 1/20/25 R1 remained in the hospital for ongoing treatment. During a phone interview on 1/20/26 at 1:47 p.m. family member (FM)-A stated the facility had yet to tell her that R1 had a wound on his buttocks. FM-A found out about the wound after a text message was sent from R1's visitor, who discovered the severity of the wound, while assisting R1 with cares a week prior to R1 being sent to the wound clinic. R1 remained in the hospital with cellulitis and osteomyelitis, he had debridement's, a wound vacuum to his buttock, possible sepsis and kidney failure. R1 could die "it is an avoidable wound they didn't tend to." During a follow-up interview on 1/22/26 at 10:05 a.m., CCLRN-B stated shearing was not a form of pressure. Interventions for R1 were in the care plan, but R1 refused to get out of bed. He was supposed to be up for meals. R1 could reposition himself and turn himself side to side in bed. R1 had a pressure-relieving mattress but if he wanted something that had more pressure relief, like an air mattress, it was up to R1 to contact the social worker or his case manager. Staff would reposition R1 to the wheelchair or recliner and that would distribute pressure in a different area. CCLRN-B had instructed R1 to move and get off his bottom various times. Pressure would be distributed to a different area if he got up in his wheelchair or recliner (did not articulate how long R1 could sit) and did not stay in his bed. R1 did go to a psychiatrist appointment in December 2025, but no interventions or suggestions for the care plan to help R1 with not refusing cares were discussed. R1's bottom was black and blue, always looked discolored and darker, and then it would heal. That was always something that was monitored. If skin was breaking	20900		

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20900	Continued from page 25 down, a Mepilex would be appropriate but the facility did not have a large enough Mepilex, possibly related to payor concerns, so an ABD pad was used. Sometimes the mepilex and/or ABD were used just to protect the skin on his bottom. Nursing staff would always look for signs and symptoms of infection but CCLRN-B was unable to find documentation to that effect. CCLRN-B stated it would depend on the injury or what it looked like, she would monitor for a day or two, add orders in the medical record based off her experience from working at the wound clinic for three years. Typically, would communicate with physician when a wound changed and most of the time the physician would give a referral for the wound clinic. /CCLRN-B acknowledged cleansing the buttock wounds with soap and water or wet wipes was not a standing order, /but was unable to articulate the clinical rationale, physician authorization, or evidence-based standard supporting this practice. /CCLRN-B stated she began the treatment of using hydrofera blue on R1's buttocks prior to getting orders from a physician. R1's hospital After Visit Summary dated 1/23/26, identified new orders for Intravenous medications ceftriaxone 50 milliliters every 24 hours, and daptomycin 600 milligrams for bone and joint infection; metronidazole 500 milligrams three times a day by mouth for osteomyelitis. During an observation and interview on 1/23/26 at 2:41 p.m., R1 returned to the facility from hospital around noon. R1 stated the facility had not provided education prior to hospitalization on the risks of not repositioning. "They about killed me; I have never been that sick." R1 would like an air mattress on the bed but the facility told R1 an air mattress would make the wounds worse. R1 was positioned on his back in bed, and two wedge cushions were lying in the recliner. R1 had heel boots on bilateral heels and stated there was a wedge under his back. R1 stated he was supposed to be turned every two hours, and it had been past two hours. R1 would turn on his side if the staff came and helped him. /R1 did not say if he ever refused position changes. During an observation on 1/26/26 at 9:02 a.m., R1 was sitting in a recliner in his room. Heel boots in place and air mattress on bed. During an interview on 1/26/26 at 10:15 a.m., RN-B could not find orders in R1's medical record to change R1's dressings, even though R1 returned to the facility on 1/23/26. RN-B alerted DON, RN-D, and DON-B. During an interview on 1/26/26 at 10:43 a.m., R1 was in bed, laying on his back. R1 stated staff had not done anything with his heels all weekend. Staff put the air mattress on his bed on 1/25/26 and staff would only put the wedges in if he told them too. During an observation and interview on 1/26/26 at 10:58 a.m., CCLRN-B and DON-B went to R1's room to complete dressing changes. CCLRN-B stated the	20900		

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20900	Continued from page 26 left lateral foot wound had been a blister prior to hospitalization, was “pretty much healed,” “looks really good, slightly open” and was not a pressure ulcer, but a diabetic wound. DON-B identified the area as partial thickness, barely open, pink, healthy tissue, slightly pink around wound with some edema, raised but that could be the bone that was raised. CCLRN-B painted the entire wound and surrounding tissue with betadine and stated the wound was not open on 1/23/26 when assessed. CCLRN-B stated the left heel was blanchable, normal pink colored skin. DON-B advised CCLRN-B to follow the current wound treatment order and update the physician on progress. Toenails on left foot were observed pressing into adjacent toes, creating indentations in the skin. Upon inquiry, CCLRN-B stated she was unaware of these skin conditions until identified during the observation. Gauze was placed between the toes to relieve pressure and CCLRN-B stated she would trim the toenails later. CCLRN-B stated prior to hospitalization the area on the right lateral side of the foot was a blister. DON-B stated the area was large, circular and dark colored inside and questioned if it was an unstageable pressure ulcer. DON-B stated it should be labeled as unstageable so the floor nurses would keep a better eye on it. DON-B did not see any blanching and that would be the other red flag for the area. CCLRN-B stated that was the weird thing, he got both of the blisters while wearing his heel boots. Measured the darkened area at 1.5 cm x 2.5 cm and noted a small open area at the top of the blister that measured 0.3 cm x 0.2 cm x 0.1 cm depth. CCLRN-B observed the right heel and stated it was blanchable, pink in color, and appeared healed. DON-B observed the right heel and stated it should be staged as a suspected deep tissue injury as it was slightly blue in color and unblanchable. R1 attempted to turn to his right side by himself and was unable to make the position change. Four briefs, a disposable chux pad, and a turn sheet were observed underneath R1. DON-B instructed CCLRN-B that excessive layers increase pressure and should be minimized. CCLRN-B described the left side wound as granulated with dry skin but would not identify a stage. DON-B examined the area and identified epithelialized, non-blanchable tissue, consistent with a healing stage 3 pressure ulcer, as the wound clinic had staged it at stage 3. CCLRN-B had applied adhesive foam over the wound to protect it from the wound vacuum; DON-B instructed that adhesives should not be placed on the wound and that Mepilex should be used instead. /The wound vacuum tubing was positioned along the upper thigh with suction not applied directly to the wound. Upon removal of the	20900		

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20900	Continued from page 27 dressing, the wound was observed to be actively bleeding. CCLRN-B stated she believed the wound was a stage 4 pressure ulcer and began cutting the wound vacuum foam into a narrow strip. DON-B stopped CCLRN-B and instructed that the foam must be cut to match the wound size, placed as one piece, and that suction should be applied directly to the foam at the wound site. Additional areas of impaired skin integrity were identified during the observation, including a red, raised area on the posterior thigh and a red area under the buttock crease, which CCLRN-B stated she was unaware of until identified during the observation. DON-B directed pressure-relief measures and initiation of data collection. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated physicians are notified of wounds on residents and 9/10 times, the physician would provide a referral for the residents to be seen by the wound clinic. Wound clinic would have weekly appointments with a resident until the wound was healed. Wound clinic would direct resident care including repositioning, non-weight bearing, air mattress, shoes, or whatever they would recommend. Wound clinic does not send dictation after appointments but will send orders and list important things the facility needs to do for residents. Facility would still complete weekly wound assessments with measurements while resident was followed at wound clinic. Nursing Admission/Readmission would be completed by CCLRN-B or DON. Wounds are assessed every day in some form, but measurements are done once a week. Any RN can do the measurements. CCLRN-B was unaware if audits were completed on comprehensive wound assessments. With R1, it was hard, sometimes it was shearing, and sometimes it would break into wounds. Staff would use barrier cream when they were not open. That is why the facility has Skin Observations and Wound Assessments, and only under Wound Assessments measurements would be included. Assessments should show that a wound is healing but R1's buttocks have always been an issue. CCLRN-B reviewed R1's medical record and identified on 12/29/25, it was charted shearing on right and left buttock, no measurement, cleansed, ABD and zinc applied to reddened areas. CCLRN-B stated measurements would only be done if there was a wound present; an assessment with measurements had been completed on 1/7/26 but was having a hard time finding other assessments that included measurements. R1 was able to position himself in bed. R1 would get explosive and angry at times and when R1 would refuse cares, NA's were educated to reapproach later. IDT, wound team, and physician were aware of R1's non-compliance. During an interview on 1/21/26 at 10:48 a.m., DON stated she was new to her position and started in September. DON was unaware of all the rules	20900		

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20900	Continued from page 28 that needed to be followed for this corporation. DON had been unaware the facility had User Defined Assessments (UDA)'s for wounds that nurses were to fill out daily. DON began by making cheat sheets for the nurses with steps to make sure things are getting done appropriately and re-educated on the UDA's. All the nurses were learning together. Prompts to chart the UDA's were added in the TAR. On 1/16/25, IDT met and reviewed R1's medical record. While reviewing, DON wondered why R1 had not been on an air mattress prior to hospitalization but was not sure if he needed one and would have to evaluate the need after he returned from the hospital. IDT decided on 1/16/26, that both CCLRN-A and CCLRN- B would complete Weekly RN Assessments for wounds together. It began on 1/16/26, and we decided to continue doing it on Wednesdays to coincide with our weekly IDT meetings so any new information could be brought to the meeting. Also discussed how best the nurses could communicate important information to IDT and if they could put specific headers on the emails. DON reviewed R1's chart and determined the last physician order she could find for R1's bottom was from after his appointment with wound care on 11/7/25. Nurses can use their own judgement and add orders in the system prior to getting an order from a physician, that must have been what CCLRN-B did for R1's wound treatments. The IJ that began on 12/31/25, was removed on 1/27/26 at 1:58 p.m., when it was determined and verified the facility implemented the following: -R1 was assessed and care plan interventions updated to align with assessments and provider orders. completed 1/27/26. -charge nurses responsible for day-to-day Wound Assessments/data collection tools. Completed 1/25/26. -CCLRN's responsible for weekly wound care assessment, along with root cause analyzed by IDT weekly. -care plan development starts with admitting nurse. -care plan reviews done by MDS and CCLRN's quarterly and with any changes. -all residents with current skin issues reassessed on 1/22/26. All current wound were reviewed, including history of wounds and are stable or healed with appropriate interventions in place. Care plans reviewed, and/or updated to ensure appropriate interventions are in place. Completed 1/27/26. -notification to physicians with current skin issues. Completed 1/26/27. -nursing staff educated on care plan, notification of change, skin assessment, pressure ulcer prevention, and documentation. Completed 1/25/26. -licensed nursing staff educated on documentation including required assessments, documentation guidelines, common wound etiologies and types, recognizing and staging wounds, best practices in wound treatment, nursing care, changes in condition, requirements of timely provider and family	20900		

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20900	Continued from page 29 notification, and steps for staff to take when changes in condition occur. Completed 1/25/26. -NA's educated on care plans, skin assessment pressure ulcer prevention and documentation, documentation requirements including importance of daily skin observation and reporting any abnormal findings to a licensed nurse, instruction to find repositioning schedules on Kardex, change of condition and examples of change of condition. Completed 1/25/26. R3 R3's face sheet dated 1/20/26, identified diagnoses on 12/19/25, abrasion left lesser toe(s), generalized edema, unsteadiness on feet, and unspecified open wound of left lesser toe without damage to the nail. On 12/23/25, incomplete paraplegia, pressure ulcer of other site stage 2. On 12/30/25, non-pressure chronic ulcer of other part of the left foot with fat layer exposed. On 1/13/26, pressure ulcer of right heel unstageable, and non-presssure chronic ulcer of other part of left foot limited to breakdown of skin. R3's progress note dated 12/19/25, identified R3 admitted to facility due to wounds on left toes. R3's Nursing Admit/Re-Admit Data Collection dated 12/19/25, identified R3 had weak lower extremity movement, numbness/tingling identified for feet. Edema to left lower extremity and unable to palpate pedal pulse to left foot. Wounds described as left toes. The great toe and second toe have bandages in place. The 3rd-5th toes have dark spots noted at the tips of the toes. R3 had a history of healed pressure ulcers. No further other wound characteristics that wound include but not limited to type of wounds and measurements. R3's Braden Scale for Predicting Pressure Sore Risk dated 12/19/25, identified a score of 17, which was mild risk for pressure ulcer development. Braden Scale Reference Tool identified an Intervention Guide for mild risk (15-18): frequent turning, maximal remobilization, pressure-reduction support surfaces if bed or chair bound, protect heels, manage moisture, manage nutrition, manage friction and shear *if other major risk factors present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) advance to next level of risk. R3's care plan dated 12/19/25, identified potential for impairment to skin integrity related to being chair bound, and poor circulation evidenced by R3 stating that he has had pressure sores before. Interventions included provide pressure relieving mattress and pillows or heel protectors as needed. If needed apply heel protectors on at bedtime, off during the day.	20900		

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20900	Continued from page 30 R3's physician orders dated 12/19/25, identified ankle foot orthoses (AFO) shoe brace on in AM, off at bedtime for foot drop, bilateral heels treatment: remove compression stockings, apply moisturizing lotion to heels at bedtime, check that foam boots are on heels and pillows under calves every night, compression socks on in AM, off at bedtime. During an interview on 1/20/26 at 11:52 a.m., CCLRN-B stated her and DON completed all admissions at facility. She did R3's nursing admission, but CCLRN-A was the clinical care lead for R3. On admission, left great toe, second toe, third, fourth, and fifth toe had dark spots on them. R3 was referred to wound clinic. "Wherever he came from, he was seeing a wound clinic and we thought to just continue that locally". CCLRN-B was unable to find measurements for heels. CCLRN-B was unable to articulate if R3 admitted to facility with heel wound or if it was acquired after admission. R3's Skin Assessment dated 1/4/26, stated heels healing nicely but did not see any measurements. CCLRN-A would be better to talk to about R3. R3's Wound Clinic Visit Report dated 12/20/25, identified R3 came to clinic for left 2nd toe ulcer. Wound identified as unclassifiable. Measured 2.0 cm x 0.6 cm x 0.1 cm. ulcer base is 100% eschar. Loose eschar debrided as it was putting pressure on the ulcer base creating indentation revealing pink base. No tunnelling or undermining. Scant serous drainage. Periwound dry and intact. No erythema or warmth. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply iodosorb to wound bed, avoid getting on surrounding skin, sterile gauze sponge to cover. Betadine to small scabs on other toes of left foot. In review of R3's care plan/treatment order there was no indication the care plan revised and/or order transcribed into the facility's physician/nursing orders electronic health record system to identify may shower with protection but do not get dressings wet. R3's Skin Observation dated 12/21/25, identified no skin conditions observed. R3's admission MDS dated 12/23/25, identified R3 was cognitively intact, no behaviors or rejection of care, used a wheelchair for mobility, dependent for lower body dressing and putting on/taking off footwear, touching assistance to roll left to right, and transfer. R3 has a pressure ulcer, is at risk of	20900		

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20900	Continued from page 31 developing pressure ulcers, has one or more unhealed pressure ulcers identified as two stage 2 pressure ulcers present on admission. Skin and ulcer treatments included pressure reducing device for chair and bed, pressure ulcer care, no turning/repositioning program, no nutrition/hydration, and no applications of dressing to feet were marked. R3's Wound RN Assessment dated 12/23/25, identified left foot great toe pressure ulcer stage 2 present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound RN Assessment dated 12/23/25, identified stage 2 pressure ulcer to second toe left foot present on admission. No other wound characteristics were included in the assessment. Modifications to interventions included repositioning/turning, support surfaces, friction/shear management, wound treatment, pain management. Continue with current treatment plan and physician notified regarding wound status. In review of R3's care plan there was no indication the interventions was added nor evident the physician was notified. R3's Wound Data Collection dated 12/23/25, identified second toe left foot measured 0.8 cm x 1.0 cm x 0.1 cm. Dressing completed. The assessment did not identify the type of wound and no other characteristics were included. R3's Wound Data Collection dated 12/25/25, identified left second toe. Wound margins intact, pink. The assessment did not identify type of wound, no measurements, and no other wound characteristics. Treatment: left 4th toe: cleanse with wound cleanser, paint with betadine and cover with non-bordered foam dressing, secure with tape, change daily and as needed. Left foot (all toes): cleanse with wound cleanser, paint each toe with betadine, do daily at hour of sleep. R3's Wound Data Collection dated 12/26/25-12/28/25, and 12/31/25, identified left second toe scabbed area. Wound margins intact, pink. No other wound characteristic were included.	20900		

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20900	Continued from page 32 R3's Skin Observation dated 12/28/25, identified no skin conditions observed. R3's care plan dated,1/1/26, identified "potential" for pressure ulcer development related to impaired mobility and incontinence evidenced by poor Braden Scale. On 1/1/26, a focus of Admitted with stage 2 pressure ulcer on left great toe and second toe of left foot related to disease process of paraplegia and impaired mobility. New interventions added since care plan dated 12/19/25 included provide pressure redistributing mattress on bed and cushion in manual wheelchair, and notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. R3's Skin Observation dated 1/4/26, identified heels are healing nicely, follows wound weekly, currently no dressing to toe areas-no open areas at present. The observation did not include type of wound(s) and measurements nor additional wound characteristics. Furthermore in review of R1's record there was no previous assessment and no prior mention that R3 had wound(s) on his heels. R3's Wound Clinic Visit Report dated 1/6/26, identified R3 returned to clinic for left 2nd toe unclassified ulcer. Measured 0.3 cm x 0.6 cm x 0.1 cm. ulcer base is 100% dry eschar. Periwound dry and intact. Plan: may shower with protection but do not get dressings wet. Left second toe cleanse with normal saline. Apply betadine to area of eschar to wound bed, sterile gauze to cover. R3's record lacked orders to shower with protection and not get dressings we. R3's Wound RN Assessment dated 1/8/26, identified left toe(s) wound "non-pressure" The assessment did not specify which toe the wound was on. Healing process evidenced by area decreasing in size, no signs of infection noted at this time. Modifications to interventions included support surfaces and wound treatment. Measurement 0.5 x 0.5 cm scabbed area on toes on left foot. R3's Wound RN Assessment dated 1/8/26, identified left toes non-pressure wound. Area decreasing in size. No signs of infection noted at this time. 0.5 cm x 0.5 cm scabbed area on toes on left foot. R3's Wound Data Collection dated 1/1/26-1/14/26, identified left second toe wounds are covered. 1/2/26 scabbed area on toe is covered. 1/5/26 scabbed area on toe is covered. 1/7/26 wound is covered. 1/10/26 wound is closed. No bleeding or drainage noted. No dressing	20900		

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20900	Continued from page 33 applied to area. 1/11/26 scabbed area. 1/12/26 nothing marked. 1/13/26 scabbed area noted.1/14/26 scabbed area on left second toe. R3's Wound Clinic Visit Report dated 1/13/26, identified R3 returned to clinic with left 2nd toe ulcer, right heel ulcer, and left great toe ulcer. Left 2nd toe currently classified as full thickness without exposed support structures. Wound margin is flat and intact, large pink granulation within wound bed. This wound is healed. Left great toe stage 3 pressure ulcer measured 0.1 cm x 0.1 cm x 0.1 cm. no tunneling or undermining noted. medium amount of serous drainage. Wound margin is distinct with the outline attached to wound base. Small amount of pink granulation within the wound bed, no necrotic tissue in wound bed. Unstageable pressure ulcer on right calcaneus (heel) measured 1.0 cm x 1.0 cm x 0.1 cm depth. No tunnelling or undermining, no drainage. Wound margin is flat and intact, no granulation within wound bed. Large amount of necrotic tissue within the wound bed including eschar. Plan: may shower with protection but do not get dressings wet. Prevalon boots to both feet when in bed. left great toe and 2nd toe cleanse with normal saline, apply betadine, cover with sterile gauze. Right heel cleanse with normal saline, apply betadine, cover with sterile gauze. The treatment was added to the physician orders in the treatment administration record (TAR), however, the record did not identify to shower with protection and not get dressings wet. In review of R1's record between 1/4/26 and 1/14/26, there were no comprehensive wound assessments completed between the assessment on 1/4/26 and the wound clinic assessment on 1/14/26. Additionally, despite the Skin Observation on 1/4/26 that indicated R3 had a wound to his "heels" and the wound clinic's identification of an unstageable pressure ulcer to R3's right heel, it was not evident R3's care plan was revised to address the pressure ulcer to R3's right heel or the shower instructions. R3's Skin Observation dated 1/14/26, identified treatment and monitoring to bilateral lower extremities ongoing. No other information documented including wound type. R3's IDT progress note dated 1/14/26, identified addendum to IDT note. Resident also has wounds to his feet for which he is seeing wound clinic. Right heel wound is painted with iodine and wrapped in gauze, left big toe and second toe have wounds. Monitoring. No other information documented including wound type.	20900		

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20900	Continued from page 34 R3's Wound RN Assessment dated 1/15/26, identified left toe(s) wound non-pressure. Healing process evidenced by covered with new skin and are decreasing in size. No other information documented including wound type. R3's Wound RN Assessment dated 1/15/26, identified left toes non-pressure wound. Covered with new skin and decreasing in size. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/16/26, identified left toes very small areas of eschar noted on all toes, largest area measures 0.3 cm x 0.3 cm; smallest unable to measure; scabbed over-no drainage noted. No other information documented including wound type and which toe(s). R3's Wound Data Collection dated 1/17/26, identified left toes area covered on left great toe and 2nd digit, 3rd and 4th digit have areas that are covered in betadine, and no dressing over them. No complaints. No other information documented including wound type. R3's Wound Data Collection dated 1/18/26, identified left toes cleansed with betadine applied to scabbed areas and covered with gauze. No pain or discomfort. No other information documented including wound type and which toe(s). R3's Wound Clinic Visit Report dated 1/20/26, identified R3 returned to clinic for follow-up treatment to left great and 2nd toes, right heel ulcer. Left second toe full thickness wound, that was classified as healed on 1/13/26, measured 0.1 cm x 0.1 cm x 0.1 cm. large amount of necrotic tissue within the wound bed including eschar. No granulation in wound bed. stage 3 pressure ulcer on left great toe measured 0.1 cm x 0.1 cm x 0.1 cm. small amount of serosanguineous drainage. Large amount of necrotic tissue in wound bed including eschar. No granulation within the wound bed. unstageable pressure ulcer to right heel measured 1.0 cm x 1.0 cm x 0.1 cm depth. No drainage, no granulation within the wound bed. Large amount of necrotic tissue within the wound bed including eschar. Continue with current treatment to all wounds. During a phone interview on 1/21/26 at 9:43 a.m., CWNP-A stated R3 began at wound clinic on 12/30/25 with a left foot second toe ulcer; 1/6/26, R3 was again seen for the left foot second toe. On 1/13/26, left second toe healed, new pressure ulcer right heel, and left great toe. On 1/20/26, bilateral foot ulcers are dry and stable and left second toe and great toe measured	20900		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/27/2026**

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Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

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20900	Continued from page 35 0.1 cm x 0.1 cm x 0.1 cm depth. Right heel pressure ulcer measure 1.0 cm x 1.0 cm. Review of medical record, the facility did not report the new ulcers to wound clinic and wounds were discovered between the 1/6/26 and 1/13/26 visit by wound clinic. R3's Wound Data Collection dated 1/20/26, identified left great toe eschar noted. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified wound name calcaneus right heel. Eschar noted. No drainage, denies pain. Treatment done at wound center. No other information documented. R3's Wound Data Collection dated 1/20/26, identified left second toe. Eschar noted on top of toe. Treatment done at wound clinic. No other information documented. R3's Wound Data Collection dated 1/22/25, identified right heel pressure ulcer measured 1.5 cm x 2.0 cm with no depth. 100% epithelized tissue to wound bed. Physician notified. No other information documented. R3's Wound Data Collection dated 1/22/25, identified left foot great toe pressure ulcer measured 0.3 cm x 0.5 cm with no depth. Left toes dark area. 100% eschar to wound bed. Modifications to interventions included support surfaces and wound management. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/22/25, identified left foot 2nd toe pressure ulcer. Left toes darkened area measured 0.6 cm x 0.7 cm, no depth. 100% eschar. Modifications to interventions included support surfaces and wound treatment. Physician notified. Modifications to the care plan on 1/22/26, identified provide pressure relieving boots on feet bilaterally. Apply at bedtime and remove when walking. Use bed/foot cradle to keep bedding off toes and feet. Physician notified. R3's Wound Data Collection dated 1/27/26, identified right heel no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink. No further information documented. R3's Wound Data Collection dated 1/27/26, identified left great toe no open wound noted, no bleeding or drainage noted, denies pain. Wound margins intact/pink.	20900		

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20900	Continued from page 36 No further information documented. R3's Wound Data Collection dated 1/27/26, identified left second toe scabbed, no open wounds noted, no drainage or bleeding, no pain. No further information documented. During an observation and interview on 1/20/26 at 7:54 a.m., R3 stated he had wounds on his toes and heels, nothing special he has to do for the wounds, "they" keep up with dressings. Stated he was going to an appointment at the wound clinic today. R3 was in a wheelchair, AFO, regular socks, and soft shoes on feet. Had a foot cradle on the end of his bed. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated NA's observe skin daily, nurses do weekly assessments during bathing. CCLRN-A and B complete the weekly RN Wound Assessments. Risk for pressure injury is determined by an individual's Braden score, mobility, how a resident transfers, and activity level. All residents are so unique, it is hard to say what model to follow. CCLRN-A did not clarify what model was meant. Interventions would change as needed if something came up. During a follow-up interview on 1/22/26 at 11:00 a.m., CCLRN-A stated R3 wore the bootie heel protectors, but was not sure if he had them since admission. He admitted with a stage 2 pressure ulcer of the left great toe and another toe. Did not admit with the right heel. R3 does have a foot cradle on his bed and that is not in his care plan. CCLRN-A stated the facility was working on better communication with the physician about sending weekly wound updates. R5 R5's face sheet dated 1/20/26, identified diagnoses of Alzheimer's, dementia, and localized edema. R5's quarterly MDS dated 10/30/25, identified R5 had moderate cognitive impairment, moderate hearing difficulty, usually understood, no behaviors, used a walker and wheelchair; needed moderate assistance with dressing upper and lower body, independent to roll side to side, touching assistance to transfer locations; was at risk of developing pressure ulcers, did not have a pressure ulcer, had a pressure relieving device on bed and chair, application of nonsurgical dressing and ointments to places other than feet. R5's care plan dated 8/4/25, identified potential for	20900		

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20900	Continued from page 37 pressure ulcer development related to terminal disease process, bladder incontinence, impaired mobility, and history of ulcers on sacrum. Interventions included to provide pressure redistribution cushion to manual wheelchair, and notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. On 11/4/25, identified impairment to skin integrity related to edema and weeping of lower extremities. Interventions included monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to physician.; keep skin clean and dry, use lotion on dry skin, do not apply to site of injury. R5's physician order dated 12/8/25 directed for bilateral heel wound treatment: remove old dressings, cleanse with normal saline, apply Medi honey to open areas, cover with non-adherent telfa dressing, wrap with cast padding. Change every three days and as needed for excess drainage. Although the physician order that identified R1 had bilateral heel wounds, R5's record between 12/8/26 and 1/2/22 did not include any comprehensive assessments or documented monitoring of R5's heel wounds. R5's progress note dated 1/2/26, identified hospice nurse visited and placed catheter due to increased swelling to the scrotum and difficulties getting to the bathroom. Also having increased pain to left foot/leg. No further mention of location of pain and/or etiology. R5's progress note dated 1/2/26 at 11:11 p.m., identified R5 expressed pain when moving left lower extremity or raising the foot of recliner. Left lower leg dressing remained dry and intact, right lower extremity dressing changed once. Condition declining. R5's progress note dated 1/3/26, identified presence of edema about below his armpit level. Dressing to right lower extremity changed as scheduled for weeping clear fluids. R5's late entry progress note dated 1/5/26 at 11:47 a.m., identified new dressing orders obtained Unna boot (calamine/zinc roll to bilateral lower legs, followed by kerramax-extra absorbent dressing to right leg wound and areas of drainage, then coflex wrap as top layer. Change daily and as needed if drainage through dressing. Does complain of mainly left leg pain. R5's record reviewed between 1/5/26 through 1/26/26 identified R1 had extensive wounds that were not	20900		

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20900	Continued from page 38 classified; however the record identified R1 had very edematous legs that were weeping. R5's physician ordered treatment that was dated 12/28/25 for R5's heels was discontinued on 1/6/26. R5's record did not identify another treatment order for the heels nor why the order was discontinued. In addition, based on the R5's record it could not be ascertained if the heel wounds had resolved. R5's physician order dated 1/7/26-1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "lower legs" and not feet or heels. R5's late entry progress note dated 1/7/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off, not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds. Monitoring. In review of R5's record between 12/28/25 through 1/14/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's late entry progress note dated 1/14/26, identified IDT met to review R5. He has some weeping from his leg edema to both legs. He has some pain, unable to rank pain. Has serous drainage, right leg has an open area. Dressing changed to an unaboot by new hospice nurse. Use for both legs. Changed daily and as need. Some progress seen to legs with initiation of una boot. Now will see wound care as needed. Right leg continues to be a concern. Also have some tiny, scattered areas to right heel, on left heel a chunk of skin has come off,	20900		

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20900	Continued from page 39 not bleeding. It is noted this has occurred since use of mechanical standing lift. Enhanced barrier precautions have been added to care plan for these wounds plus the catheter. He also has a foley catheter now. Monitoring. In review of R5's record between 1/14/26 through 1/20/26, despite the IDT progress note that identified R5 had impaired skin integrity to his right and left heels, there was no corresponding comprehensive assessment of the heel wounds, no indication of routine monitoring for worsening or healing nor evident R5's care plan was revised to identify the presence of heel wounds, goals of care, and appropriate individualized interventions. R5's physician order dated 1/16/26, identified apply calamine/zinc gauze to bilateral lower legs. Then apply super absorbent dressing over wound and draining areas. Apply layer of coflex dressing and cover with tubi-grip to keep in placed daily and as needed. Based on R5's record review, it could not be ascertained with certainty this treatment was to be applied to R5's heel wounds as the ordered specified "legs" and not feet or heels. R5's progress note dated 1/17/26 at 2:40 p.m., identified dressings stayed dry this shift. At 4:08 p.m., legs were dry bilaterally with dressings intact. During an observation and interview on 1/20/26 at 8:23 a.m., R5 was on the commode and being transferred to a high-back wheelchair with a foam cushion on the seat and heel protectors on his feet. A dressing was on the right side of his bottom. When R1 was lifted off the commode there were small drops of blood on the commode The dressing was not changed, and NA-A was not able to ascertain where the blood came from. R5 yelled out in pain when staff wiped him with wet wipes he and was placed in the wheelchair. CCLRN-A stated R5 had sores on his legs, new one on scrotum, and a Mepilex on his bottom. CCLRN-A removed heel protectors and stated the heel protectors were soaked through with fluid from R5's legs. CCLRN-A described the right heel as an open area, black in the middle, on the bottom of the heel. When observing R5's right heel, the skin was also white consistent with maceration. CCLRN-A stated the skin is dry looking on his feet. When observing R5's left heel the skin was also white consistent with maceration with a small black spot consistent with eschar in the middle. When CCLRN cleaned the left heel wound blood was on the gauze but "the wound was not actively bleeding". Bilateral legs and feet were very edematous, R5 lightly placed his hand on his leg, removed it and the imprint of his hand remained for more than 2 minutes. CCLRN-A stated he was not the greatest at	20900		

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20900	Continued from page 40 staging wounds. Since the heel protectors were soaked already, CCLRN-A did not think they would be a viable option for R5 to put back on. On 1/16/26, the Interdisciplinary Team (IDT) discussed switching things up and both CCLRN's would do wound care together to get better descriptions of wounds, not tie up the NA's, and keep the wound assessments consistent. A fair number of residents go to the wound clinic for treatments. In review of R5's record between 12/8/26 through 1/21/26, there was no indication R1 had impaired skin integrity to his right buttock nor was there a physician order for the Mepilex that was on R5's bottom during the observation on 1/20/26 at 8:23 a.m. During an interview on 1/20/26 at 10:44 a.m., CCLRN-A stated R5 had a regular pressure relieving mattress on bed. R5 rarely went to bed because he would complain of shortness of breath, so he was always in recliner but did not use or have a pressure relieving cushion for the recliner. R5 would get up to reposition for meals into the high back wheelchair and then go back to the recliner. CCLRN-A explained a resident's risk for pressure ulcers was based off the Braden Score, mobility, how residents transfer, activity level-everything goes into determining it. If there were concerns identified when the assessments were completed, then the residents would be closely monitored and precautions put into place to reduce the risk. and if seeing concerns on some of those assessments either watch closely or precautions put in place. "Everyone is so unique, it is hard to say which model to follow." During an observation on 1/20/26 at 11:49 a.m., R5 was in his wheelchair, facing the fishtank, with his eyes closed. During an observation on 1/20/26 at 1:14 p.m., R5 was in his wheelchair in front of a table, with the fishtank on his left side, with his eyes closed. R5's progress note dated 1/20/26 at 4:29 p.m., identified R5 scooted down in recliner to the point the chair tipped forward and was resting on recliner part of chair. Will attempt trial of placing cushion from wheelchair into recliner to see if that will prevent R5 from scooting down in chair and placing too much weight on front of chair and tipping it forward. In review, R5's care plan was not revised to include the cushion to the recliner until 1/22/26, two days later. During an observation and interview on 1/22/26 at 9:00 a.m., hospice nurse (HN)-A stated she received a call	20900		

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20900	Continued from page 41 on 1/21/26 that R5's bottom was getting worse. LPN-B stated the facility was using a sacral Mepilex for treatment to the bottom, after leaving the room "to check the orders". LPN-B returned to R5's room and stated the order was for calmoseptine and sacral dressing to site. HN-A stated if the wound was not open, a Mepilex would be fine to put on but if it was open she would reach out to the physician for orders. LPN-B got dry wipes from drawer and wet them in sink to cleanse wound. HN-A stated there were open spots on both sides of R5's bottom and would classify them as stage 2 pressure ulcers. R5 winced and attempted to move away in pain when cleansing wounds. LPN-B stated the facility was using calmoseptine as a barrier cream to R5's bottom and read the bottle that stated it protects, soothes, and promotes healing skin. Applied to wound bed and surrounding skin. Placed a sacral Mepilex over wounds. Neither nurse was able to articulate how long R5 had the wounds on his buttocks. R5's care plan dated 1/22/26, identified an update of actual skin impairment to include open area to lower left rear leg on 1/19/26, open areas to right lower leg rear, left heel, right heel, left buttocks, and right buttocks. Interventions for skin impairment were updated to include turn and reposition in bed or chair every 2-3 hours, weekly skin observation by licensed nurse, check brief every 2-3 hours, provide cushion to recliner and wheelchair. In review of R1's record there was no indication of comprehensive assessment was completed to determine R5's skin tolerance to pressure over time, it could not be ascertained how the 2-3 hour repositioning scheduled was determined appropriate or sufficient to prevent further deterioration and/or new ulcer development. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to right heel that measured 3.0 cm x 2.5 cm x 0.1 cm depth. 100% eschar and surrounding skin intact and pink. Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed. R5's Wound Data Collection and RN Assessment dated 1/22/26, identified open non-pressure injury to left heel that measured 4.0 cm x 3.5 cm x 0.1 cm depth. 100% eschar to wound bed. Surrounding skin pink and intact. Treatment of apply calamine/zinc gauze to lower legs, then apply super absorbent dressing over wound and draining area. Apply layer of coflex dressing, cover with tubi-grip to keep in place daily and as needed	20900		

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20900	Continued from page 42 R5's Wound Data Collection and RN Assessment dated 1/22/26, identified pressure ulcer right buttock, did not identify a stage, measured 4.0 cm x 2.0 cm x 0.1 cm depth. 90% granulation tissue and 10% slough in wound bed. Minimum amount of drainage with 'other' selected as color and slight bleeding noted. Wound margins are intact and pink. Treatment was barrier cream applied and Mepilex placed. R5's Wound Data Collection dated 1/22/26, identified left buttock open area measured 5.0 cm x 4.5 cm x 0.1 cm depth. 100% granulation tissue in wound bed. Wound margins intact and pink. Barrier cream and Mepilex applied. During an interview on 1/22/26 at 11:00 a.m., CCLRN-A stated he had a note under his door on 1/21/26 from 1/20/26 that stated R5's bottom was open. Prior, it had only been red and the Mepilex was on for protection. CCLRN-A notified hospice on 1/21/26. Facility has been working on repositioning R5 every 2-3 hours. Staff were getting him up into the wheelchair for meals because he had been eating in his room. We began elevating his feet off ground with recliner which had mixed results as R5 can run buttons himself so he will put the reclining part back down. The facility worked with family and hospice to get him to go to his bed with his bottom starting to break down. For the moment, CCLRN-A had staff moving the foam, which was a little piece of foam, nothing significant, from his wheelchair to recliner, and will look for something better. CCLRN-A wanted to ask hospice about getting an air mattress and whatever else is necessary for feet. CCLRN-A tried the heel protectors, but they got soaked with fluid, so staff were directed to try a pillow to protect from moisture for the moment. The dressings to R5's legs have changed in the number of times they were changed each day and now they have started weeping again, R5's circulation has gotten really bad at this point, stuff has started opening back up on the calves.- During an observation on 1/23/26 at 10:17 a.m., R5 was at a table by the fishtank eating breakfast. During an observation on 1/26/26 at 10:38 a.m., R5 was laying in bed, no air mattress on bed, right foot is almost off the end of the bed. A follow-up email dated 1/27/26 at 1:52 p.m., DON stated she reviewed with hospice and an air mattress was ordered.	20900		

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20900	Continued from page 43 R2 R2's face sheet dated 1/20/26, identified diagnoses of hemiplegia and hemiparesis. R2's quarterly MDS dated 10/24/25, identified R2 had moderate cognitive impairment, no behaviors, and had minimal difficulty with hearing but was able to understand and be understood. R1 was dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 had no pressure injuries and was not at risk of developing them. Treatments included pressure reducing device for chair and bed. R2's skin integrity care plan dated 1/28/25, identified R2 had potential impairment to skin integrity related to fragile skin on tailbone area, right hip, and lateral aspect right foot. Interventions dated 1/28/25 included Mepilex to tailbone/right foot area for protection as needed, monitor tailbone area and right hip for skin changes. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to health care provider, weekly skin observation by licensed nurse, and blue prevalon boot to right foot when in bed, assist to reposition every two hours or if observed leaning, pressure reduction mattress and waffle cushion in tilt/recline wheelchair, notify nurse immediately of any new areas of skin breakdown. R2's Skin Observation dated 1/3/26, identified right heel-outer right aspect of heel has "about" a 1.0 cm x 2.0 cm spongy, dark pressure area. Skin prep and mepilex applied. No further description was documented, not evident the care plan was revised with immediate pressure relieving interventions to prevent and/or reduce the risk of deterioration. Additionally, the physician notification was not completed until three days later on 1/6/26. R2's Wound Data Collection dated 1/6/26, initial data collection for lateral right heel that measured 0.75 cm x 1.5 cm. wound margins intact and pink. Looks like a bruise, slightly fluid filled, covered with Mepilex. R2's Wound RN Assessment was inconsistent with Data Collection. This document identified the impaired skin integrity as suspected deep tissue injury (not a bruise) and included interventions for repositioning/turning, support surfaces, friction/shear management, wound treatment. Continue with current treatment plan, and physician notified regarding wound status.	20900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Windom	**705 SIXTH STREET , WINDOM, Minnesota, 56101**

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20900	Continued from page 44 R2's progress note dated 1/6/26, identified a fax was sent to physician regarding a suspected deep tissue injury on right lateral heel. Mepilex covering area for protection. R2 does not know how it happened and does not have any pain when asked about it. Asked for any additional interventions. Will continue to monitor. R2's Braden Scale for Predicting Pressure Score Risk dated 1/6/26, identified a score of 10. The Braden Scale Reference Tool for use in conjunction with Braden scale included an Intervention Guide: High Risk (score of 10-12) which included: frequent turning with a planned schedule, supplement with small shifts in position, pressure reduction support surface, use foam wedges for thirty degree lateral positioning, maximal remobilization, protect heels, manage moisture, manage nutrition, manage friction and shear. Also included were interventions to manage moisture, nutrition, friction and shear, and other general care issues. In review of R2's record between 1/3/26 through 1/14/26, there was no indication the care plan was revised to identify the suspected deep tissue injury and the interventions that were identified on the 1/6/26 assessments. R2's Skin Observation dated 1/7/26, identified no skin issues observed. R2's progress note dated 1/8/26, identified physician returned fax with orders to continue with mepilex and attempt to off-load pressure. In review of R2's record despite the physician ordered intervention there was no indication the care plan was revised to include the intervention to off-load pressure. R2's annual MDS dated 1/9/26, identified R2 had minimal difficulty with hearing but was able to understand and be understood, had moderate cognitive impairment, no behaviors, dependent on staff for all activities of daily living (ADL) including rolling left to right and transfers, and moving in wheelchair, always incontinent of bowel and bladder. R2 has a pressure ulcer and is at risk of developing pressure ulcers. Pressure ulcer is identified as unstageable presenting as deep tissue injury. Treatments included pressure reducing devices for chairs, bed, and pressure ulcer care. R2 was not on a turning/repositioning program, no nutrition/hydration interventions to manage skin problems. R2's Wound Data Collection dated 1/13/26, identified right heel-mepilex in place. No measurements recorded. Surrounding tissue is pink and intact. Continues to be a dark, spongy, pressure area.	20900		

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20900	Continued from page 45 R2's Skin Observation dated 1/14/26, identified right heel-lateral right heel. Faxed physician regarding status of bruised looking area. Looking less bruised and more pink/purple, lighter in the middle. Did note a pinpoint area in the middle of the bruised area but no drainage noted. R2's progress note dated 1/14/26, identified IDT met and reviewed the spot on right lateral heel. Sort of a pink/blue area, depends on positioning. It is not open or draining. Discussed possibility of evaluation at wound clinic and R2 shook her head "no". Daughter will be consulted. Monitoring. R2's ADL care plan dated 1/15/26, identified R2 had right sided weakness and required assistance with ADLs. Interventions included assist of two staff to position up in bed, one staff to turn side to side, two staff for transfers and toileting hygiene. The care plan included a focus area of deep tissue injury to right heel dated 1/15/26 with corresponding interventions included educate resident/family as to causes of skin breakdown including: transfer/positioning requirements, importance of taking care during ambulation/mobility, good nutrition and frequent repositioning. Provide pressure redistributing mattress on bed and cushion in scoot wheelchair, offload heels when in bed and chair. R2's Skin Observation dated 1/16/26, identified right heel-bruise. Covered with mepilex and put on an off-loading boot. Has an appointment at wound clinic on 1/20/26. No further wound characteristics were documented. R2's progress note dated 1/19/26, identified CCLRN-B notified daughter the "bruising" on R2's right heel was more reddish purple now compared to the black/blue before. The area is not soft and R2 does not complain of pain. Daughter requested to cancel wound clinic appointment. R2's Skin Observation dated 1/19/26, identified right heel-right lateral heel. Skin prep to heel and covered with mepilex, protective boot applied. R2 had no complaints of pain. Bruise area is less blueish/black and more purplish noting the center is fading in color. It is not soft to the touch. Has a piece of dry skin peeling off. No further wound characteristics were documented. During an observation on 1/20/26 at 10:25 a.m., R2 was in her room, sitting in a wheelchair with a pillow positioned on her right side. R2 leaned to the right	20900		

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20900	Continued from page 46 with her right shoulder almost touching the armrest, right foot was on the floor with a heel protector on foot, not on foot pedal, left leg was crossed over right leg. During an interview on 1/22/26 at 10:05 a.m., CCLRN-B stated occupational therapy (OT) had evaluated R2 various times for right side lean. CCLRN-B indicated she was not familiar with R2's wounds or care because the director of nursing (DON) took was took over management of her care. During an interview on 1/22/26 at 10:51 a.m., NA-D stated R2 was repositioned every two hours. R2 liked to be on the right side. Staff attempted to put a pillow on the right side and one between the knees, along with the heel protector on the right foot. R2 tried to take the heel protector off but it was there to help the area not get worse. NA-D felt when R2 was in the wheelchair her heels would not touch the floor, so she was not at risk for pressure. Staff move R2 back and forth from wheelchair to recliner for position changes. R2 has a waffle cushion staff move back and forth from recliner to wheelchair. During an observation on 1/22/26 at 10:50 a.m., R2 was sitting in wheelchair in her room, leaning to right, arms bent and positioned with hands by neck on left side, heel protector on right heel, left leg crossed over right leg at knee. During an observation and interview on 1/23/26 at 11:44 a.m., R2 was sitting in a new wheelchair with a footboard attached at the foot pedals. Grippy socks on her feet, no heel protector on her right heel. Left leg crossed over the right leg at her knee. Mepilex on right heel. Mechanical lift sling was behind her in the wheelchair. Heel protector was on the recliner. Pressure relieving cushion in chair. R2 stated she likes to cross her legs. During an observation and interview on 1/23/26 at 11:48 a.m., DON came to R2's room. R2 stated she did not want to wear the heel protector and DON explained she had a sore on her right heel and the heel protector helped to cushion and protect it. R2 was okay with having heel protector applied. Examined left and right knees; skin is blanchable, no redness. DON stated mechanical lift sheet is tucked on the side of her legs, and behind her, not under her legs. DON stated she had not been aware of the information at the bottom of Braden Scale until 1/22/26, and R2's score put her at high risk for pressure related injuries.	20900		

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20900	Continued from page 47 R2's Wound Data Collection dated 1/23/26, identified right outer heel, initial data collection, scabbed area. Measured 1.7 cm x 1.7 cm. Upon assessment scab sloughed off and underlying tissue with no open area, skin pink, warm, and blanchable. R2's care plan dated 1/23/26, was updated to include supplement added for wound healing, crosses her legs when up in chair and bed at times, heel boots bilateral feet at all times, and mepilex covering bruised area on right lateral foot, assist to reposition twice a shift if R2 is in bed, recliner, wheelchair, or if observed leaning, resident can be non-compliant and does refuse to have staff apply at times, consult therapy for repositioning needs. During an observation on 1/26/26 at 9:02 a.m., R2 was in commons area by nurses station. Heel protectors on both heels, nothing between knees. During an observation on 1/26/26 at 10:43 a.m., R2 was lying in bed, heel protectors on both feet. The facility Pressure Ulcers policy reviewed 2/17/25, identified to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when necessary. Based on residents comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individuals clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Residents will receive appropriate assessments and services to promote and maintain skin integrity. If a residents clinical condition makes compromise of skin integrity clinically unavoidable, this information will be documented in the medical record. The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements revised 12/8/25, identified all residents will be identified for their risk of developing pressure ulcers using the Braden Scale for Predicting Pressure Sore Risk. Those residents determined at risk will have the Braden Scale completed weekly for the first four weeks following admission. RN will complete Braden Scale quarterly or when the resident has a change of condition that could affect risk of developing pressure ulcer. All residents will have a comprehensive skin inspection by a licensed nurse on admission/readmission to identify any skin	20900		

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20900	Continued from page 48 issues present. A comprehensive assessment, which includes the Resident Assessment Instrument (RAI), will be completed by the licensed nurse evaluation the residents risk factors, skin condition, and nature of the pressure to which the resident may be subjected. A systematic skin inspection will be made daily by the NA's assigned to the residents at risk for skin breakdown. The NA is responsible to report findings to the licensed nurse. If a pressure ulcer is identified, cleanse the area prior to observations. RN's should record the type of wound and degree of tissue damage on the Wound RN Assessment (i.e. for a pressure ulcer, record the stage). The licensed nurse records the location of the area, measurements, and ulcer/wound characteristics on the Wound Data Collection. Notify physician of the ulcer and residents condition to obtain orders fro a treatment. Notify resident and/or family/representative of pressure ulcers, orders, and planned interventions. Dietary is notified by an alert that occurs when Wound Data Collection is signed and locked. IDT should determine any modifications that are necessary to a residents plan of care. Interventions should focus on physical, mental and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with resident goals. When a pressure ulcer is present, complete the Wound Data Collection daily, documentation should include the following: evaluation of the ulcer, evaluation of the status of the dressing, status of area surrounding the ulcer, presence of possible complication, whether pain is present. If the ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within 2-4 weeks. The pressure ulcer should be assessed/evaluated weekly and documented on the Wound RN Assessment. SUGGESTED METHOD OF CORRECTION: The DON or designee should review all residents at risk for pressure ulcers to ensure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	20900		