STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Carolina Rehab and Wellness	**2575 W 5th Street , Greenville, North Carolina, 27834**

(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 A complaint investigation was conducted from 9/9/25 through 9/11/25. Event ID# 1D6530-H1. The following intakes were investigated: 2602282, 2599586, 2607206, 2568313, 831609, 831614, 831612, 831611, and 831604. Five of the nineteen complaint allegations resulted in deficiency.	F0000		10/10/2025
F0580 SS = E	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 that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F0580	1. a. For Resident #1 – the resident was discharged from the facility on 8-29-25. The wound care nurse was inserviced on 9-22-25 regarding the importance of notifying the would doctor of any new pressure areas and to ensure that any new would treatment orders are entered in the resident's electronic medical record. b. For Resident #8 – the wound nurse spoke to the wound physician and reviewed the current wound treatment order in the electronic medical record to ensure that the resident had appropriate orders for treatment to wound areas. The wound care nurse was inserviced on 9-22-25 regarding the importance of notifying the would doctor of any new pressure areas and to ensure that any new would treatment orders are entered in the resident's electronic medical record. 2. An initial audit will be performed to ensure that there are current orders in the residents electronic medical record for wound treatment(s), if the resident has a wound that requires treatment. This initial audit will be performed by the Director of Nursing along with the Administrator. After the audit is completed the audit will be reviewed with the wound nurse and wound physician for accuracy. This audit and the review of the audit will be completed by1 0-3-2025. 3. All licensed nurses will be inserviced on F580 requirements, emphasizing timely notification to physicians when there is a new pressure area that requires any sort of treatment and ensuring that any new treatment orders are placed in the resident	10/10/2025

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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F0580 SS = E	Continued from page 1 (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 observation, record review, and interviews with staff and Physicians the facility failed to notify the physician when residents developed pressure sores for 2 of 3 sampled residents with pressure sores (Residents # 1 and Resident #8). The findings included: 1. Resident # 1 resided at the facility from 3/11/25 until her discharge to the hospital on 8/29/25. Resident # 1's diagnoses included cellulitis of the lower extremities, lymphedema, venous insufficiency, chronic kidney disease, anxiety, and gout. Resident # 1's electronic record included pictures as part of the documentation regarding Resident # 1's sacral pressure sore development and assessment. The first picture was recorded on 4/4/25. In the documented picture, the sacral pressure sore appeared to have both black and yellow slough tissue in the wound bed. The electronic record did not include orders on 4/4/25 for the treatment of the pressure sore or that the physician was contacted.	F0580	Continued from page 1 electronic medical record. This inservice will be directed by the staff development coordinator and will be completed by 10-3-2025. 4. An audit will be conducted to ensure that any new pressure areas that are identified are reported to the wound physician and that orders for treatment are obtained and that those orders are placed in the electronic medical record. This audit will take place weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Director of Nursing or their designee. The audit will start during the week of 10-6-25. The results of these audits will be presented at the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings for review and further recommendations. Target date for substantial compliance: 10-10-2025.	

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F0580 SS = E	Continued from page 2 The Wound Care Nurse was interviewed on 9/9/25 at 4:15 PM and on 9/10/25 at 11:13 AM and reported she (the Wound Care Nurse) kept written notes that had not been included in the resident's electronic record. The Wound Care Nurse referenced these notes and reported the following information. Resident # 1 had been noncompliant with care. Resident # 1's sacral pressure sore was first identified by her on 4/1/25. She had been caring for the resident's legs on 4/1/25 because the resident had cellulitis. On 4/1/25 she saw the sacral pressure sore and measured the pressure sore. It was 7 cm (centimeters) X 6 cm and was not stageable because it had black necrosis (dead tissue). The Nurse Aide had not let her know about the pressure sore before she (the Wound Nurse) found it. She (the Wound Care Nurse) had been working closely with the Wound Physician, who visited every week, and the Wound Physician had educated her that black necrosis would need to be removed for healing to take place. In working with the Wound Physician, she had been told that skin prep would be an appropriate measure for necrotic tissue. Therefore, she applied skin prep for the first few days when she found the pressure sore with the plan that the Wound Physician would look at the pressure sore when the Wound Physician was next at the facility. She (the Wound Care Nurse) did not call and talk with the Wound Physician or the primary physician. She did not enter orders into the resident's record for skin prep to the pressure sore. On 4/4/25 Nurse Aide (NA) # 1 came to get her (the Wound Care Nurse) and told her that NA # 2 was applying a cream on the resident's bottom and that she (NA #1) thought it needed something more than a barrier cream. She again looked at the pressure sore and decided to use Santyl (which is a chemical debriding topical cream) and she dressed and cared for the pressure sore on that date. She again did not call the physician and notify the physician of the new pressure sore. On 4/8/25 the Wound Physician was notified when she was there to make rounds. On 4/8/25 the Wound Physician initiated a plan of care and orders were received. A review of the Wound Physician's 4/8/25 treatment plan revealed the orders included more than just the Santyl which the Wound Care Nurse had last initiated on 4/4/25. Both Santyl and calcium Alginate were to be applied to the wound bed daily per the Wound Physician's plan of care. The Wound Care Physician was interviewed on 9/10/25 at 4:32 PM and reported the following information. If she (the Wound Care Physician) had been contacted on 4/1/25 when Resident # 1 first was observed to have an	F0580		

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F0580 SS = E	Continued from page 3 unstageable wound to her sacrum she probably would not have ordered skin prep. The facility could contact her at any time to consult about orders. According to the Wound Physician, if she had been contacted on 4/1/25 she would have needed to consider how long it would be before she could actually see the resident and taken that into consideration in ordering what needed to be applied in the interim. During an interview with the Director of Nursing (DON) on 9/11/2025 at 7:55 AM the DON reported the following information. The facility does have standing orders for wound care. Nurses are supposed to apply Wet to Dry dressings until they can contact the physician for further orders if they identify new wounds. The facility also has protocols to use based on the appearance of the wound bed and the nurse should still contact the physician and obtain orders when a resident has a pressure sore. The DON indicated all this information is kept in a binder at the nursing desk and the nurses should know that. 2. Resident # 8 was initially admitted to the facility on 2/13/20. The resident had diagnoses which included diabetes, hypertension, history of stroke, dysphagia, and pain. On 7/28/25 a documented skin assessment showed no areas of skin breakdown. According to the record, Resident # 8 was hospitalized from 8/1/25 to 8/4/25 for altered mental status and a urinary tract infection. Upon the resident's return on 8/4/25 Nurse # 3 documented a nursing assessment. The assessment form included an area which included directions "note all skin issues." On this part of the assessment form, Nurse # 3 noted "sacrum." There was no further information about the size or description of what the issue was with Resident # 8's sacrum skin. There was no documentation the physician was notified on 8/4/25. Nurse # 3 was interviewed on 9/10/25 at 2:20 PM and reported she recalled Resident # 8 had an open area on the sacrum which was not deep when she was readmitted. She did not recall specific details other than that. Nurse #3 indicated would have told the Wound Care Nurse and did not recall anything else she did. On 8/4/25 the Wound Care Nurse documented a skin assessment and noted Resident # 8 had a 5.02 cm X 3.84 cm deep tissue injury to her right heel. A heel protector and specialized boot was applied. The Wound	F0580		

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F0580 SS = E	Continued from page 4 Care Nurse did not note any area of skin breakdown to Resident # 8's sacrum and she did not note the physician was notified. During interviews with the Wound Care Nurse on 9/9/25 at 4:15 PM and 9/10/25 at 11:13 AM the Wound Care Nurse reported she assessed Resident # 8's skin on 8/4/25 and she did not see an area of skin breakdown on 8/4/25 on the resident's sacrum. She did have a deep tissue injury to her right heel and she knew that skin prep would be appropriate for that. She began doing that daily with the plan for the Wound Physician to see the resident. She did not call the physician and notify the physician of any pressure sores. The Wound Care Nurse was also interviewed about how other nurses would know to do treatments when she was not there if the physician had not been consulted and orders been entered, and the Wound Care Nurse had not recognized that as a problem. There were no documented orders or treatment for any pressure sores from 8/4/25 to 8/9/25. On 8/10/25 at 9:00 PM Nurse # 2 documented Resident # 8 had a sacral wound which was observed to be open with no bleeding. The area was cleansed with normal saline and a dressing applied. Nurse # 2 was interviewed on 9/11/25 at 11:19 AM and reported the following information. She did not recall the specific appearance of Resident # 8's pressure sore on 8/10/25 when she got the one-time order to dress the pressure sore. She did recall it was open and appeared to be more than a stage one. She had told the oncoming nurse about the pressures sore and assumed that the information would be passed along to the Wound Care Nurse and physician. Review of orders and the treatment records revealed Nurse # 1 obtained a one-time order on 8/10/25 for the sacral dressing she applied and documented the dressing change on 8/10/25 on the MAR (medication administration record). Following the one-time sacral dressing application order on 8/10/25 there was no documentation the physician was consulted following the 8/10/25 one -time order for the dressing change to the sacrum until the resident was seen on 8/20/25 by the Wound Physician. On 9/11/25 at 12:05 PM the shift change report was reviewed with the Director of Nursing (DON). According to the DON, Nurse # 2 had worked a double shift which included 7:00 AM to 11:00 PM on 8/10/25. There was a	F0580		

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F0580 SS = E	Continued from page 5 notation on the shift change report that the information had been passed along to the nurse who started work at 11:00 PM on 8/10/25 that the resident had a sacral wound. According to the DON, Nurse # 3 cared for Resident # 8 on the following day of 8/11/25 starting at 7:00 AM. Nurse # 3 was interviewed on 9/11/25 at 12:15 PM and reported she could not recall specifically what she did when the information had been passed along to her in shift change report that Resident # 8 had a sacral wound on 8/11/25. She reported she would have passed the information along to the Wound Care Nurse. From 8/11/25 until 8/20/25 there was no further documentation the physician was notified about pressure sores. On 8/20/25 the Wound Physician documented she saw Resident # 8 and found a dressing to the resident's sacrum dated 8/12/25 on 8/20/25. The Wound Physician further documented the following. Resident # 8 had a Stage 4 pressure sore to the sacrum which measured 2.3 cm X 2 cm X 1 cm. There was 90 % slough and 10 % granulation tissue in the wound bed. The Wound Physician noted the area had not been known to exist by her or the Wound Care Nurse until that date (8/20/25). The treatment plan was for a medical honey and calcium alginate to be applied daily. The Wound Physician also noted Resident # 8 had deep tissue injury to her right heel which measured 5.1 x 4.7 x Not Measurable cm. The treatment plan was for a daily application of skin prep. The Wound Physician was interviewed on 9/10/25 at 4:32 PM and clarified she was not aware of the resident's sacral pressure sore until 8/20/25 and on 8/20/25 there was a dressing that was dated 8/12/25. The Wound Physician reported the facility could contact her at any time to obtain orders. The Wound Care Nurse was interviewed on 9/10/25 at 11:13 AM and reported the following information. She did not recall an old dressing being on Resident # 8's sacrum when the pressure sore was found on 8/20/25. She did not know about the pressure sore until 8/20/25. She had been on vacation from 8/11/25 to 8/15/25. On 9/8/25 an order was entered into the electronic record per the Nurse Practitioner for a hospice referral. During an interview with the DON on 9/11/25 at 7:55 AM, the DON reported the following information. Resident #	F0580		

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F0580 SS = E	Continued from page 6 8 had been declining recently. She used to eat and be involved in activities in the facility but had stopped eating and attending activities. Resident #8 also had some underlying medical problems and recent gynecological bleeding problems that had not fully been diagnosed yet. Regarding the care of Resident # 8's pressure sores, the DON reported the nurses should contact the physician about new pressures sores and obtain orders to treat any new pressure sores. On 9/10/25 at 1:30 PM the Wound Care Nurse was observed as she provided wound care for Resident # 8. Resident # 8's right heel appeared to have both pink and black tissue in the wound bed and was approximately the size of a baby food jar lid. The sacral pressure sore wound bed appeared to be pink and healing. During the interview with the Wound Care Physician on 9/10/25 at 4:32 PM the Wound Care Physician reported Resident # 8's sacral pressure sore had improved, and she did not think a lack of notifying the physician and carrying out wound care orders had resulted in the resident having a negative outcome. During an interview with the facility Medical Director on 9/11/25 at 11:45 AM, who served as the resident's primary physician, the physician reported the following information. The NP who had given the hospice order was not available that day. If Resident # 8 was appropriate for hospice services and also a diabetic, then it might be that the wounds would not heal regardless of treatment. She had not been aware of problems with communication about wound care to the facility's Wound Physician.	F0580		
F0686 SS = E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional	F0686	1. a. For Resident #1 – this resident was discharged from the facility on 8-29-2025 so we could not make corrections in regards to the cited deficient practices for this resident. b. For Resident #8 – the nurses that routinely takes care of Resident #8 will be inserviced that the nurse communicates with both the wound nurse and wound physician to ensure orders are obtained, initiated and carried out for pressure sore treatments per the wound care physician's plan of care; ensuring the settings of a pressure relieving are mattress are set correctly for pressure relief. 2. An initial audit will be performed to ensure the following:	10/10/2025

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F0686 SS = E	Continued from page 7 standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with staff and physicians the facility failed to 1) ensure Nurse Aides reported skin breakdown to a nurse prior to the wound bed being unstageable (Resident # 1); 2) ensure effective communication amongst nursing staff and the Wound Physician to ensure orders were obtained, initiated, and carried out for pressure sore treatments per the Wound Care Physician's plan of care (Resident # 1 and Resident #8); 3) ensure further diagnostic studies were completed per the Wound Care Physician's directions when a wound continued not to heal (Resident # 1), and 4) ensure the settings of a pressure relieving air mattress were set correctly for pressure relief (Resident # 8). This was for 2 of 3 of three sampled residents with pressure sores (Residents # 1 and # 8). The findings included: 1. Resident # 1 resided at the facility from 3/11/25 until her discharge to the hospital on 8/29/25. Resident # 1's diagnoses included cellulitis of the lower extremities, lymphedema, venous insufficiency, chronic kidney disease, anxiety, and gout. Resident # 1's admission Minimum Data Set assessment, dated 3/17/25, coded Resident # 1 as cognitively intact and as needing substantial to maximum staff assistance for bathing needs. The resident was coded as needing partial to moderate assistance with turning in bed. Resident # 1 was not coded as having a pressure sore upon admission. She was coded as having verbal behaviors. Resident # 1's care plan, initiated on 3/12/25 and last updated on 8/29/25, included information that Resident # 1 had a pressure sore to her sacrum for which she required treatment. The care plan also included information that Resident # 1 had the potential to show verbal and physical aggression and that she could be resistive to wound care. Staff were directed on the care plan to educate the resident about possible outcomes of noncompliance. Resident # 1's electronic record included pictures as part of the documentation regarding Resident # 1's sacral pressures sore development and assessment. The first picture was recorded on 4/4/25. In the documented picture, the sacral pressure sore appeared to have both	F0686	Continued from page 7 Every resident has a skin check performed to ensure all skin breakdown areas have been identified and are being properly treated. That the wound physician has been notified on any skin breakdown area on a resident and that orders have been obtained, initiated and carried out for pressure sore treatments as directed by the wound physician. That any diagnostic studies that were ordered by the wound care physician were completed on those wounds that continue not to heal. That the settings of a pressure relieving mattress are set correctly for pressure relief. This audit will be performed by the Director of Nursing along with the Administrator. This audit will be completed by 10-3-25. 3. The facility nursing staff (CNA's, Med Aide's, LPN's, RN's) will be inserviced on the following: When a CNA notices a skin breakdown area on a resident – the CNA is to report this to their nurse who will then report it to the wound nurse. This effective communication amongst the nursing staff is vital to ensure appropriate treatment is performed prior to the wound bed being unstable. Nurses – there needs to be effective communication with the wound physician to ensure orders for treatment are obtained, initiated and carried out for pressure sore treatments per the wound care physician's plan of care. Nurses – ensure that any diagnostic studies are completed per the wound care physician's directions when a wound continues not to heal. Nurses & CNA – ensure that the setting of a pressure relieving air mattress are set correctly for pressure relief. These inservices will be conducted by the staff development coordinator and will be completed by 10-3-25. 4. An audit will be conducted to ensure the following:	

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F0686 SS = E	Continued from page 8 black and yellow slough tissue in the wound bed. The electronic record did not include orders on 4/4/25 for the treatment of the pressure sore. A review of Resident # 1's April 2025 Medication Administration Record and Treatment Administration Record revealed no documented treatment from 4/1/25 through 4/11/25. Documentation on these records showed that sacral pressure sore treatment began on 4/12/25. The Wound Care Nurse was interviewed on 9/9/25 at 4:15 PM and on 9/10/25 at 11:13 AM and reported she (the Wound Care Nurse) kept written notes that had not been included in the resident's electronic record. The Wound Care Nurse referenced these notes and reported the following information. Resident # 1 had been noncompliant with care. Resident # 1's sacral pressure sore was first identified by her on 4/1/25. She had been caring for the resident's legs on 4/1/25 because the resident had cellulitis. On 4/1/25 she saw the sacral pressure sore and measured the pressure sore. It was 7 cm (centimeters) X 6 cm and was not stageable because it had black necrosis (dead tissue). The Nurse Aide had not let her know about the pressure sore before she (the Wound Nurse) found it. She (the Wound Care Nurse) had been working closely with the Wound Physician, who visited every week, and the Wound Physician had educated her that black necrosis would need to be removed for healing to take place. In working with the Wound Physician, she had been told that skin prep would be an appropriate measure for necrotic tissue. Therefore, she applied skin prep for the first few days when she found the pressure sore with the plan that the Wound Physician would look at the pressure sore when the Wound Physician was next at the facility. She (the Wound Care Nurse) did not call and talk with the Wound Physician or the primary physician. She did not enter orders into the resident's record for skin prep to the pressure sore. On 4/4/25 Nurse Aide (NA) # 1 came to get her (the Wound Care Nurse) and told her that NA # 2 was applying a cream on the resident's bottom and that she (NA #1) thought it needed something more than a barrier cream. She again looked at the pressure sore and decided to use Santyl (which is a chemical debriding topical cream). She dressed and cared for the pressure sore on that date by doing so. During the interview with the Wound Care Nurse, the yearly calendar was reviewed with the Wound Care Nurse, and it was pointed out that the dates of 4/5/25 and 4/6/25 would have corresponded to a week-end. The Wound Care Nurse reported she worked week-days and that the floor nurses would have cared for the pressure sore on the week-end. The Wound Care	F0686	Continued from page 8 That any new noted skin breakdown area on a resident are being properly treated That the wound physician has been notified on any new skin breakdown area(s) on a resident and that orders have been obtained, initiated and carried out for pressure sore treatments as directed by the wound physician That any diagnostic studies that are ordered by the wound care physician are completed on those wounds that continue not to heal. That the settings of a pressure relieving mattress are set correctly for pressure relief. These audits will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Director of Nursing or their designee. The audits will start during the week of 10-6-25. Target date for substantial compliance: 10-10-2025.	

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F0686 SS = E	Continued from page 9 Nurse was interviewed regarding how the primary care nurses would have known that the resident had a sacral pressure sore or what treatment orders should be followed if there were no orders entered into the resident's record. The Wound Care Nurse reported she had not recognized that as a problem. NA # 1 was interviewed on 9/10/25 at 2:50 PM and reported the following information. She did not recall a specific date but recalled that NA # 2 had called her to look at Resident # 1's bottom. NA # 2 was putting a barrier cream on an open skin area the resident had, and NA # 2 wanted her (NA # 1) to look at it. At the time, the open skin area was black and white, and she (NA # 1) told NA # 2 that it needed to be reported to the Wound Care Nurse. The Wound Care Nurse was notified that day. The Wound Care Physician was interviewed on 9/10/25 at 4:32 PM and reported the following information. She perceived the Wound Care Nurse to be very diligent in her work and very reliable but if she (the Wound Care Physician) had been contacted on 4/1/25 when Resident # 1 first was observed to have an unstageable wound she probably would not have ordered skin prep. The facility can contact her at any time to consult about orders. According to the Wound Physician, if she had been contacted on 4/1/25 she would have needed to consider how long it would be before she could actually see the resident and taken that into consideration in ordering what needed to be applied in the interim. Interview with the DON (Director of Nursing) on 9/11/25 at 11:10 AM revealed the following. NA # 2 was not available for interview during the survey. Nurse # 1 had cared for Resident # 1 on 4/5/25 (Saturday) and Nurse # 2 had cared for Resident # 1 on 4/6/25 (Sunday). An attempt was made to interview Nurse # 1 on 9/11/25 at 11:33 AM and she could not be reached for interview. Nurse # 2, who had cared for Resident # 1 on 4/6/25 (Sunday), was interviewed on 9/11/25 at 11:19 AM and reported the following information. She did not work full time at the facility, and she would not have known Resident # 1 had a pressure sore in order to do a treatment for the resident if there had been no orders. She did not ever recall caring for a pressure sore for Resident # 1. According to the record, Resident # 1 was seen by the Wound Physician on 4/8/25 for the first time. The Wound Physician documented the following information. The	F0686		

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F0686 SS = E	Continued from page 10 resident had a pressure sore with a duration of greater than four days. It measured 7 cm x 6 cm with a not measurable depth. It was 70% black necrotic tissue and, 20 % thick devitalized necrotic tissue, and 10 % granulation tissue. The Wound Physician's treatment plan for the sacral pressure sore included the following. The pressure sore was to be cleaned and an application of Santyl and Calcium Alginate was to be applied to the pressure sore on a daily basis or as needed for soiling. According to Resident # 1's electronic record, the Wound Physician's 4/8/25 treatment plan was entered in the resident's orders on 4/11/25 with a start date on the resident's MAR for 4/12/25. During the interview with the Wound Care Nurse on 9/9/25 at 4:15 PM and 9/10/25 at 11:13 AM the Wound Care Nurse reported the following information. When the Wound Physician made rounds, the Wound Physician would report to her (the Wound Care Nurse) the treatment orders/plan. She would start doing the treatments, but she would not enter the orders into the electronic record immediately. After the Wound Physician left, the Wound Physician would write the treatment plan orders and enter into a document that she (the Wound Care Nurse) would then download. From the downloaded document, she (the Wound Care Nurse) entered the orders. This was not always done on the same day that the Wound Physician visited and saw the resident. Therefore, that was why Resident # 1 had no orders from 4/8/25 until 4/11/25. Once the orders were entered they appeared on the MAR which was utilized for documentation of treatments in addition to medications. Continued review of Resident # 1's electronic record revealed the Wound Physician continued to follow Resident # 1 and on 5/30/25 orders were changed to include the application of a wound vac to the sacral pressure sore three times per week. During the interviews on 9/9/25 at 4:15 PM and 9/10/25 at 11:13 AM the Wound Care Nurse reported the following information. Resident # 1's pressure sore did not heal over several months and the Wound Physician ordered the wound vac. Resident # 1 was non-compliant and at times the wound vac seal would not work regardless of efforts to apply the dressing correctly. When the seal would break or there were problems with the wound vac, the resident would not report the issue although she was alert and oriented because she was non-compliant with the care. On 8/1/25 the Wound Physician documented the following	F0686		

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F0686 SS = E	Continued from page 11 assessment and notes. The sacral pressure sore measured 4 cm X 2.8 cm by 4.1 cm and also had undermining of 1.5 cm at the 12 o'clock position in the wound bed. (Undermining in a wound is when the edges of the wound are not connected to the lower tissues and there is an empty space beneath the edge of the wound.) The treatment still included the wound vac. Additionally the Wound Physician noted she performed a culture swab on 8/1/25. She further recommended obtaining lab work in the treatment plan to include the following: a complete blood count, an ESR (erythrocyte sedimentation rate), and a c-reactive protein. (These lab tests can help detect a possible infection and inflammation). Additionally, she recommended the resident have a x-ray of her lumbar sacral spine and coccyx to evaluate for underlying osteomyelitis or other pathology due to the resident having a chronic wound with pain. On 8/6/25 the Wound Physician documented the following assessment. The sacral pressure sore measured 6 cm X 1.4 cm X 4.6 cm with undermining of 1.3 cm at the 3 o'clock position in the wound bed. The wound bed included 10 % slough, 10 % granulation tissue, 60 % viable tissue which included subcutaneous/muscle/or fascia tissue, and 20 % skin. The Wound Physician noted the resident's lab work and x-ray were still pending and the wound culture had demonstrated that the resident had staph aureus in the wound. The antibiotic Doxycycline was ordered to be administered twice daily for 14 days. A review of Resident # 1's August 2025 MAR revealed the resident received the prescribed Doxycycline. On 8/13/25 the Wound Physician documented the following assessment. Resident # 1's sacral pressure sore measured 4.5 cm X 1.5 cm X 3. 5 cm with a total surface area of 6. 75 square cm. There was 2.5 cm undermining at the 12 o'clock position in the wound. The wound bed included 10 % slough, 40 % granulation tissue, 30 % viable tissue, and 20 % skin. The labs and the x-ray were still pending. On 8/20/25 the Wound Physician documented the following assessment. The sacral pressure sore measured 6.5 cm X 4.8 cm X 5.5 cm with a total surface area of 31.20 square centimeters. (This indicated a 24.45 square centimeter increase in total surface area in the wound bed since the Wound Physician's last assessment on 8/13/25.) The Wound Physician noted in her documentation that the lab work and x-ray were still pending. During the interview with the Wound Physician on	F0686		

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F0686 SS = E	Continued from page 12 9/10/25 at 4:32 PM the Wound Physician reported the following information. Noncompliance could have contributed to the poor healing of Resident # 1's pressure sore. She was "exceedingly unhappy" if she was not on her back and would not let the staff turn her. At times she would wiggle, and the wound vac tubing would kink and turn off the vacuum. The wound started to become more painful and she had requested the labs and the x-ray to investigate if there were further problems below the wound also contributing. She thought the Wound Care Nurse was working on getting the x-ray and labs. On 8/20/25 the wound bed seemed to ballon even more and she became "louder" about the need to get the x-ray and the labs. On 8/29/25 the Wound Physician documented the following assessment. Resident # 1's sacral pressure sore measured 6.5 cm X 4.8 cm X 5.5 cm. The total surface area was 31.20 square cm. There was 2.7 cm undermining at the 12 o'clock position in the wound bed. The wound bed included 20 % slough, 40 % granulation, 40 % subcutaneous and muscle tissue. The physician's goal for the wound had not been met. Part of the problems which contributed to the lack of progress were documented to be "patient non-compliant" and nutritional compromise. The physician noted the labs and x-ray were still pending. Review of lab work revealed the labs were completed on 8/29/25 with the following results noted. Resident # 1's white blood count was 12.72 (normal 4.50 to 11.0). (At times an increase in white blood cells can indicate infection.) Resident # 1's c-reactive protein was 119.1 (normal <5.0). Resident # 1's ESR was 66 (normal <30). (Elevated ESR lab values and elevated c-reactive proteins can indicate inflammation in the body). Additionally, the resident's hemoglobin showed a panic value of 6.4 (normal 12.0 to 16.0). During an interview with the DON (Director of Nursing) on 9/11/2025 at 7:55 AM the DON reported the following information. She had made rounds with the Wound Physician on 8/29/25 and she was made aware of the need for the x-rays and the labs on that date. The labs were obtained, and the resident was sent to the hospital based on her lab values. The x-ray was never done at the facility since she was transferred to the hospital and the DON had not known about the need prior to that. Review of hospital records for Resident # 1's hospitalization of 8/29/25 to 9/5/25 revealed the following information. The resident underwent conservative treatment for anemia and blood loss. Additionally Resident # 1 was diagnosed with	F0686		

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F0686 SS = E	Continued from page 13 osteomyelitis and underwent surgical debridement of the sacral pressure sore with administration of intravenous antibiotics. She was discharged to another facility for continued care on 9/5/25. During an interview with the Wound Care Nurse on 9/11/25 at 9:40 AM the Wound Care Nurse reported the following. When a resident had an existing pressure sore then she would print out the previous orders the Wound Physician had given during the previous week and carry it with her as she made rounds with the Wound Physician. As the Wound Physician would make treatment changes based on a new assessment, she (the Wound Care Nurse) would make notations about any new orders or changes. She was on vacation for a portion of August 2025, from 8/11/25 to 8/15/25. She did not recall the Wound Physician mentioning the needed labs and the needed x-ray in August 2025. The first she recalled about the needed lab and x-ray was when the DON talked to her about it on 8/29/25. The Wound Care Nurse reported she kept all the printed out records with notes from the weekly wound rounds in a binder. During the interview she reviewed her printed out records where she and the Wound Physician had made rounds on 8/1/25. There was a written notation on the printed out record that Resident # 1 needed the lab work and the x-rays. According to the Wound Care Nurse, the notation had been made by the physician, and she did not notice it. The Wound Care Nurse was also able to locate the printed out record for the date of 8/20/25 and it included the information that the labs and the x-ray were needed. She was not sure what happened that she had not seen the orders, transcribed them and made sure they were done. During the interview with the DON on 9/11/2025 at 7:55 AM the DON reported the following information. The facility does have standing orders for wound care. Nurses are supposed to apply Wet to Dry dressings until they can contact the physician for further orders if they identify new wounds. They should also contact the physician for changes in a wound. The facility also has protocols to use based on the appearance of the wound bed and the nurse should still contact the physician and obtain orders. All this information is kept in a binder at the nursing desk and the nurses should know that. Once orders are obtained then they are placed into the electronic medical record so they can be initiated. When the Wound Physician made rounds the protocol should be that the Wound Physician writes the orders on a physician order sheet so they can be entered into the electronic record that day or she can also enter them into the electronic record herself. The primary physician does not need to approve the Wound	F0686		

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F0686 SS = E	Continued from page 14 Physician's orders in order for them to be initiated. She did not routinely read all the Wound Physician's notes and if the Wound Physician had come to her about the need for the x-ray and lab work she would have made sure it was done. When Resident # 1 had resided at the facility she had been alert and oriented. She had also been noncompliant with some aspects of her care to include refusal of therapy and refusal of medications. The DON was also interviewed about the Nurse Aides not reporting the pressure sore before it was found by the Wound Care Nurse to be unstageable and the DON reported that the Nurse Aides are "going to tell you what is going on." According to the DON, NA # 2 had been assigned to Resident # 1 on the date the Wound Care Nurse reported she found the pressure sore and she (the DON) did not know why NA # 2 had not gone to the Wound Care Nurse. During an interview with the facility Medical Director on 9/11/25 at 11:45 AM, who served as Resident # 1's primary physician, the physician reported the following information. She did not recall being made aware of problems with providing wound care for Resident # 1's pressure sore. In general, if a resident was non-compliant and uncooperative with care, then it was her opinion that any problems that might have arisen with a wound could not be attributed as harm to the resident. During an interview with the Administrator on 9/11/25 at 10:30 AM, the Administrator reported the following information. No one had reported any problems with wound care at the facility or communication about orders between the Wound Physician and the staff. If he had known, he would have put a corrective action plan in place. 2a. Resident # 8 was initially admitted to the facility on 2/13/20. The resident had diagnoses which included diabetes, hypertension, history of stroke, dysphagia, and pain. On 7/28/25 a documented skin assessment showed no areas of skin breakdown. According to the record, Resident # 8 was hospitalized from 8/1/25 to 8/4/25 for altered mental status and a urinary tract infection. Upon the resident's return on 8/4/25 Nurse # 3 documented a nursing assessment. The assessment form included an area which included directions "note all skin issues." On this part of the assessment form, Nurse # 3 noted "sacrum." There was no further	F0686		

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F0686 SS = E	Continued from page 15 information about the size or description of what the issue was with Resident # 8's sacrum skin. Nurse # 3 was interviewed on 9/10/25 at 2:20 PM and reported she recalled Resident # 8 had an open area on the sacrum which was not deep when she was readmitted. She did not recall specific details other than that. She would have told the Wound Care Nurse. On 8/4/25 the Wound Care Nurse documented a skin assessment and noted Resident # 8 had a 5.02 cm X 3.84 cm deep tissue injury to her right heel. A heel protector and specialized boot was applied. The Wound Care Nurse did not note any area of skin breakdown to Resident # 8's sacrum. During an interview with the Wound Care Nurse on 9/10/25 at 11:13 AM the Wound Care Nurse reported she assessed Resident # 8's skin on 8/4/5 and she did not see an area of skin breakdown on 8/4/25. She did have a deep tissue injury to her right heel and she knew that skin prep would be appropriate for that. She began doing that daily with the plan for the Wound Physician to see the resident. She did not call the physician and obtain orders for the right heel deep tissue injury on 8/4/25. On 8/9/25 orders were entered into Resident # 1's electronic record to apply skin prep to the right heel deep tissue injury daily. The first documented treatment of skin prep to the right heel was on 8/10/25. There was no documented treatment for any area on the resident's sacrum from 8/4/25 to 8/9/25. On 8/10/25 at 9:00 PM Nurse # 2 documented Resident # 8 had a sacral wound which was observed to be open with no bleeding. The area was cleansed with normal saline and a dressing applied. Review of orders and the treatment records revealed Nurse # 1 obtained a one time order on 8/10/25 for the dressing she applied and documented the dressing change on 8/10/25 on the MAR (medication administration record). Following the dressing application of 8/10/25 there were no orders or plan to treat the Sacrum pressure sore until 8/20/25. There were no documented dressing changes until 8/20/25. Nurse # 2 was interviewed on 9/11/25 at 11:19 AM and reported the following information. She did not recall	F0686		

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F0686 SS = E	Continued from page 16 the specific appearance of Resident # 8's pressure sore on 8/10/25 when she got the one time order to dress the pressure sore. She did recall it was open and appeared to be more than a stage one. She had told the oncoming nurse about the pressures sore and assumed that the information would be passed along to the Wound Care Nurse and physician. She did not routinely work at the facility full time. She was not aware of any protocols the facility had. On 9/11/25 at 12:05 PM the shift change report was reviewed with the DON (Director of Nursing). According to the DON, Nurse # 2 had worked a double shift which included 7:00 AM to 11:00 PM on 8/10/25. There was a notation on the shift change report that the information had been passed along to the nurse who started work at 11:00 PM on 8/10/25 that the resident had a sacral wound. According to the DON, Nurse # 3 cared for Resident # 8 on the following day of 8/11/25 starting at 7:00 AM. Nurse # 3 was interviewed on 9/11/25 at 12:15 PM and reported she could not recall specifically what she did when the information had been passed along to her in shift change report that Resident # 8 had a sacral wound on 8/11/25. She reported she would have passed the information along to the Wound Care Nurse. On 8/20/25 the Wound Physician documented she saw Resident # 8 and found a dressing to the resident's sacrum dated 8/12/25 on the date of 8/20/25. The Wound Physician further documented the following. Resident # 8 had a Stage 4 pressure sore to the sacrum which measured 2.3 cm X 2 cm X 1 cm. There was 90 % slough and 10 % granulation tissue in the wound bed. The Wound Physician noted the area had not been known to exist by her or the Wound Care Nurse until that date (8/20/25). In part of the documentation the Wound Care Physician documented "noted to be present on admission per staff." In another part of the documentation the Wound Physician noted "not present upon admission." The treatment plan was for a medical honey and calcium alginate to be applied daily. The Wound Physician also noted Resident # 8 had deep tissue injury to her right heel which measured 5.1 x 4.7 x Not Measurable cm. The treatment plan was for a daily application of skin prep. The Wound Physician was interviewed on 9/10/25 at 4:32 PM and clarified her notation that read "not present upon admission" should have read "noted present upon admission" because it was her understanding the area had existed upon admission on 8/4/25. She was not aware of it until 8/20/25 and on that date there was a	F0686		

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F0686 SS = E	Continued from page 17 dressing that was dated 8/12/25. That was disturbing to her that a dressing could have been on for eight days and therefore she had documented it. She did not recall how soiled the dressing was. The wound bed did not look infected. The Wound Care Nurse was interviewed on 9/10/25 at 11:13 AM and reported the following information. She did not recall an old dressing being on Resident # 8's sacrum when the pressure sore was found on 8/20/25. She did not know about the pressure sore until 8/20/25. She had been on vacation from 8/11/25 to 8/15/25. On 8/22/25 the first orders for more than a one- time treatment were entered into the electronic medical record for the resident's sacral pressure sore. The order was for the medical honey and calcium alginate to be applied daily. The first application of this dressing was documented on 8/23/25. During an interview with the Wound Care Nurse on 9/9/25 at 4:15 PM and 9/10/25 at 11:13 the Wound Care Nurse reported she would have done the dressing change to Resident # 8's sacrum on 8/21/25 and 8/22/25 per the directions of the Wound Physician. She had not entered the order into the electronic system until she downloaded the Wound Physician's instructions on a date following 8/20/25. On 8/27/25 the Wound Physician noted the following assessment and plan. Resident # 8's right heel deep tissue injury measured 5.2 cm X 5 cm X not measurable depth. There was a plan to change the treatment to an application of medical honey and calcium alginate daily. Resident # 8's sacrum pressure sore was noted to have improved and measured 2.3 cm X 1.5 cm X 0.7 cm and included 60 % granulation tissue and 40 % slough. The treatment plan remained the same for the sacral pressure sore. A review of the record revealed the new treatment plan for Resident # 8's right heel never got transcribed as an order into the electronic record. According to treatment documentation the skin prep continued. On 9/8/25 the Wound Physician documented the following assessment. Resident # 8's right heel had improved and measured 3 cm X 4.7 cm X 0.3 cm. The wound bed included 60 % necrotic tissue and 40 % granulation tissue. The treatment plan was to apply calcium alginate with a nickel thick layer of Santyl to the right heel daily. Resident # 8's sacral pressure sore had improved and was 1.4 cm X 1.6 cm X 0.1 cm. It was 100 % granulation tissue.	F0686		

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F0686 SS = E	Continued from page 18 On 9/8/25 an order was entered into the electronic record per the Nurse Practitioner for a hospice referral. During an interview with the DON on 9/11/25 at 7:55 AM, the DON reported the following information. Resident # 8 had been declining recently. She used to eat and be involved in activities in the facility but had stopped eating and attending activities. She also had some underlying medical problems and recent gynecological bleeding problems that had not fully been diagnosed yet. Regarding the care of Resident # 8's pressure sores, the DON reported the nurses should contact the physician and obtain orders to treat any new pressure sores. There was a protocol to follow. Orders should be entered into the system and be followed. According to the electronic record, orders were entered to start on 9/11/25 for the calcium alginate and Santyl to the right posterior heel. The orders, which should have been discontinued on 8/27/25 for skin prep to the right heel, were discontinued on 9/10/25. On 9/10/25 at 1:30 PM the Wound Care Nurse was observed as she provided wound care for Resident # 8. The Wound Care Nurse reported she would apply the calcium alginate to the right heel but she did not yet have the Santyl that was part of the Wound Physician's treatment plan on 9/8/25. This was because the order had not been entered on 9/8/25 and therefore the pharmacy had not sent the Santyl yet. Resident # 8's right heel appeared to have both pink and black tissue in the wound bed and was approximately the size of a baby food jar lid. The Wound Care Nurse was observed to care for Resident # 8's sacrum pressure sore as per the Wound Care Physician's orders. The wound bed appeared to be pink and healing. During the interview with the Wound Care Physician on 9/10/25 at 4:32 PM the Wound Care Physician reported Resident # 8's sacral pressure sore had improved, and she did not think a lack of communication and not carrying out orders had resulted in the resident having a negative outcome. It was her expectation that the treatment plan be carried out when she made the rounds and not days later. She routinely put the treatment plan in her notes and provided her notes to the facility before "leaving the parking lot" on wound round days. During an interview with the facility Medical Director on 9/11/25 at 11:45 AM, who served as the resident's primary physician, the physician reported the following	F0686		

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F0686 SS = E	Continued from page 19 information. The NP who had given the hospice order was not available that day. If Resident # 8 was appropriate for hospice services and also a diabetic, then it might be that the wounds would not heal regardless of treatment. She had not been aware of problems with communication about wound care. The Wound Physician could enter her own orders in the electronic system and did not need her (the primary physician's approval). 2b. Review or Resident # 8's quarterly Minimum Data Set assessment, dated 8/10/25, revealed the resident weighed 188 pounds. On 9/9/25 at 10:27 AM Resident # 8's air mattress was observed to be on a setting for an individual that weighed 420 pounds. (The air mattress had settings which correlated to a resident's weight.) On 9/10/25 at 1:30 PM Resident # 8's air mattress was again observed to be on a setting for an individual that weighed 420 pounds. The Wound Care Nurse was interviewed at the time and reported the setting was incorrect. She reported that at times the staff might turn the setting higher to make the mattress firmer in order to turn and reposition her easier. The Wound Care Nurse reported the setting should be at 150 pounds because that was the weight setting closest to the resident's weight. The Wound Care Nurse was interviewed regarding who was responsible for checking the settings and reported that everyone was accountable to look at it and make sure it was right when they cared for Resident #8. During the interview with the Wound Care Physician on 9/10/25 at 4:32 PM the Wound Care Physician reported that if the air mattress was set for a weight more than what an individual weighed then this meant there would be more pressure on the resident.	F0686		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F0689	The mechanical lift sling that was used on Resident #3 was immediately taken out of circulation. The sling was thrown away in the dumpster outside to make sure that it was not removed from a trash can for any reason. The administrator was the person who threw the sling in the dumpster. 2. All other mechanical lift slings in the facility were inspected to ensure that they were all in good condition with no rips, tears or worn areas. The seams of the hooks were also inspected to make sure that there were no compromised areas. The slings were inspected by the maintenance department along with the administrator. The inspections took place on 1-7-25.	10/10/2025

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F0689 SS = G	Continued from page 20 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with resident, staff, and a representative from the company that manufactures the mechanical lifts used at the facility, the facility failed to ensure a resident was safely transferred by a mechanical lift. A mechanical lift sling broke while Resident # 3 was being transferred resulting in Resident # 3 sustaining a fractured humerus (large bone of the upper arm). This was for 1 of 3 residents reviewed for accidents (Resident # 3). The findings included: Resident # 3 was admitted to the facility on 10/20/20. The resident had diagnoses which included stroke and chronic pain. Resident # 3's quarterly Minimum Data Set assessment, dated 7/18/25, coded Resident # 3 as cognitively intact and as totally dependent on staff for transfers. Resident # 3's care plan, last updated on 8/29/25, included the information that Resident # 3 required total staff assistance for transfers. On 1/7/25 at 12:33 PM Nurse # 4 documented the following information. Two Nurse Aides were transferring Resident # 3 with a mechanical lift when one of the four straps broke, and the resident was lowered to the floor. The resident hit her head and her left shoulder. The Nurse Practitioner was made aware, and the resident was sent to the hospital for evaluation. Nurse Aide (NA) # 3 was one of the Nurse Aides who had been assisting in the transfer on 1/7/25. NA # 3 was interviewed on 9/10/25 at 3:11 PM and reported the following information. As he and NA # 4 were transferring Resident # 3 with the mechanical lift one of the straps tore away from the body of the sling where the strap was joined into the body of the sling. He had not noticed anything wrong with the sling or strap prior to the transfer, and they had been using the correct size lift sling also. NA # 4 was one of the Nurse Aides who had been assisting in the transfer on 1/7/25. NA # 4 was interviewed on 9/10/25 at 3:19 PM and reported the following information. On the day of the incident one of the straps broke away from the body of the lift sling where the strap joined the body of the sling. She	F0689	Continued from page 20 3. The maintenance department along with the laundry department were inserviced on making sure that the mechanical lift slings were in good condition. The laundry department looks at the condition of the slings when they are brought down to be washed and will report any problems with a sling to the environmental services director. This inservice was led by the administrator. The inservice took place on 1-7-25. The facility CNA's and nurses will be inserviced on making sure that the mechanical lift slings are in good condition prior to being used. They are to look at the condition of the slings to ensure that there are no rips, tears or worn areas that may compromise the sling. This inservice will be led by the staff development coordinator and will be completed by 10-10-25. 4. A weekly audit will be performed to check on the condition of the mechanical lift slings. The audit will be completed by a member of the maintenance department. The audit will be reviewed with the administrator after they are completed. This audit will be completed weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the facility Quality Assessment and Assurance committee meeting to ensure that the mechanical lift slings are in good condition with no compromised areas.	

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F0689 SS = G	Continued from page 21 had not noticed anything wrong with the lift sling prior to the incident. They lowered the resident to the floor and called the nurse immediately. Nurse # 4 was interviewed on 9/10/25 at 3:05 PM and reported the following information. It was reported to her that one of the straps broke and the resident was lowered to the floor. Resident # 3 bumped her head and left arm on the bed rail while going down. She did not recall what the sling looked like specifically that day. In general, she thought some of the slings had looked thin. After the incident Resident # 3 was sent to the hospital. Resident # 3 was interviewed on 9/9/25 at 10:00 AM and reported the following information. She recalled earlier in the year NA # 3 and NA # 4 were helping transfer her in the mechanical lift when the sling broke and she was dropped. It hurt when they dropped her. As she recalled it was her “collarbone” area that was broken. Review of 1/7/25 hospital records revealed Resident # 3 was evaluated in the hospital ED (Emergency Department) for left shoulder pain. The ED physician documented the following information. The resident was on Eliquis (an anticoagulant medication) at the facility. She was transferred to the ED for assessment following a fall. He had spoken to the facility staff who reported that a strap on the mechanical lift had broken, and the resident did not fully fall out of the lift. Her left arm dropped, and she hit her head on the bed rail. She was then lowered to the ground. X-rays and a CT (computerized tomography) scan were done. Resident # 3 was identified to have a left humerus fracture. An orthopedic consult was done, and the resident was not deemed to need surgery. Her arm was placed in a sling for immobilization with plans for an orthopedic follow up in three weeks. A CT of the head showed no evidence signs of hemorrhage. The resident’s facility medications were reviewed by the ED physician who noted the resident already had orders for Cymbalta (used for chronic pain), baclofen (a muscle relaxer), and gabapentin (a seizure medication used to treat chronic pain) and also had orders for acetaminophen and tramadol (a controlled medication used for pain control) to be used as needed for pain. She was discharged back to the facility on 1/7/25 at 5:01 PM in stable condition according to hospital records. On 9/10/25 at 3:40 PM a Representative from the manufacturing company of the mechanical lifts was interviewed and reported the following information. It would be hard to say what had occurred with the sling	F0689		

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F0689 SS = G	Continued from page 22 without viewing the sling. It could have been that the sling was worn from normal use and laundering, or it could have been defective. The Representative indicated when incidents occur, the facility was welcome to call one of their regional representatives and the representative would come and view the sling to see if they could determine what had occurred. The Director of Nursing (DON) was interviewed on 9/8/25 at 7:38 AM and reported the following information. The lift sling was assessed by the facility after the incident, and it had been broken. The weight limit for all their slings was 600 pounds and Resident # 3 had not exceeded the weight limit of the sling. After the incident the Administrator and the Maintenance Director looked at all the lift slings and any old slings were thrown away by them. New slings were ordered by the Administrator. Every resident had a lift sling. If a lift sling was sent to laundry for laundering, the laundry personnel checked the sling before it was returned for use. There were two laundry staff members during the day and then a staff member who worked from 3:00 PM to midnight in the laundry room. These laundry staff were available to give the lift slings to a Nurse Aide after laundering. There was an in-service for the laundry room staff incident regarding checking the lift slings after laundering. The Administrator and the Maintenance Director were interviewed on 9/11/25 at 9:07 AM. The Administrator reported the following information. He had obtained the broken sling after the 1/7/25 incident and saw that it was ripped at the seam. The hook itself was not broken. He did not want the sling to ever be used again and therefore he threw it in the dumpster that day. The sling wasn't very old. Slings were replaced every six months. Resident # 3's weight had not been an issue because the sling went up to 600 pounds. After the incident, maintenance went through every sling in the facility to ensure they were in good condition and did not find other slings in disrepair. He (the Administrator) ordered new slings as well. Because the slings were seen by laundry the most, the laundry staff were inserviced to check the slings after they went through the laundry each time they were laundered to ensure they remained in good condition after the laundry process. The Administrator presented a corrective action plan which they had implemented on 1/7/25 and completed on 1/8/25. A review of the corrective action plan revealed it did not include training for the nursing staff regarding the safety of the slings. Therefore, the corrective action plan was not accepted.	F0689		

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