STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING ______ B. WING ______	C 01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 1/2/25. Areas surveyed included a resident who fell from a mechanical lift that resulted in a fracture. Good Samaritan Society De Smet was found not in compliance with the following requirements: F600, F609, and F686.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the facility failed to protect the resident's right to be free from neglect when one of one sampled resident's (1) physician orders following a left lower extremity (LLE) fracture were not followed to promote healing. Findings include:	F 600	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1- CNA E terminated due to not following policies and procedures. Immediate action was taken to ensure the interviewed resident #1 leg was properly secured in the knee immobilizer per physician orders. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? The Director of Nursing has reviewed and assessed all residents for fall risk, due to the need for utilization of sit to stand or total lift devices. All residents were reviewed, no other residents exhibited the same type of lower left leg injury or fracture at this time.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamesfoster
TITLE: Administrator
(X6) DATE: 1/30/2025

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 instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 1. Review of the provider's 10/23/24 SD DOH FRI regarding resident 1 revealed: *On 10/21/24 resident 1 was being transferred with a sit-to-stand lift (mechanical lift used to assist from a seated to a standing position) and she was lowered to the floor. -CNA E assisted her up from the floor with a full body mechanical lift to the wheelchair. -Resident 1 complained of left leg pain that afternoon. -Orders were received for an x-ray and a doppler (ultrasound) for her left leg from her primary care provider. --The primary care provider did not feel these tests were urgent. -Radiology was not able to schedule the tests until 10/23/24. *On 10/23/24 the provider received a fax from x-ray that indicated resident 1 had a fracture of her left lower leg. -The primary care provider recommended emergency room (ER) consult for orthopedic care. -Resident 1 was transferred via ambulance to the ER. *On 10/24/24 resident 1 was discharged from the hospital with orders that no surgery was needed and a stabilizer was placed on her left leg. -She was non-weight bearing to her left leg and needed a full body mechanical lift (mechanical lift and sling used to lift a person's full body) for all transfers. *CNA E stated she had immediately reported the incident to registered nurse (RN) C. Observation and interview on 1/2/25 at 3:10 p.m. with resident 1 revealed: *She was seated in her recliner with her feet elevated.	F 600	3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Education was provided to all staff by the Director of Nursing for which residents were using a knee immobilizer and what the physician orders were to promote healing and ensure compliance with orthopedic devices. The facility will also implement a process change to include a daily clinical monitoring meeting with the Director of Nursing and other essential departments to review any new physician order changes or a change in condition that need to be addressed and reviewed. Education was provided to all staff regarding fall prevention management including sit-stand and total lifts. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Random audits will be completed by the Director of Nursing, or designee, for residents who are using any orthopedic devices to ensure physicians orders are being followed and proper use of lifts. Audits will be conducted 3X a week for 4 weeks, then 2X a week for 1 month, and 1X monthly for 3 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	Substantial Compliance date of 01/28/2025

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F 600	Continued From page 2 *A black knee immobilizer was present on her left leg from mid-thigh to mid-calf and was secured with Velcro. *When asked about her fall, she stated that she had broken her leg during the fall. *She indicated that she had been seeing a "specialist" and she was told that she was now able to do "therapy" on her leg. *She stated she didn't know how much to share, but her daughter could give more information. Phone interview on 1/2/24 at 4:12 p.m. with resident 1's daughter revealed: *Regarding resident 1's fall on 10/21/24, and she stated she "Only knew what nursing home folks told me [what] mom told me, but she [resident 1] was confused at the time." *She was told by resident 1: -A certified nursing assistant (CNA) was transferring her. -She told the CNA that it [the lift] didn't "feel right". -The CNA told her; it would be alright and continued the transfer. *Resident 1's daughter stated that she did not think that resident 1 had fallen, but when she talked to her mother on 10/21/24 it was unclear. *She was aware that the provider was notified, and an x-ray was ordered after the fall. *She stated the x-ray could not be scheduled for three days. *She talked to the nurse, and it didn't seem to her that the nurse thought it was serious. *She felt there was some minimization of the situation, and they should have taken her mother to the hospital right away. *On 10/22/24 she noticed that resident 1 was confused. *She stated, when she saw resident 1 on 10/23/24 at the hospital, she was concerned that	F 600		

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F 600	Continued From page 3 resident 1 had been "miserable in pain" for three days. *A urine test at the hospital showed she had a urinary tract infection (UTI). *On 10/24/24 resident 1 was discharged from the hospital and returned to the facility. *Her discharge orders included resident 1 was to always wear the leg immobilizer and keep her leg elevated. *When the facility staff picked up resident 1 from the hospital the staff was given those instructions by the hospital staff. *She stated she felt the management staff understood the instructions but did not feel it was being followed by the CNAs. *At resident 1's two-week follow-up appointment she witnessed: -The knee immobilizer was below resident 1's knee, when it should have been placed mid-thigh. -Her pants were over-the-knee immobilizer. -Her knee was bent at a 90-degree angle and not elevated. *She stated, that after the appointment, it took another two weeks before the staff cared for her leg "properly". *She and her sister had posted pictures on resident 1's wall regarding the care of her leg. *Her sister had come to the facility daily and educated the CNAs on the care of resident 1's leg. *At resident 1's second follow-up appointment with the orthopedic (bone specialist) surgeon resident 1's daughter was told that unless the leg was cared for as he instructed, the bone would not heal. *She indicated that resident 1 had told her that if she tried to tell the CNAs about the care of her leg the CNAs would "dismiss" her. *Resident 1 reported to her that a CNA had left	F 600		

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F 600	Continued From page 4 the immobilizer off her leg when she was placed in bed. -She told the CNA that the immobilizer needed to be on, and the CNA stated she did not need it on in bed. *Resident 1 had told her daughter that she felt that the staff did not like her because she kept getting the staff in trouble. Review of resident 1's medical record revealed: *She was admitted on 5/27/22. *Her 10/18/24 Brief Interview of Mental Status assessment score was 15, which indicated her cognition was intact. *Her diagnoses included: fracture of shaft of tibia (10/23/24), urinary tract infection (10/23/24), Type 2 diabetes, macular degeneration, chronic kidney disease, arthritis, hearing loss, and folate deficiency (when the body does not have enough water-soluble B vitamin that is essential for cell growth and development, symptoms include fatigue and weakness). Review of resident 1's falls risk reports revealed: *On 10/7/24 she had slipped out of her wheelchair due to her wheelchair cushion. -Her fall risk assessment score was a 9, which indicated she was at a low risk of falls. *On 10/22/24 she had fallen from a mechanical lift and was referred to her medical provider. -Her fall risk assessment score was an 11, which indicated she was at a low risk for falls. Review of resident 1's nurses progress notes revealed: *On 10/21/24 she was lowered to the floor by a CNA while using a sit-to-stand mechanical lift. -An x-ray was ordered for her left lower leg. *On 10/23/24 "Updated daughter in resident's	F 600		

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F 600	Continued From page 5	F 600		

increased confusion and requiring assistance with eating breakfast this morning. Daughter stated she noticed the confusion last night during her phone call. DON discussed with daughter about sending an order for UA [urinalysis] to rule out UTI as res [resident] has a hx [history] of UTI. Daughter thought this was a good idea and thanked DON for following up on this."
-UA was obtained "Resident tolerated well. Resident continues to be drowsy and has no remained in bed to rest.
-The certified nurse practitioner notified the provider that the x-ray results indicated a fracture to resident 1's lower left leg, and to send her to the emergency room to be evaluated for increased confusion and diagnosis of urinary tract infection and to see the orthopedic specialist "right away".
-Her daughter was notified, and stated she would meet resident 1 at the hospital.
-"Resident left facility via gurney transport to the ER.
-The ER notified the provider that there would be no surgery and they would be placing a stabilizer (brace) on resident 1's left leg.
*On 10/24/24 "resident returned ...via facility van in facility w/c [wheelchair]".
*On 10/28/24 she had been prescribed hydrocodone for left leg pain and she had increased confusion since starting this.
-Her primary care provider (PCP) was notified.
-On 10/29/24 her PCP stopped the order for hydrocodone related to her confusion.
-He ordered to start tramadol 50 mg every 8 hours as needed for "extreme pain."

Review of resident 1's pain assessments revealed:
*Between 9/16/24 and 10/17/24 her pain scores

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F 600	Continued From page 6	F 600		

were a 0 on a 0 to 10 scale, which indicated she did not have pain.
*On 10/21/24 her pain scores were six and four.
*On 10/22/24 her pain score was a six.
*On 10/23/24 her pain score was a nine.
*Her physician orders included:
-On 10/24/24 non-weight bearing to her left lower extremity (LLE).
-On 11/5/24 when resident 1 was in her wheelchair her left foot pedal needed to be elevated in the highest position and immobilizer to LLE was to be always on, when she was in bed the brace could be open to help with skin integrity.
--"Make sure brace is over the knee and is put on over resident's pants per ortho [orthopedic specialist]".
Review of resident 1's skin observations assessments revealed:
*On 11/7/24 she had a brace to her left lower leg.
-The brace "may be open while she was in bed and was to be over her pants when she was up.
-The leg needed to be elevated when she was sitting in her wheelchair, with a pillow on her leg for support.
-A note that indicated a heel cushion and air mattress would be added.
*On 12/16/24 and on 12/30/24 she had a brace to her left lower leg.
-The brace "may be open" while she was in bed and was to be over her pants when she was up.
-The leg needed to be elevated when she was sitting in her wheelchair, with a pillow on her leg for support.
-A note that indicated her heel was to be floated on a pillow and she had an air mattress on her bed.

Review of resident 1's orthopedic progress notes

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F 600	Continued From page 7 revealed: *On 10/24/24 she must be in "straight leg brace at all times." -"If resting in bed can have the brace open to help with skin integrity." *On 11/5/24 a note that included "continue knee immobilizer at all times except skin care", and non-weight bearing left lower extremity. *On 12/12/24 a note that included "non weight bearing" to her left lower leg, "continue knee immobilizer no standing". Interview on 1/2/25 at 5:02 p.m. with director of nursing B regarding resident 1 revealed: *Staff complete safe resident handling training and competencies during orientation and before they worked with residents. *Training is reinforced at staff stand-up huddles and staff meetings. *They had the provider come to the nursing home to see the resident. -The provider ordered an x-ray; the provider did not feel it was urgent. *Pain medication was given, and the resident's pain was managed. *The resident's cognition was intact and there were no cognitive changes at the nursing home. *Neither the resident nor the daughter demanded she be taken to the hospital. *The Nurse Practitioner gave orders to transport the patient to the emergency room after the X-ray results showed a fracture. * The facility transported her to the hospital. *The hospital tested and treated her for a UTI, they had felt the cognitive changes were related to her pain. *She was at the hospital for one night on observation and then discharged and transported back to the facility with the orthopedic physician's	F 600		

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F 600	Continued From page 8	F 600		

discharge orders for the non-weight bearing of the left leg, immobilizer brace, and to elevate her left leg.
*The charge nurse received the orders and relayed them to the staff during shift change.
*The only time she was aware of the immobilizer not being used correctly was when the daughter called her from the follow-up orthopedic appointment.
*When the daughter and resident 1 voiced concerns to DON B regarding the care of resident 1's LLE fracture, DON B educated the staff.
-She "intermittently" observed the placement of the brace and the elevation of resident 1's LLE to ensure proper care.
*The resident was very good at expressing how her immobilizer should be placed and maintained on her leg.
-DON B stated she felt the staff listened to resident 1.

Review of the provider's 11/13/24 Abuse and Neglect Reporting policy revealed:
*"Definitions:"
-"Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness."
*"Policy:"
-"The agency will comply will all applicable federal, state or local laws regarding abuse or neglect."

Review of the provider's 7/22/24 Abuse and Neglect policy revealed:
*"Policy
-The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation."

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F 609	Continued From page 9	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to ensure an incident involving one of one sampled resident (1) who fell from a mechanical lift during a transfer that resulted in a major injury was	F 609	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1- All staff were re-educated on the timely reporting with abuse and neglect policy and procedure. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? The Director of Nursing has reviewed and assessed all residents for fall risk, due to the need for utilization of sit to stand or total lift devices. Residents using sit to stand 5 and total lifts 17. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Re-education was provided to all staff on abuse and neglect policy and procedures and timely reporting. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing, or designee, will complete random audits of staff interviews for timely reporting with abuse and neglect policy and procedure 3X a week for 4 weeks, then 2X a week for 1 month, and 1X monthly for 3 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee	Substantial Compliance date of 01/28/2025

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F 609	Continued From page 10 reported timely to the SD DOH. Findings include: 1. Review of the provider's 10/23/24 SD DOH FRI regarding resident 1 revealed: *On 10/21/24 resident 1 was being transferred with a sit-to-stand lift (mechanical lift used to assist from a seated to a standing position) and she was lowered to the floor. -CNA E assisted her up from the floor with a full body mechanical lift to her wheelchair. -Resident 1 complained of left leg pain that afternoon. -Orders were received for an x-ray and a doppler (ultrasound) for her left leg from her primary care provider. *On 10/23/24 at 2:52 p.m. the provider received a fax from x-ray that resident 1 had a fracture of her left lower leg. -The primary care provider recommended emergency room (ER) consult for orthopedic care. -Resident 1 was transferred via ambulance to the ER. Review of the provider's Fall Scene Huddle Worksheet regarding resident 1 revealed: *The form included the fall occurred on 10/21/24 at 8:30 a.m. -A staff member was in the room assisting resident 1 with a transfer using a sit-to-stand lift (mechanical lift used to assist from a seated to a standing position). -A registered nurse was called to the room after resident 1 was lowered to the floor from the lift. -Under the section labeled "Comments" there was a note the incident was reported after the resident complained of pain to her left leg, resident stated she had told the CNA her feet were not positioned right. CNA stated the resident	F 609		

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F 609	Continued From page 11 said she was slipping. The CNA lowered resident 1 to the floor as the bed was too high and her wheelchair was not ready for resident 1 to sit in. Interview on 1/2/25 at 5:02 p.m. with director of nursing B regarding resident 1 revealed: *She was not in the facility on 10/21/24. *She was notified of the incident on 10/22/24. *Registered nurse C should have notified her of the incident on 10/21/24 and had not. *She stated the CNA's changed her version of what happened a couple different times and those did not match what the resident had reported. -This caused a one-day delay in starting the investigation and reporting to the SD DOH. Review of the provider's 11/13/24 Abuse and Neglect Reporting policy revealed: *"Purpose -To ensure that employees, contracted staff, and volunteers are knowledgeable in reporting abuse and neglect of their patients/clients -To provide intervention and reporting in the case of suspected or confirmed abuse, exploitation, or neglect". *"Definitions:" -"Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." *"Policy:" -"The agency will comply will all applicable federal, state or local laws regarding abuse or neglect." -"The agency will ensure that all identified incidents of alleged or suspected abuse/neglect are promptly reported, investigated, and documented." *"Procedure"	F 609		

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	435074	A. BUILDING ____ B. WING ____	C 01/02/2025

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F 609	Continued From page 12 -"The employee will report any situation that may be considered abuse, neglect or misappropriation of property immediately to the Administrator/designee. --Immediately means without delay." Review of the provider's 7/22/24 Abuse and Neglect policy revealed: *"Purpose" -"To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated." *"Policy -The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation." -"Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediately reporting of alleged violations: the director of nursing services or the supervisor of social services." *"Notification procedures:" -"Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. -In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.)" -"Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency." -"if there is an allegation of abuse, neglect,	F 609		

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F 609	Continued From page 13 exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than 24 hours after the allegation is made."	F 609		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to initiate preventative interventions for one of one sampled resident (1) who was at risk for and developed a pressure ulcer to her left heel after fracturing her left lower leg during a fall. Findings include: 1. Observation on 1/2/25 at 2:45 p.m. of resident 1's room revealed: *Two light blue padded heel protector boots were on the bed. *An air mattress was present and inflated on the bed frame. *Resident 1 was seated in her wheelchair	F 686	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident number #1 - the nurses caring for this resident at the time were provided with immediate re-education on following policy and procedure on Skin Assessment Pressure Ulcer Prevention and Documentation requirements. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? The Director of Nursing has reviewed all residents, utilized the BRADEN assessment tool, and identified those at higher risk depending on their score; 1 resident determined at high risk, 10 residents determined at moderate risk and preventative measure identified to be in place. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Education provided to all staff regarding Skin Assessment Pressure Ulcer Prevention and Documentation and implementing preventative measures to prevent pressure ulcers. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Audits will be completed by the Director of Nursing, or designee, for residents at risk for developing pressure ulcers and to ensure	

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F 686	Continued From page 14 listening to an audiobook with her back towards the door. *There was a gait belt, pillow, and hangers on the recliner seat. Observation and interview on 1/2/25 at 3:02 p.m. with certified nursing assistant (CNA) F revealed: *She exited resident 1's room with a full-body lift. *She stated resident 1 had needed to be transferred with a full-body lift since she started working at the facility. *She was a travel CNA who had been working at the facility since the end of October. *She stated resident 1 had needed to be transferred with a full-body lift (a mechanical lift and sling used to lift a person's full body) since she started working at the facility. Observation and interview on 1/2/25 at 3:10 p.m. with resident 1 revealed: *She was seated in the recliner with her feet elevated. *A black knee immobilizer (splint) was present on her left leg. -The splint extended from her lower calf to her mid-thigh and was secured in place with Velcro. *When asked about her fall, she stated that she had broken her leg during the fall. *She indicated that she had been seeing a "specialist" and she was told that she was now able to do "therapy" on her leg. Review of resident 1's medical record revealed: *She was admitted on 5/27/22. *Her 10/18/24 Brief Interview of Mental Status assessment score was 15, which indicated her cognition was intact. *Her diagnoses included: fracture of her left lower leg on 10/23/24, Type 2 diabetes, macular	F 686	preventative measures are put into place. Audits will be conducted 3X a week for 4 weeks, then 2X a week for 1 month, and 1X monthly for 3 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	Substantial Compliance date of 01/28/2025

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F 686	Continued From page 15 degeneration, and folate deficiency. *Her physician orders included: -A 10/24/24 non-weight bearing to her left lower extremity (LLE). -An 11/5/24 when resident 1 was in her wheelchair her left foot pedal needed to be elevated in the highest position and immobilizer to LLE was to be on at all times, when she was in bed the brace could be open to help with skin integrity. *Her 1/2/25 care plan included: -A 6/1/22 focus that she had the potential for pressure ulcer development R/T [related to] impaired mobility. --Interventions imitated on 6/1/22 and revised on 12/10/24 included "provide pressure relief cushion in wheelchair and recliner. Pressure reducing mattress on bed." -A 10/24/24 focus that she was at risk for falls related to weakness, poor activity tolerance and impaired mobility evidenced by a history of falls with the most recent fall being 10/21/24. --Interventions for this focus included "remind resident to call for assistance to reposition in wheelchair and lock brakes prior to attempting to rise from wheelchair" and "Reminded resident if feeling tired to call staff to sit in recliner to nap". -A 11/11/24 focus that she had a deep pressure injury to her left heel. --The goal for this focus included "Resident will have no complications R/T [related to] non-pressure wound to L foot through the review date." --Interventions initiated on 11/7/24 included to elevate her heels off bed, to use heel protectors, and provide an air mattress. Review of resident 1's 10/16/24 Braden Scale (an assessment used to predict pressure sore risk)	F 686		

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F 686	Continued From page 16	F 686		

score was a 15.0 which indicated she was at mild risk for developing a pressure ulcer.

Review of resident 1's skin observations assessments revealed:
*On 11/7/24 she had a Stage 1 (red non-blanchable skin area) pressure ulcer (PU) on her left heel that measured 1.5 cm (centimeters) by 1.3 cm.
-Her left leg was to be elevated as she had a brace on her left lower leg due to a fracture.
-A note that indicated a heel cushion and air mattress would be added to her care interventions.
*On 12/16/24 her left heel was a scabbed area and classified as a Stage I PU.
-Her left leg was to be elevated as she had a brace to her left lower leg due to a fracture.
-A note that indicated to "Float heel on pillow" and she had an air mattress on her bed.
*12/30/24 the PU on her left heel was noted to be a Stage I.
--A note that indicated "Float heel on pillow" and she had an air mattress on her bed.

Interview on 1/2/25 at 5:02 p.m. with DON B regarding resident 1 revealed a Braden Scale assessment should have been done when she returned from the hospital, but it was not done.

Interview on 1/2/25 at 6:05 p.m. with RN/WCN D and DON B regarding resident 1 revealed:
*A significant change assessment was not completed when she returned from the hospital.
-She was not reassessed for a potential change in pressure ulcer risk when returned from the hospital.
*Preventative measures in place to prevent pressure ulcers prior to the development of

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F 686	Continued From page 17 resident 1's documented pressure ulcer were a daily multivitamin with zinc, and nutritional supplements. *The provider's process for completing skin assessments was that was to be completed weekly by a nurse or the wound nurse on bath day. *On 11/7/24 when resident 1's skin wound was found, the wound was measured, documented, and the provider was notified. -At that time the air mattress and heel protectors were added as pressure relieving interventions. * The expectation after a skin wound was identified was: -The dietician was to be notified. -The area was to be measured and documented weekly until the wound was healed. *The skin assessment on 12/16/24 and 12/30/24 identified a stage I PU to resident 1's left heel. -RN/WCN D stated she had never identified the wound as a stage I PU, she had always documented it as a suspected deep tissue injury (SDTI). --A SDTI wound indicates damage to deep tissue under the skin and may appear purple or maroon. Skin can be firmer or soft (boggy), and warmer or cooler than surrounding tissue. A blood-filled blister with a dark wound bed may also be present. --After reviewing the documentation on both assessments she stated she felt the documentation was probably copied and pasted. *RN/WCN D stated that the SDTI wound was documented as healed on 12/26/24. *DON B stated her expectation would be that the skin be assessed rather than copied from the previous assessment. -She confirmed copying information from a	F 686		

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F 686	Continued From page 18	F 686		

previous assessments was not an acceptable form of documentation of an assessment.

Observation and interview on 1/2/24 at 6:16 p.m. with resident 1, RN/WCN D and administrator A revealed:
*Resident 1's posterior left heel had an approximate one-half cm (centimeter) by one cm reddened non-blanchable area.
-RN/WCN D stated that the current reddened area appeared to be in a different area than the original wound.
*She stated the first wound had started as a flat area, red in color with some "purplish" areas.
-She stated that the first wound was a SDTI.
-She stated that the SDTI had progressed to look like a scab, that was dry and loose around edged.
*Then one day she could not find it.
*RN/WCN D stated she thought at first the wound may have been caused by her brace but the brace was higher up and could not have caused the wound.

Review of the provider's 4/26/24 Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy revealed:
*"Purpose
-To systematically assess residents regarding risk of skin breakdown
-To accurately document observations and assessments of residents
-To appropriately use prevention techniques and pressure redistribution surfaces on those resident at risk for pressure ulcers."
"Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA (user defined assessment), should be repositioned as often as directed by the care plan approaches.

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F 686	Continued From page 19 Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time." "Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for a treatment". -"Inquire whether physician/practitioner believes it is clinically necessary to see resident." *"Notify resident and/or family representative of the pressure ulcer, orders and planned interventions." *"When a pressure ulcer is present, complete the Wound Data Collection UDA daily, documentation should include the following: -An evaluation of the ulcer, if no dressing is present -An evaluation of the status of the dressing; if present (whether it is intact and whether draining, if present, is or is not leaking) -The status of the area surrounding the ulcer (that can be observed without removing the dressing) -The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection" -"Whether pain, if present, is being adequately controlled".	F 686		