STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAIMONIDES HEALTH CENTER OF VIRGINIA BEACH	6401 AUBURN DR VIRGINIA BEACH, VA 23464

(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 An unannounced Medicare/Medicaid Abbreviated survey was conducted 4/8/2025-4/10/2025. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Nine complaints were investigated during the survey: VA00063701- S w/ def VA00063547- S w/def VA00062410- U VA00061762-U VA00061656-S w/ def VA00061511-U VA00060609-S w/ def VA00061295- U VA00059306- S w/ def The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 20 resident reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		5/9/25

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

Electronically Signed | 05/08/2025

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, the facility staff failed to immediately notify the physician and also notify	F 580	F580-D	

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F 580	Continued From page 2 the Resident's Representative when there is a significant change in the resident condition for one Resident (#1) in a survey sample of 20 Residents. The findings included: For Resident #1 the facility staff failed to notify the Resident Representative of changes in skin condition, (injury of unknown origin, skin tear, possible pressure areas, and open area on shoulder). Resident #1 was admitted to the facility on 4/19/20 with diagnoses that included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. Resident #1 expired in the facility on 2/14/25. On 4/9/25 a review of the clinical record revealed that on several occasions changes in Resident #1's condition were not reported to the Resident Representative. On 4/9/25 a review of the clinical record revealed the following notes from RN#1:	F 580	Resident is no longer in the facility The last 30 days of progress notes and provider notes for current residents were reviewed to identify changes of conditions that would require provider or representative notification. Reeducated completed with Licensed nursing staff on Change of conditions and Notification of changes by Director of Nursing and Staff Development Director. Progress notes and provider notes will be reviewed 5x a week for 4 weeks then 3x a week for 2 weeks, then randomly, to ensure that all changes of condition have been addressed and Physician and Responsible Party have been notified. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 580	Continued From page 3	F 580		

"10/15/24 10:35 a.m. The above resident has an area to her chest which is black and blue will notify the nurse practitioner."

"10/22/24 2:27 a.m.- This nurse noted skin tears/skin flaps on bilateral posterior wrist that had dried blood on the areas. Resident crosses arms and has been noted scratching self at times, Areas cleaned and steri strips applied, booked for medical."

"1/3/25 10:05 p.m. - Redden [sic] blisters noted to outside of both feet no discomfort noted."

"1/25/25 2:04 a.m. -Open area noted on left posterior shoulder. New treatment initiated. Left posterior shoulder- Cleanse with DWC [Dermal Wound Cleanser], pat dry, apply bacitracin and cover with a foam dressing or border gauze, Q Day. Every evening shift for wound care. Referred to medical for further orders. Will have on coming shift notify POA."

On the morning of 4/9/25 an interview was conducted with the Administrator who stated that when he started working at the facility, he "cleaned house." When asked what was meant by the phrase "cleaned house," he stated that they had gotten rid of staff that were not performing to facility expectations.

4/10/25 at 4:00 p.m. an interview was conducted with the ADON who stated that she has only been working in the facility a month but reviewed the record and was unable to find documentation of immediate Physician and / or RP notification of changes in condition for 10/15/24, 10/22/24, 1/3/25, and 1/25/25.

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F 580	Continued From page 4	F 580		

A review of Resident#1's care plan revealed the following:

"FOCUS: Resident is at risk for impaired skin integrity r/t incontinence, r/t impaired mobility. Date Initiated: 01/23/2025

GOAL:
Resident skin will remain intact throughout the review period. Date Initiated: 01/23/2025 Revision on: 02/18/2025 Target Date: 04/23/2025

Keep skin dry, clean and well lubricated Date Initiated: 01/23/2025

Monitor skin condition daily during care and report changes Date Initiated: 01/23/2025

INTERVENTIONS:
Report to MD any signs of deterioration or significant change to area of impairment Date Initiated: 01/23/2025
Skin Observation Date Initiated: 01/23/2025."

A review of the policy entitled "Notification of Changes" dated 9/2024 read:

Page 1:
"Policy: The purpose of this policy is to ensure the facility promptly consults the resident's physician and notified consistent with his or her authority the residents representative when there is a change requiring notification.

Compliance Guidelines:

Circumstances requiring notification include:
1. Accidents
a. Resulting in injury

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F 580	Continued From page 5 b. Potential to require physician intervention. 2. Significant change in the residents physical, mental or psychosocial Condition such as deterioration in health, mental or psychosocial status that may include: a. Life -threatening conditions or b. Clinical complications 3. Circumstances that require a need to alter treatment This may include: a. New treatment b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition iii. Exacerbation of a chronic condition ..." On 4/10/25 during the end of day meeting the Administrator was notified of the concerns and no further information was provided.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		5/9/25

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F 607	Continued From page 6 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to implement the abuse, neglect policy for one (1) Resident (#1) in a survey sample of 20 Residents. The findings included: For Resident #1 the facility staff failed to implement the abuse policy when an injury of unknown origin was found. Resident #1 was admitted to the facility on 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1 ' s Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the	F 607	F607-D Resident is no longer in the facility. Reviewed progress notes and practitioner notes on current residents for the last 30 days to make sure that there was no documentation of bruises or injuries of unknow origin. No issues were identified. Reeducation was completed with Licensed nursing staff on Abuse and Neglect by the Director of Nursing and Staff Development Director.	

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F 607	Continued From page 7 Minimum Data Set Coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. Resident #1 expired in the facility on 2/14/25. On 4/9/25 a review of the clinical record revealed the following note from RN#1: "10/15/24 10:35 a.m. The above resident has an area to her chest which is black and blue will notify the nurse practitioner." Between 4/9/25 - 4/10/25 attempts times three were made to contact RN #1 (who discovered the black and blue to Resident #1's chest) were met with a recording stating the phone number was unable to accept calls at this time. On the morning of 4/9/25 an interview was conducted with the Administrator who was asked who the Abuse Coordinator is, and he responded that he was. When asked if an injury of unknown origin should be reported to the physician, Resident Representative and the appropriate state agencies, he stated that it should be investigated and reported. At that time a request was made to the Administrator to for the investigation into this injury of unknown origin, the Administrator stated that he did not have any investigations related to the Resident #1 and an injury of unknown origin. On 4/9/25 at approximately 2 p.m. an interview was conducted with CNA #2 who stated that if the CNA's find any new skin areas, either injury or skin breakdown they are supposed to immediately report it to the nurse on the floor. On 4/9/25 at 3:00 pm an interview was conducted	F 607	Progress notes will be reviewed 5x a week for 4 weeks then 3x a week for 2 weeks, then randomly, for any documentation of bruises or injury that cannot be explained. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 607	Continued From page 8	F 607		

with LPN #4 who stated that the facility policy is to notify the physician, and family of any injury or changes in condition for all Residents. When asked if a discolored area is described as "black and blue" would that be something that should be reported to the physician and family she stated that it should. When asked if a "black and blue" area to the chest, is found on a Resident who is nonverbal, should be of concern, she stated that it would be a" bigger concern." When asked why this would be a "bigger concern" she stated that it could possibly be from abuse or neglect.

On 4/9/25 at approximately 5 p.m. an interview was conducted the ADON who stated that it is the expectation of the facility to notify the physician and Resident Representative of any changes in the condition of the Resident to include any injury of unknown origin. The ADON was asked to provide any documents related to the injury of unknown origin

4/10/25 at 4:00 p.m. an interview was conducted with the ADON who stated that she has only been working in the facility a month but reviewed the record and was unable to find documentation of immediate Physician and Resident Representative notification of changes in condition for 10/15/24.

On 4/10/25 a review of the policy, entitled "Unexplained Injuries" dated 09/2024 24 revealed the following excerpts.

"All unexplained injuries, including bruises, and injuries of unknown source will be investigated. Policy explanation and compliance:

1. observations of any unexplained injuries shall

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F 607	Continued From page 9	F 607		

be reported immediately to the residence nurse.
2. Care and treatment shall be provided to the resident as needed. This includes physician, notification, implementation of physician, orders, or facility protocols.
3. An incident report shall be completed. If an allegation of abuse is made or if the injury is of unknown source reporting and investigating procedures shall be implemented in accordance with the facilities, abuse policies, and procedures.
4. An injury should be classified as "injury of unknown source" when both of the following conditions are met:
a. The source of the injury was not observed by any person, or the source of injury could not be explained by the Resident; and
b. The injury is suspicious because of:
I. The extent of the injury or
ii. The location of the injury (e.g.., the injury is located in an area not generally vulnerable to trauma) or:
iii. The number of injuries observed in one particular point of time or:
iv. The incidents of injuries overtime
5. Relevant information shall be documented in the residence, medical record, including, but not limited to:
a physical assessment, findings, including objective description of the injury.
b. Risk factors and conditions that could cause or predisposed someone to similar signs and symptoms.
c. Notification of physician and his or her response.
d. Actions taken to meet the residence, immediate needs and implementation of physician orders.
e. notification of resident representative.

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F 607	Continued From page 10 6. The facility shall modify the residence care plan as needed to prevent reoccurrence or to stabilize, reduce, or remove underlying risk factors contributing to the injury." A review of the facility policy for Abuse Neglect and Exploitation revealed the following excerpt from page 5: Pg 5: "A. The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse and the deprivation by an individual of goods and or services. This includes staff to resident abuse and certain resident to resident altercations. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family member report of abuse 2. Physical marks such as bruises or patterned appearances such as a handprint, blet or ring mark on a residents body. 3. Physical injury of a resident, of unknown source." On 4/10/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 607		
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:	F 609		5/9/25

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F 609	Continued From page 11 §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 interview, clinical record review and facility documentation the facility staff failed to ensure the timely reporting of allegations of abuse and neglect, to include injury of unknown source, for one (1) Resident (#1) in a survey sample of 20 Residents. The findings included: For Resident #1 the facility did not report an injury of unknown origin in the required timeframes. Resident #1 was admitted to the facility on	F 609	F609-D Resident is no longer in the facility. Reviewed progress notes and practitioner notes on current residents for the last 30 days to make sure that there were no bruises/injuries of unknown origin, and if so, were they reported. No issues were	

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F 609	Continued From page 12 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4 total dependence, on staff, for Activities of Daily Living care. Resident #1 expired in the facility on 2/14/25. On 4/9/25 a review of the clinical record revealed the following note from RN#1: "10/15/24 10:35 a.m. The above resident has an area to her chest which is black and blue will notify the nurse practitioner." Between 4/9/25 - 4/10/25 attempts times three were made to contact RN #1 (who discovered the black and blue to Resident #1's chest) were met with a recording stating the phone number was unable to accept calls at this time. On the morning of 4/9/25 an interview was conducted with the Administrator who was asked who the Abuse Coordinator is, and he responded that he was. When asked if an injury of unknown origin should be reported to the physician, Resident Representative and the appropriate state agencies, he stated that it should be investigated and reported. At that time a request was made to the Administrator to for the investigation into this injury of unknown origin, the Administrator stated that he did not have any	F 609	identified. Reeducated administrator on Reporting Alleged Violation Policy by the Director of Nursing and Staff Development Director. Audit all injuries/bruises that cannot be explained 5x a week for 4 weeks then 3x a week for 2 weeks, then randomly, to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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MAIMONIDES HEALTH CENTER OF VIRGINIA BEACH	6401 AUBURN DR VIRGINIA BEACH, VA 23464

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F 609	Continued From page 13	F 609		

FRI's (Facility Reported Incidents) related to the Resident #1 and an injury of unknown origin.

On 4/9/25 at approximately 2 p.m. an interview was conducted with CNA #2 who stated that if the CNA's find any new skin areas, either injury or skin breakdown they are supposed to immediately report it to the nurse on the floor.

On 4/9/25 at 3:00 pm an interview was conducted with LPN #4 who stated that the facility policy is to notify the physician, and family of any injury or changes in condition for all Residents. When asked if a discolored area is described as "black and blue" would that be something that should be reported to the physician and family she stated that it should. When asked if a "black and blue" area to the chest, is found on a Resident who is nonverbal, should be of concern, she stated that it would be a" bigger concern." When asked why this would be a "bigger concern" she stated that it could possibly be from abuse or neglect.

On 4/9/25 at approximately 5 p.m. an interview was conducted the ADON who stated that it is the expectation of the facility to notify the physician and Resident Representative of any changes in the condition of the Resident to include any injury of unknown origin. The ADON was asked to provide any documents related to the injury of unknown origin

4/10/25 at 4:00 p.m. an interview was conducted with the ADON who stated that she has only been working in the facility a month but reviewed the record and was unable to find documentation of immediate Physician and Resident Representative notification of changes in condition for 10/15/24.

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F 609	Continued From page 14 On 4/10/25 a review of the policy, entitled "Unexplained Injuries" dated 09/2024 24 revealed the following excerpts. Policy: "All unexplained injuries, including bruises, and injuries of unknown source will be investigated. Policy explanation and compliance: 1. observations of any unexplained injuries shall be reported immediately to the residence nurse. 2. Care and treatment shall be provided to the resident as needed. This includes physician, notification, implementation of physician, orders, or facility protocols. 3. An incident report shall be completed. If an allegation of abuse is made or if the injury is of unknown source reporting and investigating procedures shall be implemented in accordance with the facilities, abuse policies, and procedures. 4. An injury should be classified as "injury of unknown source" when both of the following conditions are met: a.The source of the injury was not observed by any person, or the source of injury could not be explained by the Resident; and b.The injury is suspicious because of: i.The extent of the injury or ii.The location of the injury (e.g.., the injury is located in an area not generally vulnerable to trauma) or: iii.The number of injuries observed in one particular point of time or: iv.The incidents of injuries overtime." A review of the facility policy for Abuse Neglect and Exploitation revealed the following excerpt from page 5: Pg 5.	F 609		

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F 609	Continued From page 15 "A. The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse and the deprivation by an individual of goods and or services. This includes staff to resident abuse and certain resident to resident altercations. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family member report of abuse 2. Physical marks such as bruises or patterned appearances such as a handprint, blet or ring mark on a residents body. 3. Physical injury of a resident, of unknown source." Pg 5. "VII. Reporting / Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately but not later than 2 hours if the allegation is made, if the events that cause the allegation, involve abuse OR result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ..." On 4/10/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 609		

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 interview, clinical record review and facility documentation the facility staff failed to ensure allegations of abuse and neglect to include injuries of unknown origin, are thoroughly investigated for one (1) Resident (#1) in a survey sample of 20 Residents. The findings included: For Resident #1 the facility staff failed to thoroughly investigate a "black and blue" bruise to the Resident's chest area. Resident #1 was admitted to the facility on 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age	F 610	F610-D Resident is no longer in the facility. Reviewed progress notes and practitioner notes on current residents for the last 30 days and it was determined that there were no allegations of abuse, neglect or injuries that cannot be explained. Reeducation was completed with the	5/9/25

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F 610	Continued From page 17 related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1 ' s Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. Resident #1 expired in the facility on 2/14/25. On 4/9/25 a review of the clinical record revealed the following note from RN#1: "10/15/24 10:35 a.m. The above resident has an area to her chest which is black and blue will notify the nurse practitioner." Between 4/9/25 - 4/10/25 attempts times three made to contact RN #1 (who discovered the black and blue to Resident #1's chest) were met with a recording stating the phone number was unable to accept calls at this time. On the morning of 4/9/25 an interview was conducted with the Administrator who was asked who the Abuse Coordinator is, and he responded that he was. When asked if an injury of unknown origin should be reported to the physician, Resident Representative and the appropriate state agencies, he stated that it should be investigated and reported. At that time a request was made to the Administrator to for the investigation into this injury of unknown origin, the Administrator stated that he did not have any FRI's (Facility Reported Incidents) related to the Resident #1 and an injury of unknown origin.	F 610	administrator and DON on Investigating of Allegations of Abuse by the Staff Development Director. Audit progress notes for allegations of suspected abuse, neglect, or injuries of unknown cause to make sure they are investigated 5x a week for 4 weeks then 3x a week for 2 weeks, then randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 610	Continued From page 18	F 610		

On 4/9/25 at approximately 2 p.m. an interview was conducted with CNA #2 who stated that if the CNA's find any new skin areas, either injury or skin breakdown they are supposed to immediately report it to the nurse on the floor.

On 4/9/25 at 3:00 pm an interview was conducted with LPN #4 who stated that the facility policy is to notify the physician, and family of any injury or changes in condition for all Residents. When asked if a discolored area is described as "black and blue" would that be something that should be reported to the physician and family she stated that it should. When asked if a "black and blue" area to the chest, is found on a Resident who is nonverbal, should be of concern, she stated that it would be a" bigger concern." When asked why this would be a "bigger concern" she stated that it could possibly be from abuse or neglect.

On 4/9/25 at approximately 5:00 p.m. an interview was conducted the ADON who stated that it is the expectation of the facility to notify the physician and Resident Representative of any changes in the condition of the Resident to include any injury of unknown origin. The ADON was asked to provide any documents related to the injury of unknown origin.

A review of the policy entitled Abuse, Neglect and Exploitation revealed the following excerpt from page 5:

"V. Investigation of alleged, abuse, neglect, and exploitation.
A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur.
B. Written procedures for investigations include:

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F 610	Continued From page 19 1. identifying staff responsible for investigation. 2. Two. Caution and handle evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence) 3. Investigating different types of alleged violation. 4. Identifying an interviewing, all involved persons, including the alleged victim, alleged, perpetrator, witnesses, and others who might have knowledge of allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and 6. Providing complete and thorough documentation of the investigation." On 4/10/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		5/9/25

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F 655	Continued From page 20 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to ensure that the baseline care plan was person-centered and effective for one Resident (Resident # 15) in a survey sample of 20 Residents. 1. For Resident # 15, the facility staff failed to address communication needs for a Spanish speaking resident. The findings included:	F 655	F655-D Resident is discharged. Reviewed the last 30 days of admission to ensure communication method was listed on the Base Line Care Plan. One care plan was updated with the proper	

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F 655	Continued From page 21 For Resident #15, the facility staff failed to address communication needs for a Spanish speaking resident. Resident #15 was admitted to the facility on 4/75/2025 with the diagnoses of, but not limited to, Sepsis, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3B, Essential Hypertension and Peripheral Vascular Disease, anemia. Resident #15 was admitted the day prior to the start of the survey. Therefore,no Minimum Data Set (MDS) Assessment was completed because it was too soon. indicating no cognitive impairment. Review of the clinical record was conducted on 4/92025-4/10/2025. Review of the baseline care plan revealed there was no mention of the fact that Resident # 15 spoke Spanish. There were no concerns, goals nor interventions listed for communication. During rounds on 4/8/2025 at 1:15 p.m., Resident # 15 was observed lying in the bed and facing the door. When the surveyor said hello, Resident # 15 turned to the visitor in the room and spoke in another language. The visitor stated he was the son of Resident # 15 and could translate for Resident # 15. On 4/9/2025 at approximately 1:10 p.m., Resident # 15 was observed sitting up in bed. The lunch tray was on the overbed table located at the foot of the bed. There was a staff member standing in the room. The staff member identified herself	F 655	communication method. Reeducation was completed with licensed nursing staff on Base Line Care Plan to ensure method of communication is included in the Base Line Care Plan by the Director of Nursing and Staff Development Director. Audit new admissions to ensure Base Line Care Plan is in place including method of communication 5x a week for 4 weeks then 3x a week for 2 weeks. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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as Therapy staff and stated the resident did not want to eat. The therapy staff person stated the resident spoke Spanish but that she did not speak Spanish. The Therapy staff member pulled out her cellular phone while stating that she guessed she could try to use the phone to translate. The Resident's son was not in the room.

In Spanish, the surveyor asked Resident #15 if she wanted to eat. Resident # 15 responded "no." When the surveyor asked Resident #15 if she saw what was on the tray, Resident # 15 stated "no." The surveyor lifted the cover on the tray and described in Spanish the foods that were on the tray, Resident # 15 said "yes" to the fish and potatoes that were on the tray. When the surveyor asked Resident # 15 in Spanish what she wanted to drink, she replied "agua" (water). She stated she did not want the tea that was on the lunch tray. There was a cup of water on the bedside table Resident # 15 was observed eating some of the fish and potatoes.

On 4/9/2025 at 2:10 p.m., Resident # 15 was in the room alone. The son was not in the room.

On 4/9/2025 at 4:45 p.m., Resident # 15 was observed sitting was up in the chair by the bed. The son was not in the room.

On 4/10/2025 at 9:11 a.m., an interview was conducted with the Certified Nursing Assistant # 2 who stated Resident # 15 spoke Spanish but did say some words in English. Certified Nursing Assistant # 2 stated that Resident # 15's son stated he was available to translate anytime the staff needed him to do it.

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On 4/10/2025 at 9:18 a.m., an interview was conducted with the Certified Nursing Assistant # 6 stated she was aware that the Resident # 15 spoke Spanish and that she tried to communicate with her by pointing to objects and letting the nurses know if there was something the son needed to help convey.

On 4/10/2025 at 1:15 p.m., an interview was conducted with Licensed Practical Nurse # 4 who stated it was important for the staff to be able to communicate with the Resident. Licensed Practical Nurse # 4 stated she had an app on her phone that could help to translate.

On 4/10/2025 during the end of day debriefing, the Administrator, Assistant Director of Nursing and Regional Nurse Consultant were informed of the findings. The Administrator stated the facility staff could communicate with Resident # 15 by consulting with the son. The Administrator stated the staff posted the telephone number to a Translation Services line after the surveyor questioned how the staff communicated with the resident.
The Regional Nurse Consultant (Corporate-1) stated it was not appropriate for the staff to utilize the son for translation of some of the concerns that might be medical or sensitive to Resident # 15. She stated the staff should use the Translation services line provided by the facility. She also stated that the couple of words Resident # 15 spoke in English did not ensure the resident understood what the staff members were saying. They stated communication needs should be addressed on the care plan.

No further information was provided.

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F 657	Continued From page 24	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to develop and implement a person-centered care plan that is reviewed and revised for one (1) Resident (#1) in a survey sample of 20 Residents.	F 657	F657-D Resident is discharged.	5/9/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25 The findings included: For Resident #1 the facility staff failed to review and revise the care plan after injuries, skin tear, pressure areas, and failed to have the required members of interdisciplinary team input on one care plan meeting. Resident #1 was admitted to the facility on 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. Resident #1 expired in the facility on 2/14/25. A review of the clinical record revealed the following progress notes: "10/22/24 2:27 a.m.- This nurse noted skin tears/skin flaps on bilateral posterior wrist that had dried blood on the areas. Resident crosses arms and has been noted scratching self at times, Areas cleaned and steri strips applied, booked for medical." "1/3/25 10:05 p.m. - Redden [sic] blisters noted to outside of both feet no discomfort noted." "1/25/25 2:04 a.m. -Open area noted on left posterior shoulder. New treatment initiated. Left	F 657	Reviewed current care plans for communication methods, hospice services, weight loss, wounds, Congestive Heart Failure, to ensure that they were included on the Comprehensive Care Plan. Care plans were updated as needed. Reeducation was completed with licensed nursing staff and MDS coordinators on Comprehensive Care Plan by the Director of Nursing and Staff Development Director. Audit new admissions to ensure Comprehensive Care Plans are in place including method of communication, hospice services, weight loss, wounds, Congestive Heart Failure if needed 5x a week for 4 weeks then 3x a week for 2 weeks. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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posterior shoulder- Cleanse with DWC [Dermal Wound Cleanser], pat dry, apply bacitracin and cover with a foam dressing or border gauze, Q Day. Every evening shift for wound care. Referred to medical for further orders. Will have on coming shift notify POA."

"2/9/25 9:42 p.m. - Call [sic] to room by CNA noted darken [sic] area under resident [sic] left foot great toe. left [sic] message for on call NP no pain noted. spoke to resident POA Daughter concern [sic] about resident [sic] health condition. Appetite poor. Drinking small sips of water. Reposition for comfort."

A review of Resident #1's care plan for skin integrity read:

FOCUS: Resident is at risk for impaired skin integrity r/t incontinence, r/t impaired mobility. Date Initiated: 01/23/2025

GOAL:
Resident skin will remain intact throughout the review period. Date Initiated: 01/23/2025 Revision on: 02/18/2025 Target Date: 04/23/2025
Keep skin dry, clean and well lubricated Date Initiated: 01/23/2025
Monitor skin condition daily during care and report changes Date Initiated: 01/23/2025

INTERVENTIONS:
Report to MD any signs of deterioration or significant change to area of impairment Date Initiated: 01/23/2025
Skin Observations Date Initiated: 01/23/2025

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4/10/25 at 4:00 p.m. an interview was conducted with the ADON who stated that she has only been working in the facility a month but reviewed the record and was unable to find documentation of immediate Physician and / or RP notification of changes in condition for 10/15/24, 10/22/24, 1/3/25, and 1/25/25. When asked when care plans should be updated, she stated that when there are changes in a Resident's condition, treatment or new diagnoses the care plan should be updated, and also quarterly with the care plan meetings.

A review of the policy, entitled "Comprehensive Care Plans" dated September 2024 read as follows:
"Policy:
It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives, and time frames to meet a residents. Medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Policy Explanation and Compliance Guidelines:
4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:
a. The attending physician or non-physician practitioner design involved in the president and the residence care if the physician is unable to participate in the development of the care plan.
b. A registered nurse with the responsibility for the resident.
c. A member of food and nutrition services staff
d. The resident and the resident representative

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F 657	Continued From page 28 to the extent practical. e. Staff or professionals in disciplined as determined by the residents needs or as requested by the resident. Examples include but are not limited to: I. The RAI coordinator ii. Activities Director / staff iii. Social Services Director / Social Worker iv. Licensed therapist v. Family member, surrogate or others desired by the resident. vi. Administrator vii. Discharge coordinator 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6.The comprehensive care plan will include measurable objectives, and time frames to meet the residence needs as an identified in the residence comprehensive assessment. The objectives will be utilized to monitor the residence progress alternative interventions will be documented as needed." On 4/10/25 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.	F 657		

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2. The facility staff failed to review and revise the person centerd care plan as the resident's condition changed for Resident #10.

Resident #10 was originally admitted to the facility 3/6/2025 after an acute care hospital stay. The current diagnoses included chronic non-occlusive DVT and congestive heart failure with a reduced ejection factor of 30 percent. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/12/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making were severely impaired.

An interview was conducted with Resident #10 on 4/9/25 at approximately 12:10 PM. Resident #10 stated she had an opened sore on her bottom and it was painful and itched, although the nurses put a bandage on it daily. The resident also stated she used a wheelchair to get around but several hours each day she sits in a reclining chair beside her window and watches the people outside.

A review on the resident's person centered care plan revealed the following problem dated 3/6/25: Resident is at risk for impaired skin integrity related to deconditioning, the goal stated, the resident's skin will remain intact through out the review period, 6/17/25, the interventions stated, apply moisturizer as needed to the skin, do not massage over bony prominences and use mild cleansers for peri care/washing. The care plan failed to address the opened area to the resident's sacrum identified on 3/17/25.

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F 657	Continued From page 30 On 4/10/25 at approximately 11:00 AM an observation was made of Resident #10's sacral pressure ulcer with the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) #4. The observation revealed the resident had three small openings in the crack of the buttock, the injured tissue was pink, without drainage and measured 2.5 cm by 1 cm. The sacral pressure ulcer was assessed to be a stage two. On 4/10/24 at approximately 5:43 PM, a final interview was conducted with the Administrator, the ADON and a Corporate Consultant. The above information was reviewed, and the Administrator stated Resident #10's care plan would be revised to address the pressure ulcer.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and a clinical record review, the facility staff failed to recognize and act on symptoms of an exacebation of heart failure for 1 of 20 residents (Resident #10), in the survey sample. The findings included:	F 684	F684-E Resident is discharged.	5/9/25

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F 684	Continued From page 31 Resident #10 was originally admitted to the facility 3/6/2025 after an acute care hospital stay. The current diagnoses included chronic non-occlusive DVT and congestive heart failure with a reduced ejection factor of 30 percent. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/12/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making were severely impaired. An interview was conducted with Resident #10 on 4/9/25 at approximately 12:10 PM. Resident #10 stated she was with a dry cough and she needed to take some cough syrup her mother taught her to make and she had passed the recipe on to her daughter. The resident further stated the cold was not getting any better and it was unusual for the homemade cough syrup not to work. The resident stated the cough syrup normally clears a cold in just a few days and this had been going on for weeks. Resident #10 also stated the edema to her left leg was the results of a blood clot and she did not know why the right leg was swelling. An observation of the left leg, ankle and foot revealed plus two to three pitting edema and the right leg, ankle and foot revealed plus two pitting edema. The resident stated she had compression hose at one time but was told the fit was not good therefore more would be obtained but currently she did not have any. The resident was observed wearing non-skid socks which were leaving	F 684	Reviewed physician□s orders on current residents who have Congestive Heart Failure to ensure interventions are in place. Care plans were updated on Congestive Heart Failure interventions. Education was completed with licensed nursing staff on Congestive Heart Failure Signs and Symptoms and quality care by the Director of Nursing and Staff Development Director. Monitor new admission with Congestive Heart Failure to ensure interventions and Care Plans are in place 5x a week for 4 weeks then 3x a week for 2 weeks then randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 684	Continued From page 32	F 684		

indentations into both legs. The resident stated she had not been weighed on 4/9/25 or for a few days therefore she was unaware of her current weight.

An interview was conducted with the Assistant Director of Nursing (ADON) on 4/9/25 at approximately 4:40 PM. The ADON weighed the resident and the resident's weight was 149 pounds, an increase of over 3 pounds in one day. A physician's order dated 4/10/25 revealed an additional diuretic, Metolazone Oral Tablet 5 MG, Give 1 tablet by mouth one time a day for CHF, edema for 3 days, was added to the resident's treatment plan.

On 4/10/25 at approximately 5:43 PM, a final interview was conducted with the Administrator, the Assistant Director of Nursing (ADON) and a Corporate Consultant. The above information was reviewed, and the ADON stated that the resident wound have ongoing assessments with interventions if needed.

If you have heart failure, your heart can't supply enough blood to meet your body's needs. Symptoms may develop slowly. Sometimes, heart failure symptoms start suddenly. Heart failure symptoms may include:
Shortness of breath with activity or when lying down.
Fatigue and weakness.
Swelling in the legs, ankles and feet.
Rapid or irregular heartbeat.
Reduced ability to exercise.
Wheezing.
A cough that doesn't go away or a cough that brings up white or pink mucus with spots of blood.
Swelling of the belly area.

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F 684	Continued From page 33 Very rapid weight gain from fluid buildup. Nausea and lack of appetite. Difficulty concentrating or decreased alertness. Chest pain if heart failure is caused by a heart attack. (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142)	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and a clinical record review, the facility staff failed to prevent a pressure ulcer and manage care of an avoidable pressure ulcer after it was acquired for 1 of 20 residents (Resident #10), in the survey sample. The findings included: Resident #10 was originally admitted to the facility 3/6/2025 after an acute care hospital stay. The current diagnoses included chronic non-occlusive	F 686	F686-E Resident is discharged. Completed skin assessment on current residents and appropriate treatments were in place.	5/9/25

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F 686	Continued From page 34 DVT and congestive heart failure with a reduced ejection factor of 30 percent. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/12/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #10's cognitive abilities for daily decision making were severely impaired. An interview was conducted with Resident #10 on 4/9/25 at approximately 12:10 PM. Resident #10 stated she had an opened sore on her bottom and it was painful and itched, although the nurses put a bandage on it daily. The resident also stated she used a wheelchair to get around but several hours each day she sits in a reclining chair beside her window and watches the people outside. A review on the resident's person centered care plan revealed the following problem dated 3/6/25: Resident is at risk for impaired skin integrity related to deconditioning, the goal stated, the resident's skin will remain intact through out the review period, 6/17/25, the interventions stated, apply moisturizer as needed to the skin, do not massage over bony prominences and use mild cleansers for peri care/washing. The care plan failed to address the opened area to the resident's sacrum identified on 3/17/25. Based on information from a weekly skin observation tool completed on 3/12/25 Resident #10 had intact skin. The resident was identified to have a sacral pressure ulcer on the weekly skin observation tool completed on 3/17/25. The pressure ulcer measure 4.0 centimeters (cm) by 4.5 cm by 0, but the stage of the pressure ulcer was not documented.	F 686	Reeducation was completed with licensed nurses on skin assessments and documentation of pressure ulcer if present by the Director of Nursing and Staff Development Director. Audit weekly skin assessment to ensure completion, treatments are in place and notification of MD and RP 5x a week for 4 weeks then 3x a week for 2 weeks and randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 686	Continued From page 35	F 686		

The weekly skin observation tool completed on 3/19/25 revealed the resident had an ongoing pressure ulcer to the sacrum and no further documentation was included. The 3/26/25 weekly skin observation tool revealed the resident continued to have an ongoing pressure ulcer to the sacrum and again there was no documentation such as measurements, stage, characteristics or extent of the tissue injury.

No further weekly skin observation tools were observed in the clinical record, therefore an interview was conducted with Licensed Practical Nurse (LPN) #4 on 4/9/25 at approximately 12:18 PM. LPN #4 stated the resident's skin assessment was due to be performed on the next shift.

An interview was also conducted with the Assistant Director of Nursing (ADON) on 4/9/25 at approximately 4:40 PM. The ADON reviewed the resident's weekly skin observation tools and stated the resident should have had a weekly skin observation completed on 4/2/25 but she was unable to locate it in the clinical record. The ADON further stated she would ensure the weekly skin observation tool was completed that evening.

A weekly skin observation tool was completed on 4/9/25 and the documentation stated Resident #10's skin was intact. On 4/10/25 at approximately 11:00 AM an observation was made of Resident #10's sacral pressure ulcer with the ADON and LPN #4. The observation revealed the resident had three small openings in the crack of the buttock, the injured tissue was pink, without drainage and measured 2.5 cm by 1

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F 686	Continued From page 36 cm. The sacral pressure ulcer was assessed to be a stage two. On 4/10/25 at approximately 5:43 PM, a final interview was conducted with the Administrator, the ADON and a Corporate Consultant. The above information was reviewed, and the ADON stated that the resident should have ongoing weekly skin observations and the findings should be documented on the tool, The ADON also stated the an order had been obtained for the pressure ulcer to be assessed weekly and the characteristics documented in the nurse's notes.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		5/9/25

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F 692	Continued From page 37 by: Based on interview, clinical record review, and facility documentation, the facility staff failed to ensure adequate nutrition to prevent significant weight loss for 1 Resident (#1) in a survey sample of 20 Residents. The findings included: For Resident #1 the facility failed to obtain recognize signs of significant weight loss and consult with the Registered dietician for recommendations as ordered by physician on several occasions, resulting in 29 lb. weight loss from 12/31/24 - 2/11/25. Resident #1 was admitted to the facility on 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1 ' s Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. Revealed the following excerpts from the medical provider: "6/16/24 BMI 17.4-Underweight Consider dietary consult for further recs re weight/nutritional." "10/4/24 1p.m. continues to avg. 2 meals/day, weight loss, 89-->85lbs ..."	F 692	F692-D Resident is no longer in the facility. Reviewed the last 30 days of the weight summary report for weight loss. If weight loss was documented, was Registered Dietitian/Physician/Responsible Party notified for weight loss. No new weight loss was documented. Reeducation was completed with licensed nursing staff on weighing residents monthly and notifying Registered Dietitian/Physician/Responsible Party for weight loss by the Director of Nursing and Staff Development Director. Monitor Weight Summary Report for weight loss 5x a week for 4 weeks then 3x a week for 2 weeks, then randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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"12/12/24 11:15 a.m.: BMI 17.2, indicating severe malnutrition. Decline in oral intake reported by nursing, 50-75%, previously75-100%. Measures to sustain intake maintained, including appropriate consistency of food/food preferences. Patient requires assistance to feed. Continue to monitor weight closely. Dietitian to follow regarding potential for weight loss and provide recommendations for nutritional support. Encourage oral intakes tolerated and assist with meals as needed."

"1/10/25 - Follow up within 1 week for monitoring- Continue to monitor BMI - Consider dietary consult for further recommendations regarding weight and nutritional status."

"1/15/25 GENERAL- Frail/cachectic elderly female, In no acute distress, Limited due to impaired cognition...
Follow up within 1 week for monitoring- Continue to monitor BMI (19 - Underweight) - Consider dietary consult for further recommendations regarding weight and nutritional status."

A review of the document entitled "Nutrition Evaluation" dated 1/9/25 signed by the Registered Dietician (other employee#15) revealed the following excerpts:

"1 C. Most recent wt. -. [left blank] date [left blank]
3 E. BMI: Underweight/Normal weight/Obese I, II, III/ - Unable to determine Last BMI was 17.2 indicating she is underweight.
F. Usual body wt. 85 lbs.
G. Ideal body wt. >/= 120 lbs.
L. Malnutrition Diagnosis: Detail if "not present" or if present detail signs/symptoms:

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Severe PCM [Protein Calorie Malnutrition] as noted.
M. At Risk for Malnutrition: NO
O. Comments: Additional notes from interview/general appearance/nursing notes/summary/etc. - Unable to determine if there have been any recent wt. changes. Documented PO intakes exceed needs making it likely that resident has maintained wt. or possibly gained. Gain would be beneficial with underweight BMI. Hx of dysphagia with no difficulties tolerating current texture documented. Current nutrition dx of severe PCM remains appropriate."

4. A Recommendations: Provide nutrition recommendation changes, diet order changes, supplement changes,
enteral feed changes, etc... -No recommendations as current intake meets/exceeds EEN. Continue plan of care."

On the afternoon of 4/9/25 an interview was conducted with Other #7 the current Registered Dietician, who stated that she began in Jan 2025. The RD stated that she reviewed the Resident's chart and started "house supplements" and magic cup.

A review of the clinical record revealed that Resident #1 had already been on magic cups with meals since 8/29/23 and the "house shakes" were not ordered until 2/14/25 the day of the Residents death.

Review of the document entitled "Care Plan Acknowledgement Form" dated 1/17/25 at 1 p.m. signed only by the Social Worker (Other employee #3) boxes checked off were "Quarterly

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/ Annual" and "Comprehensive Care Plan." Written in handwriting on the upper half of the form was the following:

"[Resident Representative name] Via phone"

"Are the CNA's taking time to feed her? - She takes a while."

A review of the policy, entitled Comprehensive Care Plans dated September 2024 read as follows:
Policy:
"It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives, and time frames to meet a residents. Medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment
Policy explanation and compliance guidelines
4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:
a. The attending physician or non-physician practitioner design involved in the president and the residence care if the physician is unable to participate in the development of the care plan.
b. A registered nurse with the responsibility for the resident.
c. A member of food and nutrition services staff
d. The resident and the resident representative to the extent practical.
e. Other appropriate staff or professionals in disciplines as determined by the residence needs or as requested by the resident. Examples include but not limited to:

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F 692	Continued From page 41 1. RAI coordinator 2. Activities Director/staff 3. Social Services Director / Social Worker 4. Licensed Therapist 5. Family member surrogate or others desired by the resident. 6. Administration 7. Discharge coordinator" A review of the clinical record revealed the following excerpts from Resident #1's care plan: Focus: The resident has nutritional problem or potential nutritional problem r/t underweight, poor POI, on hospice. On hospice w/ orders for no routine weights Date Initiated: 08/01/2024 GOAL: The resident will have gradual weight gain (1-2 lbs. per month) through review date. Date Initiated: 08/01/2024 Revision on: 02/13/2025 Target Date: 04/23/2025 Cancelled Date: 02/13/2025 INTERVENTIONS: Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 08/01/2024. RD to evaluate and make diet change recommendations PRN. Date Initiated: 08/01/2024 Revision on: 02/18/2025 As evidenced by documentation of Skilled	F 692		

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F 692	Continued From page 42 Nursing Notes in the electronic health record Resident #1 was on skilled care at the time the Focus area was entered (8/1/24) stating she was on hospice. This Resident had previously graduated from Hospice due to lack of decline and was not put back on Hospice until 2-11-25. The Goal is unattainable if you are not checking weights. The interventions are not possible without checking weights and following physician recommendations for dietary consults. On 4/10/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and a clinical record review, the facility staff failed to ensure medications were administered in accordance to accepted professional standards for 1 of 20 residents (Resident #9), in the survey sample. The findings included: Resident #9 was originally admitted to the facility 7/27/2023 and readmitted 2/14/2025 after an acute care hospital stay. The current diagnoses included afib, diabetes and high blood pressure. The admission significant change annual quarterly Minimum Data Set (MDS) assessment	F 760	F760-D Staff went back and gave the resident his medication. Resident took the medication on April 08, 2025. Audited current residents rooms after medications were given to ensure that medications were taken and not left at residents bedside. No medications were observed at residents bedside.	5/9/25

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F 760	Continued From page 43 with an assessment reference date (ARD) of 2/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were intact. On 4/8/25 at approximately 10:54 AM, Resident #9 was observed in bed asleep. The resident did not answered when the door was knocked on. Upon entrance into the room to awaken the resident it was observed that a medication cup with approximately ten pills of various sizes and colors was on the bedside table. The resident stated he could not take them when the nurse brought them in because he had a piece of candy in his mouth and it was still in the roof of his mouth. The resident was reminded of the time and the wound care observation and he stated he would take them as soon as he finished his candy. An interview was conducted with Licensed Practical Nurse (LPN) #7 on 4/8/25 at 11:04 AM regarding the medication observed at Resident #9's bedside. LPN #7 stated the resident is non-compliant with all aspects of care and he would not accept the medications when she went in to administer them therefore they were left upon his request. LPN #7 went into the residents room and returned with an empty medication cup in her hand. She stated he had taken them. On 4/9/25 at approximately 5:43 PM, a final interview was conducted with the Administrator, the Assistant Director of Nursing (ADON) and a Corporate Consultant. The above information was reviewed, and the Administrator stated LPN #7 should not have left the resident's medications at	F 760	Reeducation was completed with licensed nurses on Medication Administration Policy by the Director of Nursing and Staff Development Director. Audit residents rooms after med pass to ensure no medication is left at residents bedside 5x a week for 4 weeks then 3x a week for 2 weeks, and then randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 760	Continued From page 44 the bedside, she should have returned them to the medication cart.	F 760		
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to	F 849		5/9/25

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provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

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(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those

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residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a

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F 849	Continued From page 48 description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to have a written agreement with hospice before hospice care is furnished for 1 Resident in a survey sample of 20 Residents. The findings included: For Resident #1 the facility staff failed to have a hospice contract before providing hospice services to the Resident and also failed to maintain hospice records within the clinical record. Resident #1 was admitted to the facility on 4/19/20. Diagnoses for Resident #1 included but are not limited to dementia, severe protein calorie malnutrition, major depressive disorder, age related physical debility, restlessness, dysphagia, insomnia, osteoporosis, rheumatoid arthritis and pain. Resident #1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/9/25 coded Resident #1 as unable to assess, indicating Resident #1 has severe cognitive impairment. In addition, the Minimum Data Set, coded Resident #1 as requiring 4- total dependence, on staff, for Activities of Daily Living care. On 4/10/25 at approximately 1 p.m., a review of the clinical record revealed that Resident #1 was started on hospice services on 2/10/25 with Hospice Provider Other #13. The clinical	F 849	F849-D Resident is no longer in the facility. Reviewed current hospice residents to ensure contracts are in place prior to the date of service. Current hospice residents have contracts in place. Reeducation was completed with the administrator and social worker on ensuring hospice contracts are in place prior to the date of service by the Director of Nursing and Staff Development Director. Audit new hospice resident to ensure contracts are in place prior to the date of service 5x a week for 4 weeks then 3x a week for 2 weeks, and then randomly. Results of Audits will be presented to the Quality Assurance and Performance	

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F 849	Continued From page 49 revealed that the Hospice provider #13 provided services to Resident #1 from 2/10/25 - until she expired at the facility on 2/14/25. Hospice care plan, visit notes, and medication and treatment orders initiated by hospice could not be located in the electronic health record. Employe other #8 (Medical Records) contacted the Hospice provider and obtained paper copies of all the hospice notes and orders not in the EHR. On 4/10/25 during the end of day meeting the Administrator (who started working at the facility in Jan 2025) the ADON (who started on 3/11/25) and the Corp Nurse Consultant ant were present. The Administrator stated that there were 3 hospice companies servicing the facility. A review of the three Hospice provider contracts revealed the following: Hospice Provider (Other # 11) had a contract that was signed on 8/30/24, Hospice Provider (Other #12)'s contract was signed on 3/28/25 and the third Hospice provider (Other #13)'s contract was signed on 4/8/25 (the first day of survey). When asked why the contract was signed only 2 days prior, the Administrator stated that he did not know where the previous Administrator had put the Hospice Contracts. He states that he reached out to the hospice company, and they did not have it, so he told them to send a new one. When asked what the communication process is, between the facility and the hospice provider, to ensure that the needs of the resident are addressed, the ADON stated that the nurses communicate with the Hospice company verbally when the nurses and cna's come to the facility and also by telephone.	F 849	Improvement committee for 2 quarters and as needed.	

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	495186	A. BUILDING _____ B. WING _____	C 04/10/2025

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F 849	Continued From page 50 The Corporation Nurse Consultant stated that they needed to look into giving hospice access to the EHR On 4/10/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/9/25

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F 880	Continued From page 51 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 880	F880-D	

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F 880	Continued From page 52 facility staff failed to adhere to hand hygiene practices to help prevent the development infections for 1 of 20 residents (Resident #9), in the survey sample. The findings included: Resident #9 was originally admitted to the facility 7/27/2023 and readmitted 2/14/2025 after an acute care hospital stay. The current diagnoses included afib, diabetes and high blood pressure. The admission significant change annual quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #9's cognitive abilities for daily decision making were intact. On 4/9/25 approximately at 11:24 AM, an observation of wound care to the resident's sacral pressure ulcer was conducted. Licensed Practical Nurse (LPN) #7 positioned the resident on his left side with help of Certified Nursing Assistant (CNA) #7. LPN #7 sprayed the sacral wound with the dermal wound cleanser, patted the wound with four by fours, sprinkled Nyastatin powder around the wound bed, put the Hydrofera Blue on the border gauze and placed the border gauze to the resident's sacral wound. The bottom edges of the border gauze folded therefore it had to be removed and another applied to adhere to the resident's skin. LPN #7 failed to remove the gloves used to clean the wound and she failed to wash or sanitize her hand prior to handling the clean wound care	F 880	The dressing was changed. The employee was educated on dressing changes using a clean technique on April 08, 2025. Competencies completed with licensed nurses to ensure clean technique is being followed during dressing changes. Reeducation was completed with licensed nurses on dressing change using clean technique by the Director of Nursing and Staff Development Director. Audit nurses to ensure clean technique is being followed during dressing change 5x a week for 4 weeks then 3x a week for 2 weeks, and then randomly. Results of Audits will be presented to the Quality Assurance and Performance Improvement committee for 2 quarters and as needed.	

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F 880	Continued From page 53	F 880		

supplies. An interview was conducted with LPN #7 immediately after she completed the sacral wound dressing, she acknowledged that she failed to adhere to best practice hand hygiene.

On 4/10/25 at approximately 5:43 PM, a final interview was conducted with the Administrator, the Assistant Director of Nursing (ADON) and a Corporate Consultant. The above information was reviewed, and the Administrator stated that LPN #7 had been educated on hand hygiene during pressure ulcer care.

Using a clean dressing technique.

Step one
Assemble all of your wound care supplies that you will need to change the dressing.
Clean gloves (sterile gloves are not needed)
A clean surface to place everything on (such as a clean piece of aluminum foil or clean paper
The new bandage to be applied
Saline or wound cleanser to clean the wound
Several pieces of gauze to use in cleaning or wiping the wound
Trash bag

Step two
Wash your hands with soap and warm water for 20-30 seconds. After washing and drying your hands, put on clean gloves to remove the old dressing and perform the dressing removal step. Observe if there is fluid or drainage and note the drainage or wound fluid that is on the gauze. Wounds with a lot of fluid draining from them are exuding wounds. Now clean the wound by wiping with some gauze pads and saline or wound cleanser. Wipe the wound in small circles this from the middle of the wound outward and finally

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the skin around the wound edge. You may need several pieces of gauze. Dispose of the dirty bandage, gauze used to clean the wound, and dirty gloves in the trash.

Step three
Measure the wound and record the length and width and the depth of the wound. Measuring should occur anytime the wound looks different and at least once per week. Write the measurements down so you can give them to your doctor or nurse.

Step four
Rewash your hands with soap and water for 20-30 seconds and dry them. Put on a new pair of clean gloves (you do not need sterile gloves). Now you will apply the new wound treatment and dressing. Your doctor may prescribe a medication to apply, such as an ointment, a gel, a liquid, or a spray. The medication should be applied as directed and, if needed, to spread it across the wound, clean cotton-tipped applicator like a Q-tip should be used. After any medication has been applied, you will place the primary dressing (this is the one that is placed in contact with the wound bed first).

The primary dressing will then be covered by a secondary dressing (if one is recommended by your doctor). The dressing may have a part that sticks to the skin to hold it in place, or you may need to use tape to secure the secondary dressing. If no secondary dressing is used, you may need to secure the primary dressing with bandage tape. There are several types of dressings, each used for different reasons, and we will describe them below with some tips for correctly applying them to the wound

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F 880	Continued From page 55 (https://cert.vohrawoundcare.com/how-to-change-a-wound-dressing/). Hydrofera Blue CLASSIC® is a PVA foam that improves epithelialization while wicking exudate and debris from the wound bed, resulting in a multifaceted, non-toxic healing environment that kills bacteria and reduces bioburden. (https://www.woundsource.com/product/hydrofera-blue-classic)	F 880		