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M 000	INITIAL COMMENTS On 05/23/2024, with information obtained through 06/06/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Comfort Care Group Home LLC, an adult family home located in Waukesha, WI. As a result of the survey, 2 deficiencies were identified. The complaint was substantiated. Census: 4	M 000		
M 136	88.03(5)(e)2 DEATH DUE TO INCIDENT OR ACCIDENT A death due to incident or accident not related to use of a restraint, psychotropic medications or suicide shall be reported to the licensing agency within 3 days. In addition the home shall; a. immediately notify the resident's guardian if any and those identified in HSS 88.09(1)(d)3. b. Record the date, time and circumstance of the resident's death in the resident record, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's death, resulting from severe sepsis in part due to multiple skin wounds, was reported to the Department within 3 working days.	M 136		

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

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M 136	Continued From page 1 Findings include: On 05/23/2024, Surveyor reviewed a wound care note, dated 04/26/2024, as part of outside medical records obtained for Resident 1. The note documented that Resident 1 had a "[Deep tissue injury (DTI)] which has evolved to unstageable pressure injuries over both buttocks and coccyx. Slough and eschar noted to the wound beds with surrounding DTI. Patient is incontinent of stool...Left hip DTI, maroon discoloration noted. Open blisters noted. Optiview dressing applied...Large cluster of purple DTI noted to left back. Cluster of DTI noted to both anterior hips. DTI also noted to both ischials [bony prominences of the pelvic bones]...Blister noted to right medial 1st toe. Cluster of DTI noted to left lateral foot. DTI with blister noted to left medial 1st toe." Photographs attached with the note showed the following: - Area of pink skin, measuring approximately 1 x 1 cm, on Resident 1's right medial big toe, consistent in appearance with the blister documented above - Area of pink skin, measuring approximately 1 x 1 cm, on Resident 1's left medial big toe, consistent in appearance with the blister documented above - Three separate areas of red / dark purple discoloration to Resident 1's back, consistent in appearance with the cluster of DTIs documented above - Three photographs showing the DTI spanning nearly the entire width of Resident 1's buttocks area, where the skin varied in color from red to purple. Three open areas of skin, consistent with	M 136		

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the pressure injuries documented above, were observed at his left buttocks, right buttocks, and midline coccyx area.

- Purple areas of skin, consistent with the deep tissue injuries documented above, at Resident 1's left hip.

On 05/23/2024, at approximately 10:15 a.m., Surveyor interviewed Licensee A regarding Resident 1. Licensee A reported that Resident 1 resided with the provider from 04/02/2024 - 04/25/2024, when s/he was then hospitalized and subsequently passed away. Licensee A reported that Resident 1 did not have any skin concerns upon his/her admission, including any known wounds, or any skin concerns throughout his/her admission with the provider. Licensee A reported that s/he thought Resident 1 passed away sometime around 04/26/2024, while hospitalized, but s/he didn't know what from.

On 05/24/2024, Surveyor reviewed outside hospital records for Resident 1, obtained from the hospital s/he admitted to on 04/25/2024. Within the notes, Surveyor observed the following:

- Emergency department admission note, dated 04/25/2024, which documented that various lab findings suggested "severe sepsis."

- History and Physical, dated 04/25/2024, which documented: "Pressure Ulcers of Buttocks: -Present on arrival -Appreciate wound [registered nurse] consult." The note also documented, "[Resident 1]...with a past medical history significant for dementia...presents from a group home with complaints of altered mental status, generalized weakness, and poor oral intake for the last few days...Patient reportedly has been

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sitting in [his/her] chair or lying in bed for the most part. Has not been very active and has appeared generally weak. Up until last week [s/he] was ambulating with a walker. [Patient] has been increasingly confused from [his/her] baseline." The physical exam section of the note documented, "Elderly [person], disheveled and smells heavily of urine..." The note documented that Resident 1 was admitted inpatient from the emergency department due to severe sepsis and acute metabolic encephalopathy. An addendum by another medical provider documented that Resident 1 was assessed with the following: "#Acute kidney injury ...possibly partly related to rhabdomyolysis ...# Mild hypercalcemia: Likely from dehydration...#Acute rhabdomyolysis:...reported immobilization/ not moving much x 2 days, poor [oral] intake...#Sepsis - meets criteria with leukocytosis, lactic acidosis, tachycardia (although could be partly due to dehydration)...#Bilateral buttock wounds:...Appears to have small infected appearing area. Wound care consult ..."

- Death summary note, dated 04/27/2024, which documented that Resident 1 continued to experience "decreased responsiveness despite appropriate treatment." Resident 1 was transitioned to comfort measures and was documented as passing away on 04/27/2024. The note also documented, "Cause of death: severe sepsis due to streptococcus bacteremia, secondary to pneumonia, [urinary tract infection], multiple skin wounds. Note - there was concern for neglect at [patient]'s group home facility given multiple skin wounds..."

On 05/24/2024, Surveyor reviewed Department records for the provider. Surveyor did not observe any self-reports submitted for Resident 1's death

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M 136	Continued From page 4 related to his/her wound development and subsequent infection. On 06/06/2024, at approximately 4:41 p.m., Surveyor interviewed Licensee A. Licensee A confirmed s/he did not send any report to the Department regarding Resident 1's significant change or death. Licensee A reported s/he was unaware of any self-report requirements and requested for Surveyor to send him/her the regulatory section where self-reports were covered. Cross Reference: M0448 DHS 88.07(2)(b)5 Monitoring Health	M 136		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's skin health, nutritional intake, or functional decline was monitored with changes s/he experienced documented in his/her record. Resident 1 admitted to the provider on 04/02/2024 with no known skin concerns. While at baseline s/he required staff assistance for all cares, including to manage his/her incontinence, s/he was known to ambulate and transfer with contact guard assistance (1 or 2 hands on him/her for steadying assistance).	M 448		

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M 448	Continued From page 5 As early as 04/17/2024, as evidenced by Resident 1's neurology clinic note, Resident 1 began to decline in his/her physical activity with reportedly no longer walking. Staff interview and daily charting notes by Licensee A, who is a registered nurse, documented repeated instances of Resident 1's poor nutritional intake, incontinence episodes, and prolonged immobility - all factors that increased his/her risk for skin breakdown. Interview and documentation from both Resident 1's home health nurse and physical therapist demonstrated findings of a superficial buttocks pressure wound on 04/22/2024, managed by a wound dressing, and education provided to at least 3 provider staff regarding Resident 1's skin breakdown on 04/22/2024 and 04/23/2024. Despite Resident 1's documented skin breakdown risks, the skin breakdown education provided by his/her home health staff on 04/22/2024 and 04/23/2024, and the buttocks wound first observed on 04/22/2024, managed with a dressing that was in place at least on 04/23/2024, there was no evidence that staff assessed these risks, monitored Resident 1's skin health throughout his/her admission, or documented any of the above changes regarding Resident 1's skin. Interview with the provider's staff revealed no awareness of any skin concerns for Resident 1 and denial of any observed changes in Resident 1's skin throughout his/her admission. Medical records and interview revealed observed worsening of Resident 1's buttocks wound on 04/25/2024 (3 days after the wound was first observed), with Resident 1 having been discovered soiled through 2 incontinence briefs, underwear, and a pair of jeans, upon arrival of his/her physical therapist for a routine visit at	M 448		

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10:13 a.m. that morning. Interview with the sole caregiver who worked from 8:00 a.m. on 04/24/2024 through the day shift on 04/25/2024 identified that Resident 1 was last changed sometime the previous night and had not yet been changed prior to the physical therapist's arrival at 10:13 a.m. - a period of at least 10 hours. Progression of Resident 1's wound, in conjunction with his/her overall change in condition, resulted in his/her emergency department admission and subsequent hospitalization. While hospitalized, Resident 1 was discovered to have at least 6 areas of varying skin breakdown. One of these areas, Resident 1's left hip, was consistent with how Resident 1 was found by the physical therapist that morning day upon his/her routine visit, left sidelying. Resident 1 passed away in the hospital on 04/27/2024, with the cause of death documented to be severe sepsis secondary to pneumonia, a urinary tract infection, and his/her multiple skin wounds.

On both 04/22/2024 and 04/25/2024 (the days of his/her emergency department admissions), Resident 1 was discovered by home health staff with acute physical and cognitive declines - the extent of which, including limited responsiveness and requiring total assistance for transfers, were not documented in the provider's record for Resident 1. While Resident 1 was found to be dehydrated during his/her emergency department admission on 04/22/2024, there was no evidence of staff taking or documenting measures to monitor or address his/her oral intake from then throughout the remainder of his/her admission. Resident 1 was still found to be dehydrated on his/her 04/25/2024 hospital admission. Other medical concerns experienced by Resident 1 upon his/her 04/25/2024 hospitalization included

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acute rhabdomyolysis (in relation to his/her prolonged immobilization and poor intake), acute kidney injury, and dehydration.

Findings include:

According to Mayo Clinic, pressure wounds, or "bedsores" are "injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time." Constant pressure on a part of the body decreases blood flow to the area's tissues which results in tissue damage and death over time. People who are identified as being "most at risk of bedsores" are people that have medical conditions that limit their mobility or those that "spend most of their time in a bed or chair." Major risk factors for developing pressure wounds, or "bed sores" include immobility, incontinence, and poor nutrition and hydration. When warning signs of a pressure wound are observed, affected people are recommended to have their position changed to help ease pressure on the affected area. While "most" pressure wounds can heal with treatment, "rarely, a skin ulcer leads to sepsis, which is a life-threatening complication of an infection," (Source: Mayo Clinic, Bedsores (Pressure Ulcers), February 22, 2024, https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893 (retrieval date - June 07, 2024).).

On 05/23/2024, Surveyor conducted a complaint investigation into skin monitoring and resident care concerns.

On 05/23/2024, Surveyor reviewed a wound care note, dated 04/26/2024, as part of outside medical records obtained for Resident 1. The note documented that Resident 1 had a "[Deep

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tissue injury (DTI)] which has evolved to unstageable pressure injuries over both buttocks and coccyx. Slough and eschar noted to the wound beds with surrounding DTI. Patient is incontinent of stool...Left hip DTI, maroon discoloration noted. Open blisters noted. Optiview dressing applied...Large cluster of purple DTI noted to left back. Cluster of DTI noted to both anterior hips. DTI also noted to both ischials [bony prominences of the pelvic bones]...Blister noted to right medial 1st toe. Cluster of DTI noted to left lateral foot. DTI with blister noted to left medial 1st toe." Photographs attached with the note showed the following:

- Area of pink skin, measuring approximately 1 x 1 cm, on Resident 1's right medial big toe, consistent in appearance with the blister documented above

- Area of pink skin, measuring approximately 1 x 1 cm, on Resident 1's left medial big toe, consistent in appearance with the blister documented above

- Three separate areas of red / dark purple discoloration to Resident 1's back, consistent in appearance with the cluster of DTIs documented above

- Three photographs showing the DTI spanning nearly the entire width of Resident 1's buttocks area, where the skin varied in color from red to purple. Three open areas of skin, consistent with the pressure injuries documented above, were observed at his left buttocks, right buttocks, and midline coccyx area.

- Purple areas of skin, consistent with the deep tissue injuries documented above, at Resident 1's

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left hip.

On 05/23/2024, at approximately 9:55 a.m., Surveyor interviewed Caregiver B regarding Resident 1's care needs. Caregiver B confirmed that Resident 1 was sometimes "grumpy" and didn't like to be touched. Caregiver B reported that Resident 1 experienced a past functional decline that resulted in him/her being taken to urgent care where s/he was found to be dehydrated. Caregiver B reported that staff attempted to give him more water after this for rehydration. Caregiver B reported that Resident 1 kept getting weaker to the point that s/he had stopped eating. Caregiver B reported that a nurse "from the state" visited the following day but told them to continue monitoring Resident 1 and call emergency services the next day if things got worse. Caregiver B reported that Resident 1 typically needed staff assistance for bathing and toileting, and that s/he experienced incontinence which required staff assistance for changing briefs. Caregiver B reported that Resident 1 typically walked with a walker independently but was working with therapy to improve his/her ambulation. Caregiver B reported that Resident 1's outside services included nursing and therapy. When asked if Resident 1 had any skin concerns or required skin cares, Caregiver B reported that s/he was unable to recall any but stated, "You can ask my boss." When asked if s/he had personally conducted any skin or wound cares for Resident 1, Caregiver B replied that s/he was "unsure."

At approximately 10:15 a.m., Surveyor interviewed Licensee A regarding Resident 1. Licensee A reported that Resident 1 resided with the provider from 04/02/2024 - 04/25/2024, when s/he was then hospitalized and subsequently passed away. Regarding Resident 1's

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functioning, Licensee A reported that Resident 1's baseline was walking with a walker with the assistance of 1 for safety. Licensee A reported that Resident 1 required staff assistance for transfers, bathing, and toileting. Licensee A reported that Resident 1 did not have any skin concerns upon his/her admission, including any known wounds, or any skin concerns throughout his/her admission with the provider. Licensee A reported that Resident 1 typically spent his/her days watching television while seated in his/her recliner and s/he was known to yell at staff to leave him/her alone. Licensee A reported that even upon Resident 1's admission s/he was known to refuse some meals, but always requested chips and Pepsi to consume, which was provided.

Regarding Resident 1's decline, Licensee A reported that on 04/22/2024 s/he contacted emergency medical services (EMS) because Resident 1 had refused to eat for the previous day and s/he was concerned about him/her being dehydrated. Licensee A reported Resident 1 was sent out via EMS to the emergency department but returned 3 hours later with no recommendations. Licensee A reported that after this s/he seemed to return to his/her baseline and was taking his/her medications. Licensee A reported that on 04/24/2024 s/he started noticing differences in Resident 1's functioning again and that s/he was eating/drinking less. Licensee A reported that on 04/25/2024, staff called him/her to inform him/her that Resident 1 was not doing well. Licensee A reported that Caregiver C and Manager D were the staff working that day.

At approximately 11:00 a.m., Surveyor interviewed Caregiver C about Resident 1's decline on 04/25/2024. Caregiver C reported that

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Resident 1 was lying in bed, had refused his/her medications, and refused to get up. Caregiver C reported that Resident 1 was responsive but weak. Caregiver C reported that s/he then spoke on the phone with Resident 1's home health nurse who told him/her that s/he would arrive soon for his/her scheduled visit that day. Caregiver C reported that the home health nurse came on site approximately 1 hour after this phone conversation, assessed Resident 1, and then instructed Caregiver C to contact EMS. Caregiver C reported that s/he was also working the previous night's shift and that Resident 1 seemed fine then. Caregiver C reported that s/he had not yet changed Resident 1 that morning, but that Resident 1 was last changed sometime the previous evening (04/24/2024).

Regarding Resident 1's functioning, Caregiver C reported that Resident 1 typically liked to keep to him/herself and stay in his/her room. Caregiver C reported that Resident 1 did not have any skin or wound concerns. Caregiver C reported that s/he had been involved in showering and changing Resident 1 and had never seen any skin concerns or changes in Resident 1's skin.

On 05/23/2024, Surveyor reviewed all the records the provider had at the home for Resident 1, provided by Licensee A. Within the records, Surveyor observed a notebook where staff appeared to write resident observations. Surveyor observed only one note related to Resident 1, written by Caregiver B and dated 04/23/2024 - 04/24/2024. The note documented the following:

"Today...[Resident 1] [sic] family members visit [him/her] and them was [sic] very sad because [s/he] was very sick they had just bring [sic] [him/her] from emergency room not too long and

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them [sic] had told us that [s/he] was dehydrated and need to drink plenty water so we give [him/her] more water to drink but [s/he] did not wanted [sic] to eat nothing [his/her] family members was [sic] asking [him/her] questions and [s/he] was being so rude to them and them [sic] ask me if [s/he] normally behaves like that but I told them no [s/he] normally sweet and [illegible] so they ask me what the doctor told us at the [emergency room] I told them I was not on turn when [s/he] went but my boss can answer all of them question [sic] so [s/he] ask [sic] to call my boss so I did, and [s/he] told [him/her] that them told [him/her] that [s/he] was dehydrated and that if [s/he] can drink less Pepsi and more water so that was the order from the [emergency room] and when the nurse came to see [him/her] [s/he] say [s/he] looks prety [sic] [illegible] and if [s/he] continue to not eat and the same way then call 911 and [s/he] say if it was [him/her] [s/he] will call them now but then again they just see [him/her] and they will just send [him/her] back so [s/he] suggested to wait tell [sic] Friday for I for got [sic] the exact word but any how [illegible] lift and I then was concern about [him/her] so I told [him/her] to come out and in the living room and give [him/her] some water and [s/he] say [s/he] wanted a cookie so I give [him/her] one and [s/he] eat a little peace [sic] and then ask me to take [him/her] to the room so I did and got [him/her] ready for bed and then I give [him/her] [his/her] nigh [sic] meds and I record everything and left and the next day I hard [sic] [s/he] was taken to the [emergency room] again."

Surveyor reviewed the rest of the records on hand for Resident 1, which included his/her medication administration record during his/her admission, a physician visit form for a visit Resident 1 had with his/her primary care provider,

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dated 04/09/2024, a physician visit form for Resident 1's first visit with his/her home health physical therapist, dated 04/09/2024, a home health care welcome packet, an after-visit summary for a neurology appointment Resident 1 had on 04/17/2024, and an after-visit summary for Resident 1's emergency room admission on 04/22/2024. The after-visit summary on 04/22/2024 documented that Resident 1 had admitted to the emergency department with altered mental status and was diagnosed with dehydration, which was treated by rehydration measures while s/he was admitted. None of the records, including staff charting notes, documented anything regarding Resident 1's skin, oral intake monitoring or measures, or functional decline.

At approximately 12:30 p.m., Surveyor interviewed Licensee A and Caregiver C. Surveyor reviewed Resident 1's wound pictures from his/her medical record, as documented above. Licensee A reported that this was new information for him/her and s/he had never been aware of any skin concerns for Resident 1. Caregiver C denied seeing any of the above areas of skin breakdown on Resident 1. During the interview, Licensee A called in Caregiver B. Caregiver B denied seeing any of the above areas of skin breakdown on Resident 1. Surveyor requested from Licensee A all additional records s/he had for Resident 1 that Surveyor hadn't already reviewed onsite, due on 05/24/2024 at 8:00 a.m.

On 05/24/2024, Surveyor reviewed the additional records provided by Licensee A, which consisted of 1 document that contained near daily charting notes from 04/02/2024 - 04/25/2024. While reviewing the notes, Surveyor observed the

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following:

- Documentation that staff changed Resident 1 or Resident 1 specifically experienced episodes of bladder and/or bowel incontinence on 04/02/2024, 04/05/2024, 04/06/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/10/2024, 04/11/2024, 04/12/2024, 04/13/2024, 04/14/2024, 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, and 04/22/2024.

- Documentation that Resident 1 experienced decreased nutritional intake on 04/22/2024 (decreased breakfast intake and lunch refusal), 04/24/2024 (only intake noted being a Pepsi drink), and 04/25/2024 (breakfast refusal) until s/he was hospitalized later that morning. There was no documentation of anything that occurred for 04/23/2024. (Of note, the charting note by Caregiver B, documented above, for 04/23/2024, documented that Resident 1 did not want to eat anything and only ate a small piece of a cookie that day.)

- Documentation of Resident 1's seated sedentary patterns, including the following in the days prior to his/her decline:

1) 04/18/2024: "[Resident 1]...had urine and bowel incontinence. [S/he] got cleaned up and changed and ate [his/her] breakfast in [his/her] room. [S/he] sat on the recliner chair. [S/he] then took [his/her] medication and then stayed on [his/her] recliner and had [his/her] snack and diet Pepsi with [him/her]. [S/he] ate lunch and dinner there as well. [S/he] had incontinence again and was changed and cleaned up before [his/her] bedtime medication. [S/he] refused to get up from the chair as [s/he] started yelling and being very angry. [S/he] was changed while sitting on

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[his/her] recliner chair. Thereafter, [s/he] remained in [his/her] chair and chose to sleep there, as [s/he] yelled that [s/he] did not want to sleep on the bed."

2) 04/19/2024: "[Resident 1] woke up around 8am and got cleaned up and had [his/her] pants changed. [S/he] was changed on the chair because [s/he] refused to go to the bathroom. [S/he] then ate breakfast and took [his/her] medication there as well...[S/he] ate lunch and dinner on [his/her] chair, and got changed before bedtime medication. [S/he] then chose to stay on the chair until 10pm, and was asked to try to sleep on [his/her] bed but refused."

3) 04/20/2024: "[Resident 1] woke up on [his/her] recliner...[S/he] had bowel and urine incontinence, and had to be changed on [his/her] chair since [s/he] didn't want to get up. [S/he] also refused to go to the bathroom to wash up...[S/he] spent [his/her] day with the tv on, or napping on the recliner. [S/he] then...was heard by other residents yelling that [s/he] did not want to be bothered or asked to move to [his/her] bed so [s/he] stayed there."

4) 04/21/2024: "[Resident 1] woke up and was cleaned up on the recliner chair...[S/he] wanted to sleep on the recliner once again..."

- Observations from Resident 1's first emergency department admission on 04/22/2024 until his/her last hospitalization on 04/25/2024, which included:

1) 04/22/2024: "[Resident 1] woke up around 8am and got changed on the recliner chair, today [s/he] ate breakfast but not very much. The [physical therapist] came at around 1:10pm and

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refused to eat lunch. [S/he] seemed very tired and there was a concern. 911 was called shortly after that and was taken to the [emergency room], and came back after a few hours and was advised to drink fluid. [S/he] was diagnosed with dehydration and prerenal azotemia. There were lab tests done on [Resident 1]. [S/he] was being helped to go to [his/her] bed but refused and wanted to sit on [his/her] recliner. [S/he] took [his/her] bedtime medication after."

2) 04/24/2024: "[Resident 1] woke up, but seemed very tired. [S/he] did not refuse to lay down in bed, and wanted to nap. [S/he] barely ate [his/her] oatmeal. [S/he] asked for a Pepsi and took [his/her] morning medicine only, and not the 2pm medication. [Resident 1] was being checked on to see what [s/he] was doing, but mainly slept. [S/he] did not need to be cleaned. [S/he] was against the idea of eating dinner and then refused to take [his/her] medicine for bedtime, advising [him/her] only makes [him/her] angry, and went to sleep without it."

3) 04/25/2024: "[Resident 1] was very weak this morning and refused to eat breakfast and to take [his/her] medication. The [physical therapist] came around 10:15 am and [s/he] changed [him/her] and saw [his/her] condition. The staff asked whether to call 911 immediately and [s/he] mentioned to call after [s/he] finishes changing [him/her]. 911 was called immediately and the paramedics came. [Resident 1] was taken out of the group home and admitted into the hospital."

Surveyor did not observe any documentation about observed changes in Resident 1's skin. Surveyor did not observe any documentation indicating awareness or acknowledgement of skin breakdown risks demonstrated by Resident 1

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given the extent of his/her above documented immobility, poor nutrition and hydration, and incontinence, and by extension, any skin monitoring or breakdown prevention interventions implemented by staff. Surveyor did not observe any documentation regarding monitoring of his/her health, including nutritional/fluid intake or any other specific monitoring parameters implemented by staff in response to his/her clinical findings of dehydration from his/her emergency department admission on 04/22/2024.

On 05/24/2024, Surveyor reviewed the staff schedule from 04/22/2024 - 04/25/2024, provided by Licensee A, which showed the following:

- 04/22/2024: "[Caregiver C] day shift until 8pm", "[Caregiver H] 8pm until next morning."
- 04/23/2024: "[Caregiver H] left in the morning after 8am breakfast", "[Caregiver B] came after 8am until 8pm and [Caregiver G] came 2pm and stayed until the next day"
- 04/24/2024: "[Caregiver G] left after 8am breakfast", "[Caregiver C] came after 8am to take over until April 25th."

On 05/24/2024, Surveyor reviewed outside home health records for Resident 1, obtained from his/her home health agency. Within the notes, Surveyor observed the following:

- 04/09/2024 (home health physical therapy evaluation): "Wound assessment" information was documented as "not applicable." Under the "Skin Conditions" section, it was documented that, "Patient has no pressure ulcers or no stageable pressure ulcers." Urinary incontinence was documented as well as bowel incontinence frequency of "very rarely or never." The evaluation documented that Resident 1 was able

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to ambulate short distances and transfer with no more than contact guard assistance.

- Therapy visit notes on 04/12/2024 (from his/her physical therapist), 04/15/2024 (from his/her physical therapist), 04/16/2024 (from his/her occupational therapist), and 04/18/2024 (from his/her physical therapist) all document that Resident 1 completed transfers and ambulated various distances throughout the home during the sessions with assistance levels ranging from supervision to contact guard/steading assistance.

- Physical therapy note dated 04/22/2024 at 1:09 p.m.: "[Patient] sitting in [his/her] room in wheelchair with [his/her] eyes closed when [physical therapist] arrived. [S/he] reports [s/he] feels sick, is unable to elaborate, 'I want them to take me to the hospital but they won't.' Caregivers [Manager D] and 2nd caregiver present and participated in visit. They report [patient] has been more fatigued over the past few days, has not been walking, has been using a wheelchair today. [Patient] did not eat lunch today but did have breakfast, did have vomiting episode ~ 3 days ago. [Patient] denies pain, states 'I just don't feel good.' [Patient] has been incontinent of bowel and bladder...Much encouragement required before [patient] was agreeable to transfer out of wheelchair and into bed to allow for changing depends...[S/he] required 2 attempts and max assist/total assist of 2 for stand pivot transfer wheelchair > bed. [S/he] required max assist for rolling side to side in bed...Dependent for brief and pant change. [S/he] was found to have 2 new open areas on buttocks, superficial, picture uploaded to [patient]'s chart. No barrier cream present. Encouraged offloading, frequent repositioning, and educated on pressure relief and pressure ulcer prevention, questionable

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understanding from [patient]/caregivers. Discussed change in condition with patient, [Manager D], group home manager, and [Licensee A], group home owner (?), with concern over new sores, poor safety with transfers, high fall risk, overall decline in function. [Licensee A] states [s/he] is awaiting to hear back from county on what to do with [patient]. [Physical therapist] called [medical doctor's] office and informed of [patient] presentation and new wounds. [Physical therapist] received callback after leaving [patient]'s house from triage nurse, who recommended [patient] be seen in [emergency department] ([s/he] also states [medical doctor] will provide orders for wound care after [emergency department] assessment.) [Physical therapist] called [Licensee A] but was unable to reach [him/her] or leave message. [Physical therapist] called [Manager D] and informed [him/her] of recommendation to have [patient] be seen in the [emergency department]..." The wound assessment in the note documented visualization of a pressure injury at Resident 1's bilateral buttocks at 1:34 p.m. on 04/22/2024 and linked an image. The image in the record showed Resident 1's buttocks, with various stages of red/purple spanning an approximate 4 x 8 cm area across his/her buttocks. Two small areas of superficial skin opening were observed within the area of discolored skin.

- Nurse note dated 04/23/2024 at 10:00 a.m.: "[Patient] seen today due to recent decline in status...[registered nurse] from [Resident 1's primary care provider] office called this [nurse] back and this [nurse] received verbal order for wound care, care plan updated. This [nurse] also informed of [patient]s [sic] status today and that [patient] was seen in the [emergency room] yesterday with [diagnosis] of dehydration and

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[urinalysis] performed culture pending. Informed that can call facility on friday to get update on sttaus [sic] and if no improvement [patient] to be sent to [emergency room], group home manager aware as [s/he] was present during today's visit." The wound assessment section of the note documented that a sacral dressing was in place at Resident 1's buttocks wound.

- Physical therapy note dated 04/25/2024 at 10:13 a.m.: "[Patient] in bed, laying [left] sidelying, when [physical therapist] arrived...caregiver present intermittently during visit. They report [patient] has had another decline in function, is not eating/drinking, not taking medications, not getting out of bed. [S/he] has a new bump on back of neck. [Patient] minimally verbally responsive, does yell at [physical therapist] throughout visit to leave, increased rigidity, lays in [left] sidelying...[S/he] was found to be incontinent of large amount of urine and [bowel movement]. [Patient] dependent for changing clothing and hygiene. [S/he] was resistive to all movement, prefers to be in [left] sidelying, [bilateral upper extremities] flexed...New open area to [left] hip observed, likely pressure due to moisture and [left] sidelying. Open areas on buttocks were much larger today, bleeding. Caregiver at group home...informed of [physical therapy] concerns, agreed to call 911..."

Upon comparison of the provider's notes for Resident 1 and his/her home health notes, Surveyor observed that the extent of functional decline observed by home health staff were not reflected in the provider's record for Resident 1 - including his/her acute cognitive/alertness decline or his/her physical decline (going from transferring and ambulating with limited staff assistance at baseline to requiring total

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assistance of 2 for transfers on 04/22/2024 and being dependent on 04/25/2024). The provider's notes document that on 04/22/2024 Resident 1 "seemed very tired and there was a concern" and on 04/25/2024 Resident 1 "was very weak" with no other details regarding his/her functional decline documented for either day.

On 05/24/2024, Surveyor reviewed outside clinic visit records for Resident 1, obtained by his/her medical provider's office. Within the notes, Surveyor observed an outpatient neurology note dated 04/17/2024 (5 days prior to Resident 1's first emergency department admission and 8 days prior to his/her second emergency department admission and subsequent hospitalization). The note documented that Resident 1 had previously undergone imaging, findings of which were consistent with vascular dementia. The note also documented, "Group home provider does also provide some background. [S/he] reports the patient has not been walking because [s/he] feels [his/her] legs are too weak."

On 05/24/2024, Surveyor reviewed outside hospital records for Resident 1, obtained from the hospital s/he admitted to on 04/25/2024. Within the notes, Surveyor observed the following:

- Emergency department admission note, dated 04/25/2024, which documented that various lab findings suggested "severe sepsis."

- History and Physical, dated 04/25/2024, which documented: "Pressure Ulcers of Buttocks: -Present on arrival -Appreciate wound [registered nurse] consult." The note also documented, "[Resident 1]...with a past medical history significant for dementia...presents from a group

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home with complaints of altered mental status, generalized weakness, and poor oral intake for the last few days...Patient reportedly has been sitting in [his/her] chair or lying in bed for the most part. Has not been very active and has appeared generally weak. Up until last week [s/he] was ambulating with a walker. [Patient] has been increasingly confused from [his/her] baseline." The physical exam section of the note documented, "Elderly [person], disheveled and smells heavily of urine..." The note documented that Resident 1 was admitted inpatient from the emergency department due to severe sepsis and acute metabolic encephalopathy. An addendum by another medical provider documented that Resident 1 was assessed with the following: "#Acute kidney injury ...possibly partly related to rhabdomyolysis ...# Mild hypercalcemia: Likely from dehydration...#Acute rhabdomyolysis:...reported immobilization/ not moving much x 2 days, poor [oral] intake...#Sepsis - meets criteria with leukocytosis, lactic acidosis, tachycardia (although could be partly due to dehydration)...#Bilateral buttock wounds:...Appears to have small infected appearing area. Wound care consult ..."

- Death summary note, dated 04/27/2024, which documented that Resident 1 continued to experience "decreased responsiveness despite appropriate treatment." Resident 1 was transitioned to comfort measures and was documented as passing away on 04/27/2024. The note also documented, "Cause of death: severe sepsis due to streptococcus bacteremia, secondary to pneumonia, [urinary tract infection], multiple skin wounds. Note - there was concern for neglect at [patient]'s group home facility given multiple skin wounds..."

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M 448	Continued From page 23 On 05/28/2024, at approximately 7:45 a.m., Surveyor interviewed Nurse E, from Resident 1's home health team. Nurse E reported that s/he only had 2 visits with Resident 1 during his/her admission with the provider - one on 04/19/2024 and one on 04/23/2024 (the day after Resident 1's first emergency department admission). Nurse E reported that during his/her assessment of Resident 1 on 04/19/2024, s/he saw a skin area that potentially looked concerning for shearing, but it was not any sort of wound. Nurse E reported that on 04/19/2024 s/he did not see any pressure wounds on Resident 1. Nurse E reported that during his/her visit with Resident 1 on 04/23/2024, Resident 1 was nothing like how s/he was in his/her earlier visit. Nurse E explained that Resident 1 was known to sit in his/her recliner but on 04/23/2024 was in his/her bed. Nurse E reported that Resident 1 was known to be conversational but was not so on 04/23/2024. Nurse E reported that s/he had to keep repeating commands to Resident 1, which was new for him/her. Nurse E reported that at Resident 1's baseline s/he could transfer out of his/her chair with assistance and difficulty and that s/he could ambulate slowly with someone with him/her. Nurse E reported that during his/her visit on 04/23/2024, Resident 1 could not even roll over in his/her bed on his/her own. Nurse E reported that during his/her visit on 04/23/2024, Resident 1 kept repeating that s/he did not feel good. Nurse E reported that Manager D was present in Resident 1's room during his/her visit. Nurse E reported that s/he had called and spoken with Resident 1's primary care provider office but since s/he had just been seen in the emergency department the previous day that it was decided to wait and not send him/her back out. Nurse E reported that s/he instructed Manager D to send Resident 1 back out to the emergency	M 448		

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department if his/her condition worsened.

During the same interview, Nurse E reported that during his/her 04/23/2024 visit, upon his/her inspection of Resident 1's buttocks area, s/he observed an intact foam border dressing in place. Nurse E reported that s/he thought the dressing was placed by staff from the emergency department that Resident 1 was admitted to on 04/22/2024. Nurse E reported that since clean, intact dressings can generally stay in place for 3-5 days that s/he did not want to remove it. Nurse E reported that during his/her visit on 04/23/2024 s/he sought orders for wound care and had educated the provider's staff on this updated plan of care. Nurse E reported that s/he spoke with and educated staff about guidance for maintaining the foam border dressing, including the importance of changing it if Resident 1 was incontinent, and the importance of applying barrier cream. Nurse E reported that the importance of maintaining clean skin was that fecal matter can "eat away" at the skin. Nurse E reported that s/he told staff that s/he was ordering wound care supplies of barrier cream and foam dressings that day, which would be received in 48 hours. When asked which of the provider's staff was involved in this education and conversation, Nurse E reported that Manager D was as well as a caregiver who s/he was able to describe but wasn't sure of the name of. (Based on review of the staff schedule above and the specific identifiers given by Nurse E, this was determined to be Caregiver B, whose interview with Surveyor was detailed above.) Nurse E reported that both were agreeable to this update to Resident 1's plan of care and said, "Okay" in response to the education s/he provided. Nurse E reported that s/he also instructed Caregiver B in the importance of turning Resident 1 every 2 hours

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given his/her inability to independently turn him/herself. Nurse E reported that Caregiver B had replied, "Okay," and gave an indication like s/he understood this recommendation. Nurse E reported that it was not possible for staff to have not been aware of any of Resident 1's skin concerns based on his/her conversations and education that day with Manager D and Caregiver B.

On 05/28/2024, at approximately 3:07 p.m., Surveyor interviewed Physical Therapist F from Resident 1's home health care team. Physical Therapist F reported that s/he had 2 visits with Resident 1, on 04/22/2024 (the day of his/her first emergency department admission) and 04/25/2024 (the day of his second emergency department admission and subsequent hospitalization). Physical Therapist F reported that his/her first visit with Resident 1 on 04/22/2024 was unusual because s/he presented different than what previous therapists had reported to him/her regarding his/her abilities and personality. Physical Therapist F that the previous reports s/he had received were that Resident 1 joked around and was able to at least walk with limited assistance previously. Physical Therapist F reported that on 04/22/2024, Resident 1 wasn't really responding to him/her, didn't really open his/her eyes during the visit, and was a heavy transfer assist that required 2 people to help transfer him/her. Physical Therapist F reported that during his/her visit Resident 1 experienced an incontinence episode and so s/he cleaned him/her up. Physical Therapist F reported that while changing Resident 1 s/he observed superficial pressure injuries at his/her buttocks, which appeared to be new. Physical Therapist F reported that they did not appear to be deep but were open and s/he was able to see the areas

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where skin was sloughed off. Physical Therapist F reported that s/he observed these areas on either side of Resident 1's buttocks. Physical Therapist F reported that s/he discussed the new skin concerns with the caregiver working at the time. (Based on review of the staff schedule above and the specific identifiers given by Physical Therapist F, this was determined to be Caregiver C, whose interview with Surveyor was detailed above.) Physical Therapist F reported that s/he recommended to Caregiver C for staff to start applying barrier cream to these skin areas, but that after Caregiver C looked around the home for barrier cream, s/he told him/her that they didn't have any. Physical Therapist F reported that s/he instructed Caregiver C in the importance of keeping Resident 1 off those skin areas to prevent further breakdown. Physical Therapist F reported that s/he also spoke with Manager D regarding his/her concerns with Resident 1's functional decline and new buttocks sores. Physical Therapist F reported that Manager D then called Licensee A, and s/he spoke with him/her about his/her concern regarding Resident 1's functional decline and new buttocks sores. Physical Therapist F reported that during this phone call, Licensee A told him/her that s/he was confused about what to do because s/he was waiting for the county to get back to him/her. Physical Therapist F reported that it was not possible for staff to have not been aware of Resident 1's skin concerns based on his/her conversations that day with Caregiver C, Manager D, and Licensee A. Regarding his/her clinical visit note that day, Physical Therapist F reported s/he documented that the staff demonstrated "questionable" understanding because they only responded with, "Okay" to his/her instruction and education but didn't say anything else about the skin concerns. Physical

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Therapist F reported that based on his/her instruction, s/he would have expected staff to initiate wound care and skin protection interventions that day. Physical Therapist F reported that it was important for staff to initiate interventions when residents experience declines in function to the point of being bedbound in order to prevent skin breakdown and contractures.

During the same interview, Physical Therapist F reported that when s/he arrived for his/her visit on 04/25/2024, a caregiver was present and told him/her right away that Resident 1 wasn't doing very well. (Based on review of the staff schedule above and the specific identifiers given by Physical Therapist F, this was determined to be Caregiver C, whose interview with Surveyor was detailed above.) Physical Therapist F reported that Manager D didn't arrive to the home until sometime near the end of his/her visit. Physical Therapist F reported that upon entering Resident 1's room, s/he was observed laying on his/her left side. Physical Therapist F reported that s/he was concerned that Resident 1 had been laying like that "for some time" given his/her appearance. (Of note, this observation, which is also documented in Physical Therapist F's 04/25/2024 note above, corroborates the left hip pressure wound documented in Resident 1's wound care consult note from 04/26/2024, also above, which noted, "Left hip DTI, maroon discoloration noted. Open blisters noted.")

Physical Therapist F explained that s/he found Resident 1 soiled upon his/her arrival and upon changing him/her, s/he observed Resident 1 to have 2 incontinence briefs on, with underwear over that, and jeans over that - which were all "substantially" soiled through. Physical Therapist F reported that someone had to have dressed

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Resident 1 like that because there was no way that Resident 1 him/herself, even at his/her baseline, could have put those layers on. (Of note, interview with Caregiver C, documented above, who worked alone from 8:00 a.m. on 04/24/2024 through Physical Therapist F's visit on 04/25/2024, revealed that Resident 1 was last changed sometime during the evening of 04/24/2024, despite Physical Therapist F's arrival not having been until 10:13 a.m. on 04/25/2024.) Physical Therapist F reported that Resident 1 did not have any wound dressing in place at his/her buttocks. Physical Therapist F reported that the area of skin breakdown at Resident 1's buttocks progressed to be "much larger" than what s/he had initially observed on 04/22/2024. Physical Therapist F reported that Resident 1 was agitated and yelled out as well as swatted at him/her whenever s/he tried to move him/her. Physical Therapist F reported that s/he did not think Resident 1's wound progression was specifically discussed with provider staff on 04/25/2024 due to the focus on Resident 1's overall decline and obtaining emergency medical services. Physical Therapist F reported that from 04/22/2024, his/her first visit with Resident 1, s/he had concerns regarding Resident 1's cares. Physical Therapist F reported that during his/her visit on 04/22/2024, s/he wondered how long staff prolonged obtaining emergency department treatment for Resident 1 given the fact that they already knew prior to his/her visit that s/he experienced a decline from being ambulatory with assistance to needing a wheelchair for mobility.

On 06/06/2024, at approximately 4:41 p.m., Surveyor interviewed Licensee A. Licensee A denied that anyone had discussed any of Resident 1's skin concerns with him/her. Licensee A reported that after Surveyor was last

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M 448	Continued From page 29 on site s/he interviewed staff again who all denied ever seeing any skin concerns, including wounds or open areas, on Resident 1. When reviewing Resident 1's buttocks dressing, confirmed as present by Nurse E on 04/23/2024, Licensee A reported that staff may not have seen it, and by extension, Resident 1's wounds, because Resident 1 refused cares and only stayed in his/her recliner. Licensee A reported that because of this, staff had to do the best they could and work around him/her in the recliner. Licensee A asked Surveyor what staff should have done in this situation. Licensee A acknowledged Surveyor's concern of the thoroughness of Resident 1's cares, including peri-cares, due to all the provider's staff having denied any awareness or observations of Resident 1's skin concerns. Licensee A agreed with Surveyor that Resident 1's incontinence, limited mobility - especially after his/her decline on 04/22/2024 - and poor nutrition and hydration put him/her at increased risk for pressure wounds and that staff should have recognized these risks of skin breakdown. Licensee A acknowledged Surveyor's concern about the lack of documentation in Resident 1's record of the extent of his decline and reported that s/he "agree[d] 100 percent." Licensee A reported that s/he intended to contract with an electronic record system platform to help improve resident record keeping. Cross Reference: M0136 DHS 88.03(5)(e)2 Death due to an Incident or Accident	M 448		