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S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.610a) 300.1210b) 300.1210d)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or

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S9999	Continued From page 2 neglect a resident. (A, B) (Section 2-107 of the Act) This Requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to prevent the formation of pressure ulcers and provide pressure relief for 1 of 3 (R2) reviewed for pressure ulcers in the sample of 10. This failure resulted in the worsening of R2's 5 pressure ulcers. Findings include: R2's Minimum Data Set, dated 6/19/2019, documents a Brief Interview for Mental Status score of 8, moderately impaired cognition and requires one-person physical assist for bed mobility. R2's Physician orders, dated 8/1/2019, documents diagnoses of hemiplegia, unspecified affecting unspecified side and dementia. R2's Departmental Notes, dated 7/23/2019, documents that R2 went to the local hospital Emergency Department for a displaced femoral fracture. R2's Physician's Orders, upon return from hospitalization, were dated 7/29/2019. On this date, there was no documentation in the Departmental Notes regarding R2's readmission to the facility or an assessment completed regarding R2's skin condition.	S9999		

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R2's Evaluation of Pressure Ulcer Risk, dated 7/29/2019, documents he is at risk for pressure ulcers due to his incontinence of bowel and bladder and being bedfast. The Evaluation documented that if R2 is at risk then interventions should be placed on care plan.

The first Departmental Note written after R2's readmission, dated 7/31/2019 at 4:10 AM, documents, "Resident has several bandages to (bilateral lower extremities)." This Departmental Note did not document R2 had any pressure ulcers.

R2's Weekly Skin report, dated 7/31/2019, documents, R2 had a right lower leg skin tear that measured 7.0 centimeters (cm) by (x) 6.5 cm x 0.1 cm. The Skin Report documents R2 had a right knee skin tear, measuring 1.5 cm x 1.4 cm x 0.1 cm. The Weekly Skin Report documented that R2 had a skin tear on his right hip and knee, and the skin tear on the knee remained scabbed.

R2's Physician's Orders, dated 7/31/19, documented "Cleanse skin tear to right inner knee with wound cleanser, apply xeroform(non-adherent dressing used to maintain a moist wound environment, and is made of fine mesh gauze enriched with petrolatum) and dry dressing change daily and PRN (as needed) until healed" and "Cleanse skin tear to right lower inner leg with wound cleanser, apply xeroform and dry dressing, change daily and PRN until healed." There was no Physician Order for treatment of the area on R2's right hip.

R2's Care Plan, dated 4/9/2015, documents undated interventions of "Turn and reposition during care and activities and PRN (as needed)." The Plan documents, "Weekly skin

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assessments." It continues, "Observe skin for changes during care daily. Report any changes to the nurse immediately."

On 8/8/2019 at 8:30 AM, R2 was lying in bed on his back, with his bilateral knees bent and touching and legs drawn up towards his abdomen. R2's left arm was drawn up to his chest. V7, Certified Nurse Assistant, (CNA) was holding R2 on his back while V8, CNA, went to get V5, License Practical Nurse (LPN) to perform wound care. V7, CNA, was able to hold R2 contracted legs apart. No padding was noted in between R2's legs while in bed. No dressings were on R2's pressure ulcers on the left inner thigh, left inner knee and right inner knee. The pressure ulcer to the right inner knee measured approximately 3 to 4 centimeters (cm) with yellow mucous like tissue (slough) in the center of the ulcer and the edges were white in color. The pressure ulcer to the left inner knee measured approximately 3 to 4cm, with dark brown to black tissue (eschar) in the center of ulcer and the edges were white. The pressure ulcers to the right and left inner knees were adjacent to each other. The pressure ulcer to the left inner thigh, measure approximately 2 to 3 cm. The center of the ulcer has yellow slough and the edges were pink.

On 8/8/2019 at 8:50 AM, V5, License Practical Nurse (LPN), came into the room and removed the dressings to R2's right lower leg (shin). R2's right lower shin pressure ulcer measured approximately 7 cm in length and approximately 4 cm in width. The center of the ulcer had black eschar and some yellow slough noted to the edges. V5 removed R2's dressing from his right hip. The pressure ulcer to R2's right hip approximately measured 7 cm round with black

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eschar in the center of the ulcer and yellow slough around the edges. At 9:00 AM, V5, LPN, stated, "He didn't have any open areas on his skin when he went to the hospital. He came back with all of these (open areas) and these are not skin tears, they look like pressure sores to me."

On 8/8/2019, R2 remained in bed, in a (concave) mattress, on his right side, without benefit of repositioning from 9:30 AM until 11:45 AM based on 15 minutes or less observation intervals.

There was not a departmental note in R2's chart documenting V17, R2's Physician, was notified of the increase in size or changes of the pressure ulcers from 7/31/2019 to 8/8/2019.

The facility's Weekly Pressure Wounds report, dated 8/12/2019, documented R2 had an unstageable pressure ulcer to his right lower leg measuring 8.2 cm x 6.0 cm, granulation eschar/necrotic tissue. The report documented he had an unstageable pressure ulcer to his right knee measuring 2.6 cm x 2.2. cm, granulation/eschar/necrotic tissue. The Report documented he had an unstageable right hip pressure ulcer measuring 5.5 cm x 8.9 cm with granulation eschar/necrotic tissue. The Report documented he had an unstageable left knee pressure ulcer measuring 2.8 cm by 5.0 cm with granulation eschar/necrotic tissue. The Report documented he had an unstageable pressure ulcer to his left thigh measuring 2 cm x 3.8 cm.

The NPUAP (National Pressure Ulcer Advisory Panel) at https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf documents the definition, "Unstageable Pressure Injury: Obscured full- thickness skin and tissue

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loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed."

R2's Physician orders, dated 8/12/2019, documents change in pressure ulcer dressings, added a nutritional supplement and asked for a wound specialist consult.

On 8/7/2019 at 9:00 AM, V4, R2's Healthcare Power of Attorney, stated, "He (R2) has open sores and they (staff) are not turning him like they should."

On 8/8/2019 at 3:45 PM, V2, Director of Nurses (DON), stated that she expects the residents to be turned and repositioned every 2 hours and as needed, especially if they have pressure ulcers.

On 8/8/2019 at 9:55 AM, V2, DON, stated, "He (R2) was readmitted from the hospital with the open areas to his right hip, right shin, right and left inner knees and left inner thigh and our wound nurse (V14), who is on vacation this week, mislabeled these. I looked at them yesterday (8/7/2019) and these are not skin tears, these are pressure ulcers."

On 8/12/2019 at 1:23 PM, V14, Wound Nurse, stated, "The areas to his right hip, right leg and inner knees were skin tears when he returned to the facility (on 7/29/2019) but they are pressure sores now." V14 continued, "There are not measurements for last week (week of 8/5/2019) because I wasn't here, I was on vacation." V14, also stated, "I will get him a low air loss bed, it should be here tomorrow."

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S9999	Continued From page 7 The facility's policy, Turning and Positioning Program, dated 7/2018, documents, "1. Turning schedule will occur at designated times. 2. Charge Nurse is responsible for visually observing and assisting with the turning and positioning as needed." The facility's policy, Pressure ulcer/injury and skin conditions guide for wound evaluation documentation, dated 11/2017, documents, "Documentation of wound status will occur at least once a week. This weekly evaluation will be documented electronically or on the Wound Evaluation Form/Skin Condition Form as appropriate." It continues, "The Director of Nursing Services and/or designated Licensed Nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be addressed. Resident progress or lack of progress will be evaluated. Directives may be given for further interventions and changes in plan of care. The resident's current care plan will also be reviewed." (B)	S9999		