STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004766	A. BUILDING _____ B. WING _____	C 09/23/2021

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S 000	Initial Comments Complaint Investigation 2176329/IL137640 2176410/IL137745	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)1) 300.1210d)2) 300.1210d)5) 300.1220b) 300.1230e) 300.1230f) 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 300.1010 Medical Care Policies	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be	S9999		

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S9999	Continued From page 2 administered as ordered by the physician. 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility. Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs per day. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 3 Based on observation, interview, and record review, the facility failed to ensure that residents were free from neglect when it failed to provide structures and processes to care for residents with pressure ulcers. The facility neglected to follow their assessment policy for pressure ulcers. Multiple failures based on the policy were identified including failing to do an individual wound assessment when a pressure ulcer was identified by the wound nurse or licensed nurse, failing to stage and measure pressure ulcers and document in the medical record. The facility neglected to ensure a resident admitted to the facility with pressure ulcers received assessment and treatment by the wound care physician or podiatrist and neglected to ensure physician-ordered pressure ulcer treatments were administered as ordered. The facility neglected to ensure wound care was provided in manner to prevent infection. The facility neglected to provide nursing staff to perform wound care on the holiday weekend and weekends. The facility was cited for staffing issues on August 30, 2021 that included issues with meeting and providing wound care on weekends. The facility neglected to take measures to ensure residents received wound care the holiday weekend of September 4, 5, and 6, 2021. This resulted in R4, R5, R6, and R7 not receiving prescribed wound care. These failures apply to 5 of 5 residents (R1, R4, R5, R6, and R7) reviewed for pressure ulcers in the sample of 7. Findings include:	S9999		

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S9999	Continued From page 4 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on July 30, 2021 and was discharged from the facility on August 24, 2021 to the local hospital due to pressure ulcer wound concerns including purulent drainage, significant foul smelling odor, and erythema. R1 required hospitalization for pressure ulcer treatment with surgical intervention, intravenous antibiotics, and possible osteomyelitis. R1 did not return to the facility. R1 had multiple diagnoses including myocardial infarction, unsteadiness on feet, multiple sclerosis, abnormal posture, dysphagia, tachycardia, lack of coordination, COPD (Chronic Obstructive Pulmonary Disease), history of falling, heart failure, and metabolic encephalopathy. On July 30, 2021 at 11:36 PM, V10 (Nurse) documented: "[R1] received approximately 6:00 PM via stretcher accompanied by two attendants ...Resident has two pressure ulcers, one on sacrum, one on left hip. Resident is dependent on staff for repositioning and transfers..." Hospital documentation for R1 dated July 26, 2021 shows a left trochanter pressure ulcer, left and right knee abrasions, right breast erythema, and denuded skin of the left and right groin. The hospital's Skilled Nursing Facility Communication Form for R1, dated July 30, 2021 shows: "Decubiti Wound/Tx (treatment): Left trochanter and left ischial - daily cleanse with saline, triad at wound base, cover with {Brand Name} (absorbent, gelling) dressing and {Brand Name} (absorbent foam) dressing every other day." V2 (Director of Nursing/DON) confirmed on	S9999		

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S9999	Continued From page 5 September 13, 2021 that orders sent from the hospital were not carried out for R1. V10's (Nurse) Admission/Readmission Skin Integrity Review dated July 30, 2021 at 11:10 PM shows: "Left trochanter (hip): pressure. Sacrum: pressure." V10 did not document the appearance of R1's pressure ulcers, including measurements, pressure ulcer stage, drainage present, or wound appearance. The facility did not have documentation to show V10 notified R1's physician of the presence of pressure ulcers upon admission or ensured treatment orders from the hospital were continued at the facility. On September 13, 2021 at 12:35 PM, V10 said, "I admitted [R1] on July 30, 2021. It was a crazy day. I did not receive report from the hospital before [R1] arrived at the facility. I did my own full body assessment on her when she arrived, and I documented she had two pressure ulcers upon admission. Usually the facility does not have us do the wound measurements or put a stage of the pressure ulcer in our notes. The wound nurse comes in on Monday and does all of that. I was helped with the admission by another nurse who said he would put the physician orders in the computer. I am not familiar with doing resident admissions since I usually work a different shift and we rarely get admissions on that shift. I don't remember seeing any orders for wound care from the hospital. Both of R1's buttocks wounds had dressings on them. I took the dressings off and looked at the wounds and put the dressings back on. I documented they were pressure ulcers because they were over a bony prominence and they looked like pressure to me. I did not notify the wound care nurse or the physician the resident was admitted to the facility with any wounds."	S9999		

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S9999	Continued From page 6 Documentation in the EMR dated August 2, 2021 by V5 (Wound Nurse) shows V5 documented all the wounds R1 was admitted with as skin tears/abrasions. V5 did not have documentation to show R1 had any pressure ulcers as of August 2, 2021. V5's documentation dated August 2, 2021 shows an Initial Wound Care Nurse Assessment of the left trochanter. V5 documented: "Left trochanter: Present on admission. Skin tear/abrasion. Partial thickness. Scabbed area 1.3 cm x 1.0 cm x 0.0 cm." The area of the Initial Wound Care Nurse Assessment shows "treatment plan." The area under treatment plan was left blank by V5. No treatment plans for R1's wounds were documented by V5. The facility does not have documentation to show V5 or any other nursing staff obtained wound care orders for R1 upon admission. The facility does not have documentation to show R1 received any wound assessments or treatment from July 30, 2021 until R1 was treated by V12 (Wound Physician) on August 9, 2021. On August 9, 2021, V12 (Wound Physician) documented: "At the request of [V13] (Attending Physician), a thorough wound care assessment and evaluation was performed today." "Site 1: [R1] has an unstageable DTI (Deep Tissue Injury) of the right proximal buttock for at least 4 days duration. Etiology: Pressure. Wound Size: 6.5 cm x 2.5 cm. x not measurable. Stage: Unstageable DTI with intact skin." V12's treatment orders included: Santyl (Wound Care Medication) apply once daily for 30 days.	S9999		

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S9999	Continued From page 7 The order for Santyl to be applied to the right proximal/distal buttock was changed on August 10, 2021 to apply leptospermum honey daily due to insurance coverage for the Santyl medication. The wound treatment with leptospermum honey was not administered as ordered on August 14, 15, or 21, 2021. Recommendation: low air loss mattress, Multivitamin daily, Vitamin C 500 mg. twice a day, and Zinc Sulphate 220 mg. orally for 14 days. A review of the EMR shows the facility did not initiate V12's (Wound Doctor) orders for supplements on August 9, 2021 as ordered. The daily multivitamin ordered on August 9, 2021 was not started until August 13, 2021, four days after being ordered by V12. The Ascorbic acid 500 mg. ordered twice daily was never started. An order dated August 19, 2021 for Ascorbic acid 500 mg. once daily was started on August 19, 2021, ten days after being ordered by V12. The Zinc sulfate 220 mg. daily was not started until August 19, 2021, ten days after being ordered by V12. "Site 2: Unstageable DTI of the right distal buttock. Etiology: Pressure. Wound Size: 10.5 cm x 3.1 cm x not measurable cm. Unstageable DTI with intact skin." "Site 3: Pressure wound of the left buttock. Etiology: Pressure. Wound Size: 2.5 cm x 2.1 cm. x 0.2 cm. Stage 3. Exudate: Moderate Serous. Slough: 100%. Treatment plan: Primary dressing alginate calcium apply once daily for 30 days.	S9999		

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S9999	Continued From page 8 Gauze island with border apply once daily for 30 days." Facility documentation shows the wound treatment was not administered on August 14, 15, or 21, 2021, as ordered by the physician. V12 performed surgical excisional debridement of the left buttock pressure wound on August 9, 2021 and documented: "My goal for this wound is healing as evidenced by a decrease in surface area of the wound and/or a decrease in the percentage of necrotic tissue within the wound bed." "Site 4: Stage 3 Pressure wound of the left thigh. Etiology: Pressure. Wound size: 0.5 cm. x 0.5 cm. x 0.2 cm. Dressing Treatment Plan: Alginate calcium apply once daily for 30 days. Secondary dressing: Gauze island apply once daily for 30 days." V12 also performed surgical excisional debridement on August 9, 2021. Facility documentation shows the wound treatment was not administered on August 14, 15, or 21, 2021, as ordered by the physician. The facility provided documentation to show the low air loss mattress was not delivered to the facility until August 18, 2021. The low air loss mattress was ordered by V12 (Wound Physician) on August 9, 2021. On September 7, 2021 at 1:34 PM, V5 (Wound Nurse) said, "[R1] came into the facility and she had scabs on her buttocks, her hips and her knees. Because she was incontinent, they deteriorated because she was wet all the time. The wounds were over a bony prominence, but	S9999		

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S9999	Continued From page 9 they were scabbed over, so I called them abrasions. I did not classify them as pressure ulcers. I did not obtain any wound care orders either. I am not good at classifying wounds. I haven't had training in identifying and staging pressure ulcers since I was in nursing school many years ago. I've only been doing wound care at the facility for about a month. The wounds deteriorated and when [V12] (Wound Physician) came to the facility on August 9, I had her see the resident. That was when the wound doctor [V12] told me the wounds weren't abrasions, they were pressure ulcers, and [V12] gave orders to treat the wounds. [V12] ordered supplements for the resident to help with wound healing, like multivitamins, Vitamin C, and Zinc. [V12] ordered those supplements for [R1] on August 9, 2021. [R1] did not receive the supplements as ordered until about a week later because I did not get around to entering the orders into the computer. It was my fault the orders didn't get started. [R1] and the other residents at the facility with wounds missed wound treatments on the weekends. The facility is aware we have a problem with that. I have given training to the staff. Plain and simple, wound care is not getting done on the weekends when I am not here to do it." On September 8, 2021 at 12:05 PM, V5 said, "I have trained the staff to do wound care when I am not here, and they have turned to me and said, 'I don't do wound care'. [V2] (Director of Nursing/DON) knows that. Lack of staff caused the wound care to not be done. The supplements were missed because I missed those orders. I had two days of training to be a wound nurse at another facility where I shadowed the wound nurse." On August 24, 2021 V12 (Wound Physician)	S9999		

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S9999	Continued From page 10 documented concerns regarding R1's pressure ulcer and ordered for R1 to be sent to the local hospital. V12 documented: "Patient has significant purulent discharge. Wound culture was done. Recommend ID (Infectious Disease) consult. Also, significant foul smelling with erythema - likely will need aggressive surgical debridement and IV (Intravenous) antibiotics." At the time of V12's wound assessment on August 24, 2021, V12 documented R1's right proximal buttock pressure ulcer measured 9.5 cm x 2.3 cm x not measurable. On August 24, 2021 at 1:54 PM, V14 (Wound Nurse) documented: "Wound MD here to assess wound. Upon bedside debridement resident wound was noted with pus foul smelling drainage. Surrounding wound is reddened. Verbal order for ER eval and treat was given. Son notified of mother's wound status. He will visit mother at hospital. Ambulance called." On August 24, 2021 at 2:58 PM, V16 (Emergency Room/ER Physician) documented the following regarding R1: "Skin: Warm, dry. 7x5 cm. right-sided sacral decubitus ulcer with foul smelling pus and surrounding redness and erythema. Impression: Primary Impression: Osteomyelitis. Additional Impression: Sacral decubitus ulcer." ACT (Computed Tomography) scan of R1's abdomen and pelvis dated August 24, 2021 shows R1 was admitted to the hospital with a right sacral decubitus ulcer. Results of the CT scan showed: "Large soft tissue ulcer along right buttock and sacrum...containing fluid and osteomyelitis." On August 25, 2021 at 2:56 PM, V15 (Surgeon)	S9999		

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documented: "Post-operative diagnosis: Large right sacral decubitus ulcer with necrosis. Procedure performed: Excisional debridement of large sacral decubitus ulcer. There are 2 very large skin defects separated by a thin skin bridge with extensive necrotic tissue throughout both wounds which communicate under the skin bridge. Copious amounts of necrotic tissue were removed. At the completion of debridement, the wound was irrigated. The wound is then measured and found to be 12 cm. x 8 cm. x 3.5 cm in size with undermining from 11:00 to 6:00 with the greatest area of undermining at 5:00 measuring 7 cm. in depth."

On September 7, 2021 at 2:56 PM, V12 (Wound Physician) said, "I saw [R1] for the first time on August 9, 2021. [V5] (Wound Nurse) incorrectly assessed [R1's] wounds as abrasions; [R1's] wounds on her buttocks were pressure ulcers. When I assess a resident, my notes are immediately available to the facility, and it is my expectation that my orders are initiated immediately. They cannot wait a week or more until they are started. I was never told by the facility that my orders were not started immediately, or wound care was not getting done on the weekends. Not receiving incontinence care, not changing positions, not getting any treatments for the first nine days she resided at the facility all contributed to the wounds getting worse. Those nine or ten days she went without the wound treatment when she first came definitely added to the deterioration of the wounds. Not receiving treatments on the weekends added to the deterioration of [R1's] pressure ulcers. Wounds don't take off on the weekends. They will continue to deteriorate."

On September 9, 2021 at 1:57 PM, V12 (Wound

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S9999	Continued From page 12 Physician) continued to say, "Low air loss mattresses are the backbone of wound care. I expected the facility to start using the low air loss mattress immediately. The same with the supplements and the wound care. No one told me it was another nine days before the facility obtained the mattress or that the supplements did not start right away. I was never notified of this. I know when I saw [R1] on August 16, she still did not have the low air loss mattress in place, and I documented that in my notes. Not doing the wound care, not starting the supplements, not offloading the wound all contributed to the wound getting worse. [V5] (Wound Nurse) is a complete novice when it comes to wound care. The wound deteriorated to the point of pus and foul-smelling drainage. The wound needed immediate medical attention in the hospital setting and I told the facility to call 911." 2. On September 7, 2021 at 2:06 PM, R4 was lying in bed waiting for wound care. V5 (Wound Nurse) removed R4's incontinence brief. Stool was present in R4's incontinence brief and a pressure ulcer on his buttocks was covered in stool. No dressing was covering R4's pressure ulcer. V5 said, "I came to do [R4's] wound care today because none of the staff did his wound care yesterday and it is supposed to be done every Monday, Wednesday, and Friday." V12 (Wound Physician) documented on August 30, 2021 R4 has a Stage 3 pressure ulcer of the left buttock measuring 2.9 cm x 1.7 cm. x 0.2 cm. The EMR shows the following order dated September 1, 2021: "Wound to left gluteal fold, cleanse with NSS (Normal Saline Solution). Apply hydrogel on gauze and cover with border gauze three times a week." Facility documentation	S9999		

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S9999	Continued From page 13 shows R4 did not receive pressure ulcer dressing changes as ordered by the physician on September 6, and 9, 2021. 3. On September 9, 2021 at 10:50 AM, R5 was sitting up in a chair in her room. R5's right lower leg was red and inflamed. Open areas were noted on R5's right lower leg. R5 said her leg was "very itchy" and she had been scratching her leg to the point of causing open areas on her lower leg. R5 said she notified the nurse who cared for her the night before, as well as her current nurse, and both nurses told R5 to tell the wound care nurse of her leg redness when wound treatment took place. R5 said she has a history of cellulitis on her lower legs, and the redness and itching she was experiencing was like other times when she had experienced cellulitis. R5 said, "I am really worried about this. Most weekends they don't do my wound care. They tell me there isn't enough staff here to do get the wound care done, so over the Labor Day weekend, I did not receive dressing changes for my wounds on Saturday, Sunday, or Monday." V5 (Wound Nurse) donned clean gloves and removed dressings from R5's right ankle and toes. A yellowish drainage was present on the ankle dressing. V5 exposed an open wound on R5's right inner ankle approximately 1 inch in diameter. R5 said the wound on her right ankle was caused by pressure from a brace she had worn on her right leg. The ankle wound appeared yellow in color, with redness around the outside of the wound. R5's toes appeared dry with copious amounts of flaking skin. V5 removed betadine soaked gauze from between R5's toes. V5 did not assess the wounds between R5's toes. With the same gloved hands used to remove the soiled wound dressings, V5 touched R5's open wound	S9999		

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S9999	Continued From page 14 on her ankle multiple times. With the same gloved hands, V5 continued to touch R5's lower leg and wounds. With the same gloved hands, V5 used scissors to cut a square of {Brand Name} blue dressing material into a one-inch square. V5 set the square of dressing material directly on R5's bare, reddened shin and moistened the dressing material with normal saline solution. V5 removed the dressing material from R5's shin and applied the dressing material, which had been making direct contact with R5's inflamed right shin, directly to R5's open ankle wound. V5 removed her gloves and donned a clean pair of gloves without performing any hand hygiene between glove changes. V5 applied betadine soaked gauze between each of R5's toes on her right foot without assessing the pressure ulcers present between R5's toes. V5 removed her gloves and applied new gloves without performing hand hygiene. V5 used her gloved hands to apply Vitamin A and D ointment over R5's bilateral lower legs and feet stating, "I always do this for her because her skin is so dry." V5 removed her gloves, did not perform hand hygiene, and continued to touch R5's bilateral lower legs with both hands. The EMR shows R5 was admitted to the facility on July 27, 2021 with multiple diagnoses including Charcot's joint, right ankle and foot, anxiety disorder, morbid obesity, Crohn's disease, unsteadiness on feet, abnormal posture, muscle spasm, restless leg syndrome, insomnia, chronic pain, heart failure, venous insufficiency, chronic kidney disease, PVD (Peripheral Vascular Disease), major depressive disorder, and osteoarthritis. R5's MDS dated August 3, 2021 shows R5 is cognitively intact and was admitted with three	S9999		

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S9999	Continued From page 15 Stage 3 pressure ulcers and an open lesion on her foot. Facility documentation shows R5 was to be seen by the podiatrist in his office on July 29, 2021. The facility does not have documentation to show R5 was ever seen by the podiatrist as ordered. The facility does not have any documentation to show R5 was seen by V12 (Wound Physician) for assessment and wound treatment. On July 28, 2021, V14 (Wound Nurse) documented R5 was admitted to the facility with a left ankle partial thickness wound measuring 2.5 cm x 0.5 cm. x 0.1 cm. V14 also documented Stage 3 pressure ulcers of the left toes measuring 0.4 x 0.5 x 0.1 cm, 0.6 x 0.6 x 0.1 cm, and 0.2 x 0.2 x 0.1 cm. The facility does not have any documentation in the medical record to show when R5 developed the right ankle pressure ulcer. The facility does not have documentation to show weekly assessment of R5's pressure ulcers, as shown in the facility's pressure ulcer policy. An order dated July 28, 2021 for R5 shows: "{Brand Name} blue 4x4 pad apply to right medial ankle topically one time a day for wound care. NSS (Normal Saline Solution) cover with 4x4 gauze and [gauze] roll daily." Facility documentation shows R5 did not receive the physician-ordered treatment on August 1, 2, 7, 8, 21, 29, 2021 and September 4, 5, and 6, 2021. An order dated July 29, 2021 for R5 shows: "Wound left 3rd toe interspace, clean with NSS, pat dry, apply betadine dressing daily one time a day." Facility documentation shows R5 did not receive the physician-ordered treatment on	S9999		

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S9999	Continued From page 16 August 1, 2, 7, 8, 21, 29, 2021 and September 4, 5, 6, 2021. An order dated July 29, 2021 for R5 shows: "Wound left 4th toe interspace clean with NSS, pat dry, apply betadine dressing daily one time a day for wound." Facility documentation shows R5 did not receive the physician-ordered treatment on August 1, 2, 7, 8, 21, 29, 2021 and September 4, 5, 6, 2021. On September 9, 2021 at 12:25 PM, V12 (Wound Physician) said, "I was never notified of [R5's] pressure ulcers. Had the facility notified me of R5's pressure ulcers, I would have seen her right away. I never refuse to see any resident. I have never heard of this resident. [R5] developed a Stage 3 pressure ulcer on her right ankle. They should have notified me. As soon as I saw the pressure ulcers, I changed the treatments they were doing since her admission. I don't understand why I was not told about this resident sooner. [R5] should not have gone that long without seeing a physician, especially when her podiatrist appointments did not happen. No physician was looking at [R5's] wounds and seeing if the wound care was appropriate. Also, if [V5] touches a resident's pressure ulcer or any wound with soiled gloves, or does not perform hand hygiene between glove changes, this puts the resident at risk for cross-contamination of the wounds, which could result in severe infection for the resident. I have never watched [V5] (Wound Nurse) do wound care, so I was not aware she was touching wounds with dirty gloves or not performing hand hygiene." On September 13, 2021, V12 (Wound Physician) documented the following:	S9999		

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S9999	Continued From page 17 "Site 1: Stage 3 pressure wound of the right medial ankle full thickness. Etiology: Pressure. 1.0 x 1.5 x 0.2 cm. Moderate serous exudate. Patient states happened from her boot. Surgical excisional debridement was done." "Site 2: Stage 3 pressure wound of the right fourth toe full thickness. Etiology: Pressure. 0.6 x 0.3 x 0.2 cm." "Site 3: Stage 3 pressure wound of the right third toe full thickness. Etiology: Pressure. 0.2 x 0.2 x 0.1 cm." On September 9, 2021 at 11:00 AM V5 (Wound Nurse) said she did not obtain a wound care consult for R5 since her admission to the facility. V5 replied, "I don't know" when asked why R5 had not been seen by V12 (Wound Physician) since her admission to the facility on July 27, 2021. V5 also stated, "I don't know" when asked why she had not documented assessments of R5's pressure ulcers, including pressure ulcer measurements, appearance, and drainage, since R5's admission to the facility on July 27, 2021. On September 14, 2021 at 2:06 PM, V2 (DON) said the facility staff should refer any resident with a pressure ulcer present on admission or acquired at the facility to the wound care physician immediately. V2 said physician orders should be implemented by the facility staff immediately. 4. On September 9, 2021 at 10:20 AM, V5 provided wound care to R6's pressure ulcers. V5 said R6 did not receive daily wound care over the previous Labor Day holiday weekend. The EMR shows R6 was admitted to the facility in	S9999		

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S9999	Continued From page 18 March 2021. R6 has multiple diagnoses including osteomyelitis of the vertebra sacral and sacrococcygeal region, systemic lupus, acute pancreatitis, COPD, muscle disorder, lack of coordination, morbid obesity, sepsis, acute kidney failure, and hypertension. The EMR shows the following order dated August 4, 2021: "Sacrum, cleanse with NSS (Normal Saline Solution), pat dry, apply collagen powder, calcium alginate rope, cover with border dressing daily until healed." Facility documentation shows wound care was not provided to R6 as ordered by the physician on August 1, 7, 8, 21, 2021 and September 4, 5, 6, 2021. 5. On September 9, 2021 at 10:30 AM, R7 was lying in bed. V5 (Wound Nurse) provided wound care to R7. V5 said R7 did not receive wound care over the previous weekend. The EMR shows R7 was admitted to the facility in March 2020 with multiple diagnoses including pneumonitis due to inhalation of food and vomit, acute kidney failure, history of falling, Parkinson's disease, lack of coordination, UTI (Urinary Tract Infection), dysphagia, acute respiratory distress, Benign Prostatic Hyperplasia (BPH), cardiomyopathy, altered mental status, cognitive communication deficit, unsteadiness on feet, thoracic vertebra fracture, congestive heart failure, chronic atrial fibrillation, dementia, restless leg syndrome, presence of cardiac pacemaker, and chest pain. R7's MDS dated September 8, 2021 shows R7 is cognitively intact and continues to show R7 has one Stage 3 pressure ulcer. The EMR shows the following order for pressure	S9999		

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S9999	Continued From page 19 ulcer treatment for R7 dated August 31, 2021: "Wound: Coccyx cleanse with NSS, pat dry, apply calcium alginate, cover with border gauze daily." The facility does not have documentation to show R7 received pressure ulcer treatment on September 4, 5, and 6, 2021 as ordered by the physician. The facility's Pressure Ulcer and Skin Condition Assessment Policy dated "10/2020" shows: "Policy: It is the policy of this facility that pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved wound assessment form. Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure, and other ulcers and assuring interventions are implemented. Standards: 1. The skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission/readmission. 2. An individual wound assessment will be initiated when pressure and/or other ulcers are identified by the wound nurse or licensed nurse. 4. At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative, and attending physician will be notified. The Director of Nursing will also be notified. The initial observation of the ulcer or skin breakdown will also be described in the clinical record. 5. Pressure ulcers and other ulcers will be measured at lease weekly and documented in the medical record. Only pressure ulcers will be staged. 6. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. 7. A notation will be made in the nurse notes, treatment administration record."	S9999		

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S9999	Continued From page 20 On September 8, 2021 at 12:33 PM, V2 (DON) said, "We were recently cited for not providing wound treatment as ordered by the physician, and it's been something I've been working on. These are issues that are unfortunate. The plan of correction we had established we would have two full-time wound care nurses, but that did not work out. The QA audit tool we were using was not capturing the wound care treatments that weren't getting done on the weekend." On September 13, 2021 at 12:08 PM, V2 (DON) said, "I made arrangements for [V9] (Licensed Practical Nurse/LPN) to do all wound dressing changes over the Labor Day weekend (September 4, 5, 6, 2021). On Sunday, she was pulled from wound care to work on the floor due to lack of staff to care for residents. I reached out to the nurses working at the facility and the manager on duty to make sure wound care was rendered until I could find extra help to do the treatments. I had no success. Wound care was not provided over the weekend due to the lack of staff." On September 9, 2021 at 2:33 PM, V1 (Administrator) said, "We lost one of our wound care nurses to [illness]. We are training and cross-training other staff. But lack of staff bleeds over into other things. If a nurse only has time to pass medications, then the nurse must make a choice, and other things, like wound care, might not get done. We had deficiencies on recent surveys regarding wounds. We put steps in place that are obviously not enough." (A)	S9999		