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	IL6007702	A. BUILDING: _____ B. WING _____	C 04/27/2021

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S 000	Initial Comments Complaint 2142243/IL132393	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)5) 300.1220b)2) 300.3240 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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: 2) All treatments and procedures shall be 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.	S9999		

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S9999	Continued From page 2 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to a) implement, monitor, and modify interventions to prevent and/or promote healing of pressure ulcers, b) accurately and thoroughly identify areas and assess and/or document assessments of pressure areas, c) timely identify and treat an area of compromised skin and/or pressure ulcer, and d) follow the facility pressure ulcer policy/procedures for 3 of 3 (R1-R3) residents investigated for pressure ulcers in the sample of 9. These failures resulted in R2 being hospitalized on 4/8/2021 and diagnosed with osteomyelitis and gangrene and subsequently having bilateral	S9999		

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S9999	Continued From page 3 heel debridement after R2 refused amputations. Findings Include: 1. R2's facility admission record dated 4/15/2021 documents an admission date of 6/22/2020 with diagnoses that include peripheral vascular disease, diabetes mellitus, hypertension, heart failure, venous insufficiency, and personal history of diabetic foot ulcer. R2's Braden Scale for Predicting Pressure Sore risk dated 9/4/2020 and 11/30/2020 documents a score of 19, which indicates R2 is not at risk for skin breakdown. R2's facility care plan documents a focus area of potential for skin impairment related to immobility and documents ulcers to bilateral heels and top of right foot with an initiation date of 7/9/2020. The interventions documented include; administer medications as ordered, administer treatments and monitor for effectiveness as ordered, assess monitor and record wound healing weekly and as needed, measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed, and healing process, report improvements and decline to the physician, educate the family/resident/caregivers as to causes of skin breakdown: including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, follow policies and procedures for the prevention/treatment of skin breakdown, instruct/assist resident to shift weight in wheelchair every 15 minutes, monitor/document/report as needed any changes in skin status appearance and color; wound healing, signs/symptoms of infection, wound size, stage, wound specialist to evaluate with an	S9999		

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initiation date of 12/01/2020, float heels while in bed with an initiation date of 1/1/2021, and prevalon boots at all times with an initiation date of 3/24/2021.

On 4/23/2021 at 11:05 AM V2 (Director of Nurses) clarified R2 did not have ulcers to bilateral heels on 7/9/2020. V2 stated R2 was admitted to the facility with a diabetic ulcer on his toe and the area resolved.

On 4/8/2021 11:15 AM R2 was observed in bed with V15 (Certified Nursing Assistant/CNA) and V16 (Licensed Practical Nurse/LPN) present. R2's right heel was covered with eschar and R2's left heel and part of his foot was covered with black eschar, both with what appeared to be yellow slough under the eschar and the wound edges were separated from the surrounding tissue. The entire area of both feet were observed to shift position as V16 wipes the area with normal saline covered gauze. The area surrounding the eschar on the left foot is red and inflamed and the left foot is edematous.

On 4/15/2021 at 10:45 AM R2 was observed in bed, with V10 (CNA) and V16 (LPN) present. R2's coccyx was observed to have an open area with yellow slough in the center of the area. The surrounding tissue did not appear inflamed.

1a) R2's facility nursing progress notes dated 11/30/2020 documents R2 was transferred to the local hospital for "blister et (and) DTI (deep tissue injury) noted to R (right) heel et (and) edema noted to RLE (right lower extremity), dx (diagnosis) Rt (right) foot cellulitis."

R2's physician progress note located in the facility electronic record dated 11/22/2020 documents "

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S9999	Continued From page 5 .... Per nursing the patient has had intermittent fever, chills, nausea and vomiting for few days. Recently was tested for COVID due to the same. Per nursing he has had a blister to right heel for some time however she reports today that it deroofed and looked infected." Under physical exam the physician progress notes documents, "skin: warm and dry without rash, Right heel is mushy, dark discoloration from medial to lateral heel including posterior heel. Medial aspect of the heel has a large partially deroofed blister. There is surrounding erythema and warmth with swelling of the right foot. The right foot is severely tender to touch. The left heel is red, mushy, with non-blanchable erythema to lateral aspect." Under assessment the physician progress notes documents, 1. Left foot cellulitis with possible osteomyelitis ..." Under plan the physician progress notes documents "Will direct admit for (name of local hospital) for cellulitis." The facility was unable to provide reproducible evidence of assessment, treatment, and/or interventions implemented for R2's left heel other than the physician progress note dated 11/22/2020 located in R2's facility electronic medical record. R2's local hospital records with an admission date of 11/22/2020 documents R2 was sent to the hospital and per report of the facility had a blister to the right heel for some time however on admission it deroofed and looked infected so R2 was sent to the emergency room for evaluation. The record documents under hospital course that dressing changes were done daily, complete pressure relief was provided to bilateral heels and intravenous antibiotics were administered. R2's hospital record documents under the skin assessment on 11/22/2020 a stage 1 decubitus	S9999		

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ulcer left lateral heel. The left heel is described as being red, mushy, with non-blanchable erythema to lateral aspect. R2's hospital records document on 11/27/2020 R2 is still having pain to his left heel but the skin assessment documents it as being normal. R2's hospital assessment and plan document the Stage 1 decubitus ulcer to R2's left lateral heel as resolved prior to discharge.

R2's facility nursing admission screening history dated 11/30/2020 documents R2 returned to the facility after a stay at the local hospital for "decubitus." The assessment documents a "decubitus" on R2's right heel with no specific assessment of R2's left heel documented.

R2's medical record does not document an assessment of R2's left heel from 11/22/2020 until 12/29/2020.

R2's facility care plan documents R2 has a history of skin breakdown on his heels beginning on 7/7/2020. R2's care plan documents an intervention to float R2's heels while in bed beginning on 1/1/2021. There is no documentation in R2's care plan of an intervention to protect R2's heels while up in the wheelchair and no intervention for any heel protection prior to 1/1/2021.

R2's 11/2020 and 12/2020 facility progress notes do not document protection to R2's heels until 12/16/2020 when the progress notes document "float heels while in bed every evening and night shift for wound."

R2's facility clinical physician orders document an order to float heels while in bed with a start date of 1/1/2021.

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On 4/14/2021 at 2:49 PM when asked why R2's heels had not been protected prior to 11/30/2020 (when a skin and wound evaluation of R2's right heel documented the intervention). V2 (Director of Nurses) stated, heel protectors are a nursing measure and were implemented on 11/03/2020. V2 stated R2's heels were floated while he was in bed prior to 11/03/2020. The facility was unable to provide reproducible evidence R2's heels were protected prior to 11/30/2020.

R2's facility wound evaluation dated 12/29/2020 documents a blister to R2's left heel acquired in house with an unknown age measuring 6.02 cm x 4.28 cm. The assessment documents the surrounding tissue as erythema and the practitioner was notified and awaiting physician orders.

On 4/16/2021 at 3:21 PM V2 stated she was unable to locate an assessment of R2's left heel from 11/22/2020 until 12/29/2020 when the facility documented a blister to R2's left heel. V2 stated after R2's physician assessment on 11/22/2020 R2 was sent to the local hospital for evaluation and was admitted. V2 stated R2 returned to the facility on 11/30/2020 and the nurse did an admission assessment. V2 stated R2's left heel is not specifically addressed on the assessment, but she is sure the nurse would have assessed it and documented if there were any issues. V2 stated she believes the area healed during R2's hospital stay.

R2's facility skin observation tool dated 1/5/2021 documents a suspected deep tissue injury/pressure to left heel with no other description or assessment documented.

V14's (wound specialist) note dated 1/6/2021

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documents blister intact to R2's left heel, measures 4.0 cm x 7.0 cm, interventions include heel float boot, specialty mattress, elevate legs when in wheelchair. The treatment orders are documented as clean left heel with normal saline, paint with betadine, gauze, kling, change daily and as needed.

V14's (wound specialist) notes dated 1/13/21 and 1/19/2021 document the area increases in size from 4.0 cm x 7.0 cm to 6.5 cm x 7.0 cm. The treatment orders change to xeroform instead of betadine and the area is documented as 100% necrotic on 1/19/2021.
R2's facility skin and wound evaluation dated 1/20/2021 documents a blister to R2's left heel acquired in house measuring 5.5 cm x 4.1 cm with unknown duration, and the progress is documented as stalled. No other assessment or description of the area is documented on this evaluation. The picture attached to the report is difficult to see but appears to show an area of eschar with uneven wound edges. There is no facility assessment (only (V14) wound specialist notes) of this area from 12/29/2020 through 1/20/2021. V14's wound specialist note dated one day prior to this assessment documents the area is 6.5 cm 7.0 cm which indicates the area is larger than the facility assessment documents.

V14's (wound specialist) notes dated 1/29/2021 through 3/17/2021 document the area increases in size from 6.5 cm x 7.0 cm to 7.0 cm x 7.0 cm. The notes document the treatment is changed to add crushed flagyl to the xeroform with no other significant changes documented on these notes.

There are no facility assessments of the pressure ulcer to R2's left heel from 1/20/2021 until 3/17/2021.

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R2's facility skin and wound evaluation dated 3/17/2021 identifies the area to R2's left heel as an arterial wound measuring 7.4 cm x 7.0 cm, with no other assessment of the area documented. The picture attached to this report appears to show an area of eschar with wound edges slightly separated.

V14's (wound specialist) note dated 3/17/2021 documents R2 saw a vascular physician yesterday and treatment was changed to betadine, gauze, kling, and ace wraps change and CT (computerized tomography) is pending. There is no change to the size or description of the area to R2's left heel documented on this assessment.

V14's (wound specialist) notes dated 3/24/2021 to 4/7/2021 document the unstageable pressure area to R2's left heel increased in size from 7.0 cm x 7.0 cm to 7.5 cm x 10.0 cm with no other significant changes documented.

R2's facility skin and wound evaluations dated 3/24/2021 to 4/7/2021 document the wound measurements ranging from 1.6 cm x 1.2 cm to 7.0 cm x 6.3 cm. This indicates a significant difference in measurements from V14's (wound specialist) measurements of the area during the same time. The facility skin and wound evaluations document the area as stable and/or deteriorating with no other assessment of the area.

R2's radiology report dated 4/5/2021 documents a computed tomography angiogram (CTA) was done on 4/5/21 with impression documented as "There appears to be worsening cellulitis and osteomyelitis involving the right and left

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calcaneus ... The patients known osteomyelitis is suspect is worsening. MRI recommended ...There is a small focal narrowing of the right femoral artery in the mid-thigh with an approximately 50% diameter stenosis. There is a small focal narrowing of the right popliteal artery just proximal to the trifurcation. There is occlusion of the right anterior tibial artery just below the trifurcation. There subsequent high-grade stenosis or occlusion of the posterior tibial artery on the right inferior to the trifurcation ....Some of these findings could relate to slow or no perfusion of these vessels as bolus injection was reduced due to only having a 20-gauge venous access present. If intervention is contemplated follow-up examination prior to intervention would be recommended with a larger gauge intravenous access at higher injection rate. An additional slightly delayed phased second acquisition may also be of use in evaluation of trickle flow through the altered vessel in the lower legs." (This indicates further testing needs to be done to ensure the accuracy of the results).

R2's hospital record dated 4/8/2021 documents R2 presented with bilateral heel ulcers. R2's physical exam documents redness, warmth, wet, swelling, no tenderness with a black eschar present on both heels. R2's hospital records document x-ray of left foot to have the following under impression, "Abnormal a few soft tissue swelling, as well as multifocal areas of permeative bone change concerning for possible osteomyelitis." R2's hospital records document an X-ray of the right foot with the following impression, "calcaneal findings consistent with osteomyelitis."

R2's hospital record with a vascular report dated 4/9/2021 documents under history of present

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illness, " ...With past medical history significant for PVD (peripheral vascular disease) and significant deconditioning presents w/ (with) worsening B (bilateral) heel ulcers. The left heel ulcer started to develop malodor. He has no fevers or chills. He has confirmed osteo (osteomyelitis) by CT scan. He was in the process of undergoing w/u (workup) to assess for PVD that might be amenable to intervention. The patient developed the ulcers spontaneously as his dementia has worsened over time. He is completely non-ambulatory ...the patient has expressed that he does not want a leg amputation." Under physical exam the vascular report documents, "R (right) heel gangrenous eschar w/malodor and maceration at the edges, L (left) heel dry gangrenous eschar, B (bilateral) LE (lower extremity) edema, no erythema." Under assessment and plan the vascular report documents, "Infected B heel ulcers, no significant PVD, after long discussion w/ POA (power of attorney) it was decided to proceed w/ excisional debridement, wound care, wound c/s (culture and sensitivity), prevalon boots ..." Report signed by V12 (vascular surgeon).

R2's hospital record documents an operative note dated 4/13/2021 under description of procedure the report documents there was gross purulence obtained on the right and left and wound dimensions were 6 x 7 cm on the right and 8 x 9 cm on the left. The report documents the curette was used to remove some of the calcaneal bone that was soft and osteomyelitic.

1b) R2's facility skin observation tool dated 11/17/2020 documents a blister and a pressure ulcer/suspected deep tissue injury to right heel with no assessment, measurements and/or physician notification for treatment orders

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documented on this assessment.
R2's facility wound evaluation and the facility skin and wound evaluation dated 11/18/2020 documents the blister on R2's right heel measures 4.42 cm x 3.67 cm and 4.4 cm x 3.7 cm. The area is identified to be new and acquired in house with no further description/assessment of the area and no physician and/or family notification of the area documented on these assessments.

R2's facility skin and wound evaluation dated 11/18/2020 documents the pressure ulcer (deep tissue injury) was identified to be new, acquired in house, and measures 2.2 cm x 1.9 cm. There is no further description or assessment documented and no physician notification for treatment orders documented on this assessment.

R2's facility clinical physician orders document an order was started on 11/19/2020 to apply betadine to right heel topically. This indicates there was no physician order for treatment to the areas on R2's right heel for two days.

R2's physician progress note dated 11/22/2021 documents " .... Per nursing the patient has had intermittent fever, chills, nausea and vomiting for few days. Recently was tested for COVID due to the same. Per nursing he has had a blister to right heel for some time however she reports today that it deroofed and looked infected." Under physical exam the physician progress notes documents, "skin: warm and dry without rash, Right heel is mushy, dark discoloration from medial to lateral heel including posterior heel. Medial aspect of the heel has a large partially deroofed blister. There is surrounding erythema and warmth with swelling of the right foot. The right foot is severely tender to touch. The left heel

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RANDOLPH COUNTY CARE CENTER	312 WEST BELMONT SPARTA, IL 62286

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is red, mushy, with non-blanchable erythema to lateral aspect." Under assessment the physician progress notes documents, 1. Left foot cellulitis with possible osteomyelitis ...: R2's progress notes document R2 was sent to the local hospital for evaluation of symptoms and returned to the facility (on 11/30/2020) with a diagnosis of right foot cellulitis.

R2's facility progress notes do not document further assessment of R2's heels in November of 2020.

R2's local hospital record documents with an admission date of 11/22/2020 documents under history of present illness: " ...Per nursing had episode of nausea and vomiting this am with a fingerstick glucose over 400. Call to on call physician with orders for insulin. Per nursing the patient (R2) has had intermittent fevers, chills, nausea and vomiting for a few days ... Per nursing he has had a blister to right heel for some time however she reports today that it deroofed and looked infected." Under physical examination the hospital record documents, "skin: .... Right heel is mushy, dark discoloration from medial to lateral heel including posterior heel. Medial aspect of the heel has a large partially deroofed blister. There is surrounding erythema and warmth with swelling to the right foot. The right foot is severely tender to touch ..." Under assessment/plan the hospital record documents "1. Decubitus ulcer right calcaneous with surrounding cellulitis and possible osteomyelitis: blood culture, wound culture, IV (intravenous) vanc (vancomycin) and cefepime ....Patient will need complete relieve (sic) of pressure from both heels at all times with BID (twice daily) wound care ..."Under hospital course the record documents, "R2 was started on vancomycin and

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S9999	Continued From page 14 cefepime, wound and blood cultures were obtained. Dressing changes were done daily with a dry dressing and complete relief of pressure was provided to bilateral heels .... Wound culture was reported as MRSA (methicillin resistant staphylococcus aureus), therefore cefepime was stopped and he was continued on vancomycin." R2's hospital swing bed history and physical dated 11/27/2020 documents R2's chief complaint as right pressure ulcer with cellulitis. Under history of present illness, the record documents R2's wound was showing improvements throughout his inpatient stay but R2 will be admitted to a swing bed for more IV antibiotics. Under skin assessment the history and physical documents, "right heel with pressure wound to right medial and posterior heel ...medial aspect is open with central necrosis noted, no odor, the posterior heel is also open with central discoloration, improvement of surrounding erythema, edema, and tenderness ..." Under assessment and plan the history and physical documents, "1. Decubitus ulcer right calcaneous with surrounding cellulitis and possible osteomyelitis, improving ..." R2's facility nursing admission screening history dated 11/30/2020 documents R2 returned to the facility after a stay at the local hospital for "decubitus." The assessment documents a "decubitus" on R2's right heel. R2's facility skin and wound evaluations dated 11/30/2020 document two areas on R2's right heel. One area is documented a pressure/ulcer deep tissue injury that measures 4.8 cm x 3.2 cm and is described as 40% eschar with a light amount of seropurulent exudate and the surrounding tissue is described as calloused,	S9999		

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blanching, dark reddish brown with no edema. The second area is documented as a blister that measures 4.9 cm x 4.7 cm scabbed with no evidence of infection. Interventions are listed on the assessments to include heel suspension and protection device.

R2's facility care plan documents an intervention for R2 to be evaluated and treated by a wound specialist with a start date of 12/01/2020.

V14's (wound specialist) note dated 12/04/2020 documents R2 presents for an initial evaluation of wound to R2's right heel. The note documents R2 was recently in the hospital due to hyperglycemia and right heel infection. "CT (computerized tomography) 11/22 (2020) on right foot showed diffused heterogeneous likely from osteoporosis and osteomyelitis. Wound cx (culture) showed MRSA (methicillin resistant staphylococcus aureus) and (R2) is currently on doxycycline 100 mg BID (twice daily). Under assessment the wound specialist note documents an unstageable pressure ulcer/injury to R2's right heel measuring 4.7 cm x 5.5 cm, with interventions listed as float heels, prostat daily, and xeroform double layer change daily and as needed. R2's wound specialist note documents the two areas previously identified as a blister and pressure ulcer to R2's right heel as one area.

R2's facility skin and wound evaluation dated 12/09/2020 documents the deep tissue injury to right heel to measure 5.3 cm x 4.3 cm. The area is documented as stable with no other assessment/description documented. On 4/15/2021 at 3:00 PM V2 (Director of Nurses) stated this area was previously identified as a blister.

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V14's (wound specialist) note dated 12/10/2021 documents the area to R2's right heel has increased in size from 4.7 cm x 5.5 cm to 7.0 cm x 6.0 cm. The area is documented as being 40% granulated and 60% necrotic with the periwound area as macerated, a moderate amount of serosanguineous drainage with no changes documented to the treatment orders and an intervention of elevate legs when up in wheelchair added.

There is no documentation of facility assessments of the area identified as a pressure/DTI on R2's right heel from 12/10/2020 until 1/1/2021 and of the area originally identified as a blister on R2's right heel from 12/09/2020 until 1/5/2021.

V14's (wound specialist) note dated 12/15/2020 documents the visit was cancelled due to Covid-19. This indicates the pressure ulcers to R2's right heel was not assessed by the wound specialist from 12/10/2020 until 1/6/2020, which indicates no assessment of the areas to R2's right heel was documented by the facility and/or wound specialist from 12/10/2020 until 1/1/2020.

R2's facility progress notes document treatments and antibiotics given for cellulitis of right foot through the month of December 2020 with no assessments of the area documented.

R2's facility skin and wound evaluation dated 1/1/2021 documents the pressure ulcer to R2's right heel to measure 3.2 cm x 2.9 cm with no other assessment of the area documented on this evaluation. R2's skin and wound evaluation dated the same date also documents a separate area to R2's right heel previously identified as the blister to measure 3.7 cm x 3.4 cm with no other

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S9999	Continued From page 17 assessment/description of the area documented. R2's facility skin observation tool dated 1/5/2021 documents an unstageable pressure ulcer to the right heel with no other assessment or description of the area documented. R2's facility progress notes document on 1/6/2021 "upon providing wound care to res (resident) heels foul odor noted, redness noted to peri wound pharm (pharmacy-sic) aware." V14's (wound specialist) notes dated 1/6/2021 and 1/13/2021 documents the unstageable pressure ulcer to R2's right heel has an odor "per nurse" and R2 is started on doxycycline with the odor showing some improvement. The area is documented as 100% necrotic and increases in size from 7.0 cm x 6.0 cm to 7.0 cm x 9.0 cm. V14's (wound specialist) note dated 1/19/2021 documents R2 completed the doxycycline but is still having some odor in the unstageable pressure ulcer to R2's right heel. The note documents R2 is scheduled for a doppler and has had an overall decline in his condition. The assessment documents the wound edges are pulling away slightly with measurements remaining unchanged. Interventions are documented as including doppler, low air loss mattress, ESTEM (electrical stimulation), and a wound culture with the treatment remaining unchanged. R2's facility skin and wound evaluations dated 1/20/2021 documents the areas as stable with the area measured as two separate areas (2.5 cm x 1.7 cm and 4.5 cm x 4.0 cm) with no other assessment and/or description of the area documented.	S9999		

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S9999	Continued From page 18 R2's facility clinical physician orders document an order to start Rocephin one gram intramuscularly on 1/22/2021. V14's (wound specialist) notes dated 1/29/2021 to 3/10/2021 document the area remained unchanged in size and goes from 100% necrotic to 90% slough/eschar and 10% granulated with a moderate amount of exudate. The notes document a culture was obtained and crushed flagyl was added to the treatment on 2/17/2021. There were no other significant changes documented on these notes. V14's (wound specialist) notes dated 3/17/2021 and 3/24/2021 document R2 was evaluated by a vascular physician on 3/16/2021 and the treatment orders were changed to clean area with normal saline, apply betadine, gauze, kling, and ace wraps, change daily and as needed. The notes document a pending CT (computerized tomography) and the area is documented as decreasing in size from 7.0 cm x 9.0 cm to 6.5 cm x 7.5 cm, with no other significant changes documented. R2's facility skin and wound evaluations 3/17/2021, 3/24/2021, and 3/31/2021 begin documenting the two areas as one merged area and describe the area as an arterial wound, with measurements documented as ranging from 5.0 cm x 4.4 cm to 5.9 cm x 5.0 cm, which indicates a discrepancy in size and type of wound from V14's (wound specialist) assessments. The facility evaluation documents the area as improving on 3/24/2021 with no other assessment/description documented. R2's wound specialist note dated 3/31/2021	S9999		

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documents the CT report un-officially showed gangrene to the right heel. The note documents the area decreased in size to 5.8 cm x 6.0 cm with no other significant changes documented.

R2's wound specialist note dated 4/7/2021 documents R2 had an appointment with a vascular specialist that was cancelled (by vascular office) and rescheduled for 4/8/21. The note documents the unstageable pressure to R2's right heel is unchanged.

R2's facility skin and wound evaluation dated 4/7/21 identifies the area to R2's right heel as arterial and measures 4.5 cm x 3.9 cm. The area is documented as improving with no other assessment/description documented. The picture attached to this assessment is difficult to see but shows what appears to be an eschar covered area with wound edges that appear to be separated and pulling away, with what appears to be sloughing under the eschar and dressings with what appears to be drainage covering approximately 70 percent of the dressing laying under the raised heel. The facility assessment documents the area as improving and measures smaller than V14's assessment. This indicates a discrepancy in size and condition of the wound from the facility assessment and V14's assessment on 3/31/2021 that documents the CT scan showed gangrene.

R2's hospital records dated 4/8/2021 document R2 presented to the hospital with bilateral heel ulcers. The heels are described as being infected, gangrenous, with an odor, and to have edema. The hospital records document x-rays of both heels with findings consistent with osteomyelitis. The record documents R2 expressed he did not want leg amputations so

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excisional debridement was performed on bilateral heels.

On 4/9/2021 at 11:30 AM V10 (CNA) stated the facility used heel protection for R2 prior to the Covid-19 outbreak in December. V10 stated he had been wearing them for a while but was unable to remember when they started. V10 stated interventions that were implemented when R2 had Covid-19 were to turn and position, elevate the head of his bed, and heel protectors. R2's progress notes document R2 was diagnosed with Covid-19 on 12/16/2021.

On 4/9/2021 at 11:45 AM V3 (Assistant Director of Nurses) stated R2 had the intervention of heel protectors implemented on 12/01/2020. V3 stated the initial blister was identified on R2's right heel on 11/17/2020. When asked why they didn't implement heel protection at that time or prior to the skin breakdown since R2 had a history of skin breakdown, V3 stated the facility was floating R2's heels in 11/2020. When asked if R2 used a wheelchair for locomotion at that time V3 stated he did. When asked what protection was provided to R2's heel when he was up in a wheelchair V3 stated he did not wear shoes after they identified the blister. V3 then stated they began floating R2's heels on admission to the facility in July of 2020.

On 4/15/2021 at 1:54 PM V14 (wound specialist/Nurse Practitioner) stated the pressure ulcers to R2's heels were not preventable due to his severe arterial disease. When asked if the facility should have implemented heel protection prior to the breakdown V14 stated, "Yes." When asked why the hospital records document no significant peripheral vascular disease and her report documents severe arterial disease V14

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S9999	Continued From page 21 stated she wasn't aware of the hospital report saying that. When asked if there was anything, she felt the facility should have done differently to prevent the areas from developing on R2's bilateral heels V14 stated, "I always though he needed a longer bed. He is a bigger guy." On 4/16/2021 at 8:04 AM V13 (Physician) stated he did not recall what the findings were on R2's doppler and angiograms and that he is sure R2 has some vascular/arterial disease. V13 stated heel ulcers are generally pressure related. When asked if heel protection should have been implemented prior to the skin breakdown V13 stated, "Yes." On 4/15/2021 at 6:30 PM V12 (vascular surgeon) stated R2 has some peripheral vascular disease but it is not significant or causative for the pressure ulcers on R2's bilateral heels. Reviewed with V12, R2 had a history of ulcers on his feet and that I did not see where the facility had implemented preventative measures prior to the most recent pressure ulcers developing on R2's bilateral heels. When asked if the areas could have been prevented/unavoidable if the facility had implemented preventative measures V12 stated, "Potentially, R2 has relatively advanced dementia and can't tell when he is putting pressure on his heels for long periods of time and he has other health issues. But yes, they could have potentially been prevented." V12 stated the ulcers on R2's heels were "strictly" pressure related. V12 stated "These wounds are really, really bad. They are never going to heal." When asked about his notation in R2's hospital record regarding amputation. V12 stated although R2 had dementia he had expressed not wanting to have an amputation and his family honored his wishes. V12 stated amputation would have been	S9999		

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reasonable treatment for R2's pressure ulcers. V12 stated the areas were grossly infected and there was no chance of the areas healing. V12 stated there is a reasonable chance of them staying ok for the rest of R2's life as long as he stays in a steady state and they are treated appropriately.

1c) R2's facility progress notes document on 1/2/2021 "Noted pressure ulcer to coccyx 4.9 cm x 6.2 cm x 2.4 cm. Cleaned with NS (normal saline) et (and) covered with foam dressing. Resident will be repositioned every two hours et (and) as needed. MD (V13) notified, awaiting response."

R2's facility skin and wound evaluation dated 1/2/2021 documents a stage 2 pressure ulcer to R2's coccyx acquired in house measuring 6.2 cm x 2.4 cm with no depth documented. The area is documented as new with no other assessment/description documented. The evaluation documents physician was notified.

R2's facility clinical physician orders document an order with a start date of 1/4/2021 to apply Santyl to coccyx, with no orders documented from 1/2/2021 to 1/4/2021.

R2's facility care plan documents a focus area of potential for skin impairment related to immobility with an initiation date of 7/9/2020. R2's care plan does not document a specialty mattress as an intervention.

R2's facility clinical physician orders document an order for a low air mattress with a revision date of 1/19/2021. The facility purchase order documents this mattress wasn't ordered by the facility until 3/3/2021.

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S9999	Continued From page 23 On 4/14/2021 at 4:14 PM V2 (Director of Nurses) stated the facility had a low air loss mattress overlay they implemented almost immediately (after the area was identified to R2's coccyx) and then ordered the mattress. There is no documentation the facility implemented the specialty mattress prior to R2 developing the pressure ulcer on R2's coccyx to prevent the area from breaking down. R2's facility skin observation tool dated 1/5/2021 documents a Stage 2 pressure ulcer to sacrum with no other assessment/description of the area documented on this assessment. V14's (wound specialist) note dated 1/6/2021 documents an unstageable pressure ulcer to R2's coccyx that is 30% granulated and 70% slough with a small amount of serosanguineous drainage with no measurements of the area documented. Interventions are listed to include specialty mattress and specialty seat. Treatment orders are to clean area with normal saline, apply Santyl/gentamycin 50/50, self-adhesive foam dressing daily and as needed. V14's (wound specialist) note dated 1/13/21 and 1/19/2021 documents the unstageable pressure ulcer to R2's coccyx increases in size from 6.0 x 4.5 cm to 8.0 cm x 3.0 cm with the area described as having a small amount of serosanguineous drainage, 30% granulation, 70% slough. R2's facility skin and wound evaluation dated 1/14/2021 documents an unidentified area measuring 9.0 cm x 3.2 cm documented as stable with no other assessment/description documented. The picture attached to the report is of the coccyx.	S9999		

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S9999	Continued From page 24 R2's facility skin and wound evaluation dated 1/20/2021 documents a stage 2 pressure ulcer to R2's coccyx measuring 3.3 cm x 2.2 cm with no depth documented. The area is documented as stable with no other assessment/description of the area documented. V14's (wound specialist) weekly skin assessments dated 1/29/2021 through 4/7/2021 document the area to R2's coccyx as improving from 30% slough to 10% and 40% granulated to 90%. V14's assessments document a decrease in size from 5.6 cm x 2.6 cm to 1.8 cm x 0.8 cm x 0.3 cm. R2's facility skin and wound evaluations dated 3/24/2021, 3/31/2021, and 4/7/21 documents the area to R2's coccyx decreased in size from 2.6 cm x 1.0 cm to 2.1 cm x 0.7 cm. There is no other assessment or description of the area documented on these assessments. On 4/9/2021 at 11:30 AM V10 (CNA) stated interventions implemented when R2 had Covid-19 were to turn and position, elevate the head of his bed, and heel protectors. V10 stated R2 had a specialty mattress but she was unable to remember when it was implemented. R2's progress notes document R2 was diagnosed with Covid-19 on 12/16/2020. On 4/9/2021 at 11:45 AM V3 (Assistant Director of Nurses) stated R2 had the intervention of low air loss mattress implemented on 1/19/2020. When asked why they did not implement a specialized mattress prior to R2's skin breakdown on his coccyx to prevent the area V3 stated all of the facility mattress are considered low air and the wound nurse thought adding the other one would be extra protection.	S9999		

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S9999	Continued From page 25 On 4/14/2021 at 4:01 PM V2 (Director of Nurses) stated she would expect weekly assessments of areas of skin breakdown, treatments to be implemented, physician and families to be notified, and interventions to be implemented to prevent skin breakdown. On 4/15/2021 at 1:54 PM V14 (wound specialist/Nurse Practitioner) stated the mattress overlay the facility implemented was an acceptable alternative to the low air loss mattress and that if the facility had implemented measures prior to the development of the pressure ulcer on R2's coccyx the area could have been prevented. 2) R1's admission record dated 4/8/2021 documents R1 was admitted to the facility on 11/06/18 with diagnoses that include epilepsy and polyneuropathy. R1's MDS (Minimum Data Set) dated 2/10/21 documents R1 has a BIMS (Brief Interview for Mental Status) score of 13, which indicates R1 is cognitively intact. R1's Braden Scale for Predicting Pressure Sore Risk dated 2/10/21 documents a score of 16, which indicates R1 is at risk for skin breakdown. R1's care plan documents a focus area of potential for skin impairment dated 11/19/2018 with interventions that include lay down after lunch with a start date of 12/31/2020 and heel protectors at all times with an initiation date of 7/7/2020. R1's facility wound evaluation dated 7/7/2020 documents a new stage 2 pressure ulcer to R3's left heel measuring 1.01 cm x 0.57 cm assessed with 100% eschar and light serosanguineous	S9999		

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S9999	Continued From page 26 drainage. V14'S (wound specialist) note dated 7/17/2020 documents R1 was evaluated for a stage 3 pressure injury to the left heel measuring 0.7 cm x 0.4 cm x 0.3 cm. V14'S (wound specialist) notes dated 3/03/2021 to 4/7/2021 documents the area decreased in size from 2.0 cm x 2.0 cm x 0. cm to 0.6 cm x 0.5 cm x 0.2 cm and went from an unstageable pressure ulcer to a Stage 3 pressure ulcer. On 4/6/2020 at 6:20 PM, R1 was observed sitting in her chair in her room with soft slippers on and no heel protectors or floating of heels observed. R1 stated she had a new sore on her foot. When asked if the facility was aware of it, R1 stated she had told the nurse that morning. When asked if they had put a dressing on it R1 stated no and she was not sure how it happened. R1 was observed on 4/6/2021 at 7:13 PM and 8:30 PM sitting in her chair with soft slippers on her feet and no heel protectors or floating of heels observed. On 4/7/2021 R1 was observed at 12:25 PM and 1:40 PM sitting in her wheelchair with soft slippers on and feet resting on the wheelchair foot rests with no heel protectors or floating of heels observed. On 4/8/2021 at 3:20 PM R1 was observed sitting in her recliner in her room with soft socks on her feet with her feet resting flat on the floor. V6 (Certified Nursing Assistant) stated R1 wears heel protectors when she is in bed. V6 stated when she asks R1 if she wants to put heel protectors on. R1 just asks for her slippers.	S9999		

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S9999	Continued From page 27 On 4/8/2021 at 10:57 AM R1 was observed sitting in her chair in her room with V11 (Licensed Practical Nurse) present and changing the dressing to R1's left heel. When asked if that was the sore she had told surveyor about, R1 stated no. She also had a sore on the top of her foot. V11 (LPN) stated she was not aware of that area. V11 removed R1's slipper and sock and observed an area that appeared to be a blister that was not intact. V11 stated she would notify the physician about the area. R1's skin observation tool dated 4/7/2021 does not document an area to R1's right foot. R1's physician notification for routine orders dated 4/8/2021 documents R1's physician was notified of a 2 cm x 2 cm blister to the top of her right foot and right second toe being red. Orders were received to use skin prep to the blister and keep pressure off R1's toes. R1's skin and wound evaluation dated 4/9/21 documents a new blister to R1's right dorsum foot measuring 1.4 cm x 1.0 cm. There was no facility documentation that the areas on R1's right foot had been assessed, physician/family notified, and treatments orders obtained and implemented on 4/6/2021 when R1 reported to the surveyor she had reported a new area to the nurse. On 4/13/2021 at 11:40 AM V3 (Assistant Director of Nurses) stated R1 had not had skin breakdown on her heels prior to 7/2020. V3 stated R3 should always be wearing heel protectors on the affected foot.	S9999		

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S9999	Continued From page 28 On 4/14/2021 at 4:01 PM V2 (Director of Nurses) stated she would expect heel protection to be implemented at all times. On 4/16/2021 at 8:04 AM V13 (Physician) stated the pressure ulcer on R1's heel was avoidable, and the facility should be implementing off-loading to her heels when up in wheelchair and in recliner. On 4/15/2021 at 1:54 PM V14 (wound specialist/Nurse Practitioner) stated the pressure ulcers to R1's heel was avoidable. V14 stated R1 should only need heel protectors when in bed that there should not be any offloading of pressure when she is in her wheelchair since her wheelchair only has traditional foot pedals. 3) R3's facility admission record documents R3 was admitted to the facility on 10/08/2020 with diagnoses that include hemiplegia, anemia, and atrial fibrillation. R3's care plan documents a focus area of potential for impaired skin breakdown with an initiation date of 10/21/2020. This focus area does not include interventions to prevent skin breakdown such as a low air loss mattress, heel protectors, turning and repositioning. R3's facility skin observation tool dated 1/13/2021 documents a rash on R3's right trochanter that is described in the notes as being "scale-like in character rash noted to R (right) hip, blanchable will monitor." R3's facility wound evaluation dated 1/17/2021 documents an area on R3's right trochanter, the type of area is not identified. It measures 6.8 cm x 5.0 cm. The area is documented as stable with	S9999		

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S9999	Continued From page 29 no assessment, description, or treatment of the area documented. The picture of the area attached to the report shows what appears to be a discolored area with peeling skin in the center. R3's local hospital discharge summary dated 1/22/21 documents R3 was admitted to the hospital on 1/20/2021 and discharged back to the facility on 1/25/2021 with no wound care or skin issues documented on the discharge summary. R3's facility nursing admission screening history dated 1/25/2021 does not document any skin breakdown. R3's skin observation tool dated 1/27/2021 documents under notes, "scattered bruising noted to BUE (bilateral upper extremities) redness noted to R hip, blanchable skin intact." R3's facility skin observation tool dated 2/3/2021 documents under notes "redness noted to R hip blanchable skin intact." R3's facility skin and wound evaluation dated 2/5/2021 documents an area (type not identified) on R3's right trochanter measuring 8.3 cm x 7.7 cm there is no assessment, description, or treatment of the area documented and/or family or MD notification. The picture of the area attached to the report is difficult to see and does not offer a good assessment of the area. R3's facility progress notes do not document an assessment or treatment of the area and/or MD or family notification of the area. R3's facility skin and wound evaluation dated 2/11/2021 documents an in house acquired area	S9999		

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to the right trochanter with no type documented measuring 4.9 cm x 2.6 cm. The evaluation documents the area as stable but does not document a description and/or assessment or notification to the family or physician. The picture attached to the report is difficult to see and does not offer a good assessment of the area.

R3's facility clinical physician orders document an order for calmoseptine ointment to be applied to the right hip with a start date of 2/11/2021. There is no treatment order documented for the area to R3's right hip from the time it was first identified on 2/3/2021.

R3's facility skin and wound evaluation dated 2/14/2021 documents an in-house acquired area to the right trochanter with no type of wound documented, measuring 4.4 cm x 2.5 cm documented as stable with no description or assessment of the area documented. The picture attached to the report has what appears to be a discolored area with skin sloughing off from the outer edges in. It is difficult to see the picture, so it does not offer a good assessment.

R3's facility progress notes document on 2/14/2021 "NP (nurse practitioner) here this day rounding informed of res (resident/R3) deteriorating wound to R hip ...N.O (new order) received for wound tx (treatment) ...POA (power of attorney) notified and aware."

R3's facility clinical physician orders document an order for xeroform patch to be applied to R3's right hip with a start date of 2/15/2021.

V14's (wound specialist) notes dated 2/19/2021 documents an initial evaluation of wound to right hip. The wound specialist note documents an

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S9999	Continued From page 31 unstageable pressure ulcer to R3's right hip measuring 1.5 cm x 2.5 cm x unable to determine depth. Treatment orders to clean area with normal saline, apply Santyl, gauze and change daily and as needed. Under plan the note documents to turn and position R3 every two hours and use a low air mattress. R3's facility skin and wound evaluation dated 2/22/2021 documents moisture associated skin damage (MASD) to R3's coccyx acquired in house measuring 0.6 cm x 0.4 cm with no assessment or description documented. R3's facility progress notes document on 2/22/2021 R3's physician was notified of new area of moisture associated skin damage to R3's coccyx and R3 is to see wound specialist next week. V14's (wound specialist) note dated 2/24/2021 documents the pressure ulcer to R3's right trochanter/hip to be unstageable and measure 2.0 cm x 4.1 cm x 0.2 cm. The plan and treatment remain the same. There is no documentation of assessment of the MASD on R3's coccyx. R3's facility skin and wound evaluation dated 2/28/2021 documents an abrasion to R3's left hip measuring 4.4 cm x 3.5 cm. The area is documented as new with no other assessment/description documented on this evaluation. R3's progress notes document on 2/28/2021 area noted to left hip, turning and repositioning continues, physician notified and orders for skin prep to the area, unable to reach R3's power of attorney awaiting a call back.	S9999		

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S9999	Continued From page 32 V14's (wound specialist) note dated 3/3/2021 documents follow up for the pressure ulcer to R3's right trochanter/hip and the facility requested evaluation of a new area to R3's left hip. The note documents an unstageable pressure ulcer to R3's right hip measuring 2.0 cm x 3.1 cm x 0.2 cm. and a blister on R3's left hip measuring 1.0 cm x 0.7 cm x 0.2 cm. Treatment orders documented and to turn and position every two hours and a low air loss mattress to be implemented. There is no assessment of the MASD on R3's coccyx documented. There is no assessment of the MASD area on R3's coccyx documented from 2/22/2021 until 3/9/2021 when the skin and wound evaluation documents moisture associated skin damage measuring 1.1 cm x 0.7 cm that is stable with no other description or assessment documented. V14's (wound specialist) note dated 3/10/2021 documents evaluation of the treatment to wounds on left and right hip and nursing requested an evaluation of a new area to R3's coccyx and left buttocks. The wound specialist note documents the pressure ulcer to R3's right hip to measure 1.5 cm x 2.8 cm x 0.3 cm and the open blister to R3's left hip to measure 1.0 cm x 1.0 cm x 0.2 cm. With the new area on R3's coccyx described as a stage 3 pressure ulcer measuring 2.0 cm x 0.7 cm x 0.3 cm and a stage 3 pressure ulcer on R3's left buttock measuring 1.0 cm x 1.0 cm x 0.1 cm. Under plan the note documents turn and position every two hours and "low air loss mattress ordered. Under treatment the note documents new area to left buttock and sacrum, will use Santyl, gauze, and change daily and as needed. This indicates the area identified as MASD on 2/22/2021 that was to be evaluated by	S9999		

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S9999	Continued From page 33 V14 the next week, was not evaluated until 3/10/2021. V14's (wound specialist) notes dated 3/17/2021, 3/24/2021, and 3/31/2021 documents low air loss mattress ordered and the following measurements for R3's pressure ulcers, right hip increased in size from 1.7 cm x 2.5 cm x 0.3 cm to 2.4 cm x 1.8 cm x 0.3 cm coccyx increased in size from 1.5 cm x 0.7 cm x 0.3 cm to 1.2 cm x 4.0 cm x 0.3 cm left hip decreased in size from 0.7 cm x 1.0 cm x 0.2 cm to 0.3 cm x 0.3 cm x 0.2 cm left buttock is documented as merged with the pressure ulcer on R3's coccyx on 3/31/2021. On 4/13/2021 at 12:00 PM V3 (Assistant Director of Nurses) stated R3 did have areas on her right hip prior to hospitalization. V3 stated she was turned and repositioned, but the facility does not document it. Turning and repositioning is communicated between the CNAs and nurses. V3 stated the facility did a facility evaluation in February/March of 2021 because they knew there was improper documentation of wounds. V3 stated they looked at all the wounds in the facility and now have one person assessing the wounds and doing the documentation. When asked about the low air loss mattress for R3, V3 stated she knew hospice brought in a mattress, but she would have to check on when that was. On 4/14/2021 at 4:01 PM V2 (Director of Nurses) stated she was unable to locate documentation anything was implemented prior to 2/11/2021. V2 stated the area on R3's right hip was still blanchable on 2/3/21 and 2/5/21 and calmoseptine was ordered on 2/11/21. V2 stated she knew there was a documentation issue and as the new DON, she was addressing it. V2	S9999		

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stated the facility did not implement a specialty mattress until after the wound specialist saw R3 on 2/17/2021. V2 stated she knows she called maintenance after it was ordered by the wound specialist and it got to R3 within the next few days. V2 stated she was unable to find documentation of the mattress being implemented. V2 stated she would have expected intervention to have been implemented to prevent pressure ulcers since R3 had already had an area that had previously healed on that hip. V2 stated she was unable to find documentation the family had been notified of the area to R3's coccyx, and she did not know why it took two weeks for the wound specialist to address the area on R3's coccyx. V2 stated she would expect weekly assessments to be documented, treatments to be obtained and implemented, interventions to be implemented and family's to be notified and updated on areas of skin breakdown.

On 4/15/2021 at 1:54 PM V14 (wound specialist/Nurse Practitioner) stated she would have documented an assessment of any areas and she did not remember being told of the "MASD" to R3's coccyx prior to her first evaluation of the areas on 3/10/2021. V14 stated if she had been told of it and assessed it, she would have documented it. V14 stated MASD could deteriorate to a Stage 3 in that time frame. When asked if there was a delay on implementing the specialized mattress V14 stated she knew R3 had one when she was on hospice but could not remember prior to that. When asked if an overlay was an appropriate alternative to a low air loss mattress V14 stated it would have been better than a regular mattress. When asked if the areas would have been preventable V14 stated, R3 had just come back from the

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S9999	Continued From page 35 hospital and had been sick so she didn't think they would have prevented the areas but it may have slowed down the progression of the areas. On 4/16/2021 at 8:04 AM V13 (Physician) stated a specialized mattress is a great idea and the facility should probably have implemented it, but it is unknown if the pressure ulcers were preventable because R3's decline became more aggressive. The facility Treatment/Services to prevent/heal pressure ulcers dated 1/11/19 documents, "It is the policy of (name of facility) to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental and psychosocial needs." Under procedure the policy documents, "(name of facility) will ensure that based on the comprehensive assessment of a resident: a. A resident receives care, consistent with professional standards of practice, to prevent ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. B. A resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing ...3. Interventions will be implemented in the resident's plan of care to prevent pressure sore development when the resident has no areas of concerns ...5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure sore ...7. The pressure sore (s) will be evaluated weekly and the nurse will document the size, location, odor (if any),	S9999		

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S9999	Continued From page 36 drainage (if any), and current treatment ordered ...8. The nurse will notify the physician (Nurse Practitioner) anytime the pressure sore is showing signs of nonhealing or infection and request treatment order changes. 9. The nurse will notify the resident and or the resident's representative of any changes related to the improvement, deterioration and/or treatment changes on an on-going basis ..." (A)	S9999		