Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016885	A. BUILDING: ____ B. WING ____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF CARBONDALE	2940 W WESTRIDGE PLACE CARBONDALE, IL 62901

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S 000	Initial Comments Complaint Investigation 2250794/IL142989	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 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 manifest decubitus ulcers or a weight loss or gain of five	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having	S9999		

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pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to a) accurately and thoroughly identify pressure ulcers, b) consistently assess and/or document assessments of pressure areas, c) provide dressing changes in accordance with policy and professional standards of practice, d) timely identify and notify physician of worsening pressure ulcers, e) have a system in place to monitor the progression of pressure ulcer(s), and f) follow facility pressure ulcer policy/procedures for 2 (R1, R3) of 3 residents reviewed for pressure ulcers in a sample of 8 residents.

These failures resulted in (R3) being hospitalized for an infected stage 3 pressure ulcer and subsequently being put on comfort care after refusing amputation or surgical intervention.

Findings include:

1. R3's Face Sheet documents an original admission date of 6/16/2021 and latest return on 1/14/2022. Diagnoses in part includes Type 2 Diabetes Mellitus without complications, Sepsis, unspecified organism, Other acute osteomyelitis, left ankle and foot, Mild Protein-calorie malnutrition, local infection of the skin and subcutaneous tissue, unspecified, Bacterial Infection, unspecified, Unspecified open wound, left lower leg, Pressure ulcer of unspecified heel, unstageable, and Anorexia.

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S9999	Continued From page 3 R3's Hospital History and Physical Exam documented in part, "Admission date of 1/12/2022 and Discharge Date of 1/14/2022. Physical Exam: Extremities: Cellulitis features of both lower legs, redness, swelling, tenderness, Left Heel: Ulcer, unstageable necrotic tissue with purulent drainage. Infectious Disease (ID) Update: Decision has been made to make patient comfort focused treatment only. No surgeries or invasive treatments planned. Those heels will most probably never heal without surgery. Palliative Supportive Care consult documented Plan Do Not Resuscitate (DNR), HPOA (Healthcare Power of Attorney - V14) decided not to proceed with surgical interventions. Transition to comfort focused care and consult hospice." R3's Hospital Discharge Information for Receiving Facility documented a hospital admission date of 1/12/2022. Encounter Diagnosis: Cellulitis of left lower extremity, Wound Infection, Heel Ulceration, right with unspecified severity, Heel Ulceration, left, with unspecified severity. R3's Quarterly Minimum Data Set (MDS) dated 11/3/2021 documents a Brief Interview for Mental Status (BIMS) score of 4, which indicates severe cognitive impairment. This same MDS documents R3 requires extensive assistance for bed mobility, transferring, and toilet use with 2 staff assistance, always incontinent of bowel and bladder, at risk for pressure ulcer/injuries, and no unhealed pressure ulcers or arterial ulcers were present. R3's Admission Braden Assessments nor quarterly Braden Assessments could be found for the dates of 6/16/21 through 1/12/22. R3 was hospitalized from 1/12/2022 to 1/14/2022. R3's Braden Assessment dated 1/14/2022 documents a score 12, indicating R3 is at high risk for pressure ulcer development. A Braden	S9999		

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S9999	Continued From page 4 Assessment completed on 1/20/2022 documents a score of 15, indicating R3 is at risk for pressure ulcer development. On 2/16/2022 at 2:43 PM, when questioned about R3's Braden Assessments prior to 1/12/22, V1 (Administrator) responded via email she was unable to find (R3)'s Admission and Quarterly Braden Assessments. R3's Care Plan Problem dated 6/17/2021 documented, (R3) is at risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization. The care plan approach, dated 6/30/2021, documented heel protector boots in place at all times, as tolerated. R3's Physician Orders Report and Medication Administration Records dated from 11/1/2021 to 2/2/2022 document, in part the following treatment orders: 6/17/2021 to 12/14/2021: Skin Prep bilateral heels and monitor for signs and symptoms of skin breakdown once a day; 7/8/2021 to 1/12/2022: Bilateral Heels to be in heel protector boots as resident allows every shift; 12/1/2021 to 12/11/2021: Cleanse pressure ulcer to left heel with wound cleanser, apply calcium alginate and foam dressing daily and as needed and cleanse pressure ulcer to right heel with wound cleanser, apply calcium alginate and foam dressing daily and as needed; 1/19/22 to 1/21/2022: Cleanse pressure ulcer to left and right heel with wound cleanser and apply Santyl to heel, use foam dressing to cover ulcer and apply heel protector and wrap heel protector with Kerlix daily and as needed; 1/21/2022 to open ended: Left Heel. Cleanse areas apply wet to dry with Dakin's. Apply heel protector and wrap with Kerlix [Diagnosis: Pressure ulcer of unspecified heel, unstageable] once daily, Right heel:	S9999		

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S9999	Continued From page 5 Cleanse area, apply Santyl and foam dressing, heel protector. Wrap with Kerlix and secure with tape [Diagnosis: unspecified open wound, left lower leg, initial encounter]. On 2/4/2022 at 3:30 PM, V2 (Director of Nursing/DON) stated (R3) had previous pressure ulcers on admission that healed, and the heel protector boots were in place for prevention since June 2021. On 1/27/2022 at 11:30 AM, V4 (Licensed Practical Nurse/LPN) stated (R3) had pressure areas to her heels which were facility acquired. V4 also stated (R3) had osteomyelitis, diabetes, and areas on her heels that were stage IV. V4 said R3 has poor appetites, declining condition, and has been placed on comfort care measures since she returned from the hospital. On 1/27/2022 at 10:00 AM, V3 (Registered Nurse/RN/Treatment Nurse) stated she does all the treatments on the halls. V3 stated R3's Pressure ulcers on her heels were facility acquired. V3 stated she does weekly skin checks and rounds with (V10/Wound Doctor) and documents wounds in the Electronic Health Record (EHR). V3 stated she notifies the Doctor and Family when any new skin areas develop. On 1/27/2022 at 1:20 PM, V3 (RN/Treatment Nurse) brought in the treatment supplies and set them on R3's overbed table without cleaning or placing clean barrier. R3's lunch tray was on this same table. V3 washed hands and donned gloves then removed R3's heel boots, cut off the right foot dressing and revealed the right heel pressure ulcer wound, which appeared approximately a 1/2-dollar size, with a slough in the center, and brownish drainage on the old	S9999		

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dressing. V3 forgot tape and left the room. V3 came back to the room and proceeded to cleanse the right heel wound bed with a wet soaked gauze. V3 discarded gauze in the trash, applied the ointment to wound bed, and wrapped the foot with gauze dressing. Without performing hand hygiene, V3 then used the same gloved hands to cut off the left foot dressing, which revealed a larger pressure ulcer covered with black eschar. V3 discarded the old dressings in a trash can by the bed, and with the same gloved hands cleansed the left heel wound, applied a wet soaked gauze dressing, wrapped the left heel with gauze, and applied tape. V3 doffed the gloves in the trash can in the room, then washed her hands in the resident bathroom.

On 1/27/22 at 1:30 PM, V3 stated she did not need to perform hand hygiene and put on new gloves between taking off the old dressing and application of the new dressing because the dressing was not a sterile dressing change.

On 1/27/2022 at 2:15 PM, V2 (Director of Nursing/DON) stated (V3) was the primary treatment nurse for the facility and he would expect her to wash her hands after she removed an old dressing and before application of a new dressing per the facility policy.

R3's Medication Administration Record (MAR) for November and December 2021 and for January 2022 documents orders for "Weekly Skin Check" to be completed "once a day on Fri (Friday)" with time described as 6:00PM-6:00AM. In November, these are documented as completed every Friday on 11/5/21, 11/12/21, 11/19/21, and 11/26/21. In December, the skin checks are documented as completed on 12/3/21, 12/10/21, 12/17/21, 12/24/21, and 12/31/2021. On the January 2022

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MAR, the only documentation noted for R3's skin checks was completed on 1/7/22. There was nothing further entered for skin checks in January, and there is no section to document any description of the skin observations, only that they were completed by the nurse entering their initials on the MAR. This indicates the facility failed to assess and/or document weekly skin assessments on the MAR for the following dates 1/21/22 and 1/28/22.

On 2/15/2022 at 2:30 PM, V3 (RN/Treatment Nurse) stated the EHR (Electronic Health Record) alerts her as to who is due for their weekly skin assessments. V3 stated she does a head-to-toe skin assessment and checks the bony prominences and under the skin folds. V3 stated if there were no issues observed she did not document a detailed assessment. V3 stated (R3) had soft/mushy heels prior to the 12/1/2021 pressure ulcer development which was why she had orders for the heel booties and the skin prep to her heels daily. V3 stated during treatments she would sometimes find that (R3) did not have her heel booties on and she would have to go get them from the laundry and re-apply them. V3 stated this happened sometimes and she would reinforce the importance of R3 wearing the heel booties with the CNAs (Certified Nurse Aides). V3 stated it was the Nurses and CNA's responsibility to be sure the heel booties were on, and it wasn't very often that she found (R3) not wearing them. V3 stated (R3) complied with wearing the heel booties and she thought the pressure areas developed due to her overall frail condition.

R3's progress notes on 6/17/21 and 9/25/21 document R3's heels were boggy with blanchable redness to bilateral heels. R3's medical record does not document any other thorough

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S9999	Continued From page 8 assessments of R3's bilateral heels until 12/01/2021. On 2/17/2022 at 12:10 PM, V2 (DON) stated nursing should have been documenting the description of (R3)'s boggy/mushy heels on their weekly skin assessments. On 2/15/2022 at 4:00 PM, V18 (LPN) stated she did (R3)'s skin assessment on 11/12/2021 and both heels' skin was intact but felt "soft and mushy." V18 stated she documented the 11/12/21 assessment by signing her initials to R3's MAR, with no description of the areas documented in R3's record. On 2/16/2022 at 7:45 AM, V19 (LPN) stated she did (R3)'s 11/26/2021 skin assessment of both heels and they both had no open areas or heel redness present. V19 stated prior to (R3)'s pressure ulcers developing on the heels she wore the pressure relief booties while she was in bed and slippers when she was up for breakfast or for activities during the day. V19 stated (R3)'s slippers were loose fitting on her feet and did not put pressure on the heels. V19 stated (R3) could kick her heel booties off occasionally and staff would re-apply them. V19 stated the nurses were responsible for application of the heel protectors. V19 stated she documents weekly skin assessments in the EHR progress notes, and if a new pressure area was discovered she would document the wound in an "Event" note with measurements and description. On 2/15/2022 at 3:30 PM, V17 (CNA) stated she did (R3)'s shower on 11/27/2021 and she did not see any open areas present on (R3)'s heels, and (R3) always wore her heel protectors while she was in her wheelchair and in bed.	S9999		

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S9999	Continued From page 9 R3's Progress Notes dated on 12/1/2021 at 8:43 PM documented, "this nurse (V18 LPN) observed two pressure ulcers while applying resident's heel boots for bedtime. Pressure ulcer on right heel is measuring 1.5 cm (centimeter) x 2 cm and pressure ulcer on left heel is measuring 2 x 3 cm. Area was cleansed with wound cleanser, calcium alginate and foam dressing applied, along with heel protectors. Resident presents moderate pain to areas. Treatment orders in place and wound management updated for wound doctor to observe and round on resident next time in facility." There was no stage of the pressure ulcers documented at this time. R3's Wound Management Detail Report documents in part, pressure ulcer to left heel (not present on admission or re-entry) identified on 12/01/21 at 8:50 PM that measures 3 cm x 2 cm described as bloody, foul odor, and necrotic type tissue. The Wound Management Detail Report documents pressure ulcer to right heel (not present on admission or re-entry) identified on 12/01/21 at 8:49 PM that measures 2 cm x 1.5 cm described as bloody, foul odor, with necrotic tissue. On 12/10/21, the Observation History section of this report documents "No observations have been recorded for this wound" for both right and left heels. There are no further entries on this report until 1/21/22 at 9:15 AM (one week after R3 returned from the hospital) when the Observation History section documents, Left Heel length 10.5 cm Width 8 cm. moderate exudates, red to pink watery, slough tissue, Redness/blanchable, wound healing status declining. 1/21/2022 at 9:15 AM Right Heel Length 2.5 cm Width 1 cm light exudate; red to pink, thin and watery, foul wound odor, Slough tissue, edge not attached, erythema, wound	S9999		

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healing status declining.

On 2/15/2022 at 4:00 PM, V18 (LPN) stated she discovered (R3)'s right and left heel pressure ulcers on 12/1/2021. V18 stated she did the measurements, notified the doctor for a treatment but she did not notify (R3)'s Power of Attorney (POA) because she did not know she was supposed to. V18 stated she documented both heel pressure ulcers description on a "Wound Management Detail Report" and in the progress notes on 12/1/21. V18 stated she did not put any staging of the wounds because the Treatment Nurse or DON usually does stage (stages the pressure ulcers) and makes the referral to the wound doctor on the next day. V18 stated when she found (R3)'s pressure ulcers on 12/1/2021 to both heels, they were small open areas with a deep red/maroon color to the wound, bloody drainage, with a foul odor, without any black tissue or slough present. V18 stated (R3)'s pressure ulcer on the left heel was worse than the right heel. V18 stated (R3) always had her pressure relief booties on and the nurses made sure they were on every shift. When this surveyor asked V18 what the stage of the pressure ulcers were upon discovery and if the wounds were necrotic tissue as was described on the 12/1/2021 Wound Management Detail Report, V18 stated she was not sure if necrotic tissue was an accurate description because she did not see any black or sloughing tissue on the wound, only the deep red tissue. V18 was unable to confirm what the stage of R3's pressure ulcers were on 12/1/2021.

On 2/17/2022 at 8:15 AM, V3 (RN/Treatment Nurse) stated she did treatments to (R3)'s heels on 12/2/2021 and thinks the heels were a stage 2 at the time. V2 stated any nurse can stage a

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wound and there is a book on the treatment cart that tells the nurses what the wound stages look like. V3 stated she does not keep a wound log. V3 stated the nurses should do weekly measurements and wound descriptions on residents with pressure ulcers.

R3's December 2021 Progress Notes dated 12/4/2021 at 6:45 AM, 12/11/2021 at 5:54 AM, 12/25/2021 at 6:23 AM, 1/1/2022 at 2:41 AM, 1/5/2022 at 2:56 PM, 1/6/2022 at 4:31 PM, and 1/11/2022 at 7:06 AM all documented wounds were observed but no wound measurements, staging, or descriptions were included. There is no weekly progress note entered for wound observation on 12/18/21. R3's medical record does not document an assessment including staging of the pressure ulcers on R3's heels from 12/01/21 until 12/10/21 when R3 was evaluated by V10 (Wound Doctor).

On 2/15/2022 at 2:30 PM, V3 (RN/Treatment Nurse) stated if there were any new skin issues, or pressure ulcers, she would call the doctor for a treatment order, notify the POA, then chart the measurements and description in the progress notes and on the "Event" note in the EHR. V3 stated an Event note included the wound location, measurements, drainage, stage and skin color, and she would document weekly descriptions and measurements on a "Wound Management Detail Report" in the EHR. V3 stated she was not aware she should enter (V10/Wound Doctor)'s measurements into the Wound Management Detail Report and she usually documents (V10)'s measurements in the progress notes.

On 2/4/2022 at 3:30 PM, V2 (DON) stated he expected the nurses to document wound measurements on a weekly basis in the

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S9999	Continued From page 12 Electronic Health Record (EHR) "Wound Management Detail Report." V2 stated he expected the nurses to enter (V10/Wound Doctor)'s wound measurements into the EHR Wound Management Detail Report, but the nurses have had issues with this getting done. R3's Progress Notes dated 12/10/2021 at 4:28 PM documented (R3) seen by (V10/Wound Doctor), related bilateral heel ulcers. New orders received. R3's Wound Consultation Progress Note by (V10) dated on 12/10/2021 documented in part, Subjective: "Wound Care, Location Left Heel, Right Heel. Severity Moderate, Progression Worsening," Wound Care: Left Heel: Full thickness wound down to subcutaneous tissue, measuring 4.5 cm x 4.0 cm x .2 cm. with no maceration of erythema noted surrounded wound. Right Heel: Full thickness wound down to subcutaneous tissue, measuring 2.2 cm x 1.5 cm x 0.2 cm with no maceration of erythema noted surrounded wound. Assessment/Plan Decubitus Ulcer of left heel, Stage 3. Decubitus Ulcer of Right heel, stage 3. R3's medical record does not document a descriptive assessment of the pressure ulcers located on R3's bilateral heels from 12/10/21 until 12/16/21. R3's Progress Notes dated 12/16/2021 at 3:54 PM documented, (V10) in facility rounding on resident at this time. New wound measurements registered are 6.5 cm x 7.5 cm to left heel and 1.5 cm x 1.5 cm to right heel. Continue with current treatment orders. R3's Wound Consultation Progress Note by (V10)	S9999		

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S9999	Continued From page 13 dated on 12/16/2021 documented in part, Subjective: "Wound Care, Location Left Heel, Right Heel. Severity Moderate, Progression Worsening", Wound Care: Left Heel: Full thickness wound down to subcutaneous tissue, measuring 6.5 cm x 7.5 cm x 0.2 cm with moderate maceration, no erythema noted surrounded wound. Right Heel: Full thickness wound down to subcutaneous tissue, measuring 1.5 cm x 1.5 x .2 cm with moderate maceration, no erythema noted surrounded wound. Assessment/Plan Decubitus Ulcer of left heel, Stage 3. Decubitus Ulcer of Right heel, stage 3. R3's medical record does not document an assessment by the facility staff and/or V10 (Wound Doctor) from 12/17/21 until 1/5/22. R3's Progress Notes dated on 1/5/2022 at 2:56 PM document "When changing residents bilateral heel dressings, this nurse discovered a foul odor. Standing orders for wound culture processed at this time and obtained. Lab carrier called for pick up." R3's Progress Notes dated on 1/6/2022 at 4:31 PM documented, seen by (V10), verbal order received to X-ray left heel to rule out osteomyelitis. R3's Wound Consultation Progress Note by (V10) dated 1/6/2022 documented in part, wound care left heel: Full thickness wound down to bone, wound measures 7.0 cm x 7.0 cm x 0.1 cm erythema noted around wound, moderate maceration. No measurements of right heel pressure ulcer. Assessment, Decubitus Ulcer of the Left Heel, stage 4. Patient started on Clindamycin for cellulitis of the wound. Xray ordered to rule out osteomyelitis.	S9999		

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S9999	Continued From page 14 R3's Progress Notes dated on 1/9/2022 at 9:13 AM documented Wound culture results: Moderate Growth of Proteus, Moderate growth Escherichia Coli, Light Growth of Staphylococcus aureus. (MD) orders Bactrim DS (Antibiotic) twice a day for 7 days. R3's Progress Notes dated 1/12/2022 at 7:04 PM documents, "CNA called this nurse into room at this time due to concerns of resident's condition. Resident lethargic and diaphoretic. Vitals as follows: Temp 100.6, Pulse 109, Pulse Oxygen 93%, Respirations 20, Blood Pressure 150/62. This nurse has concerns of possible sepsis. Emergency Medical Services (EMS) to transport to (hospital) for evaluation. Will contact MD (Medical Doctor) and POA." R3's Progress Notes dated on 1/14/2022 at 5:25 AM documented in part, "This nurse called (hospital) to get update on resident...(R3)'s current nurse at (hospital) informed this nurse that they have a wound vac on her right foot and are speaking with POA (V14) today, 1/14 regarding a possible amputation of the left foot. R3's Progress notes dated 1/14/2022 at 7:05 PM documented (R3) arrived back to facility at this time via EMS. On comfort care measures. R3's Wound Consult Note by V10 for date of service on 1/20/2022 documented in part, Wound care: Left Heel Full Thickness wound down to bone, copious drainage, wound measures 10.5 cm x 8.0 cm x 1.0 cm. erythema noted around wound, moderate maceration. Right Heel: Full thickness wound down to subcutaneous tissue, wound measures 2.5 cm x 1.0 cm x 0.2 cm no erythema, minimal maceration noted around wound. Assessment/Plan Decubitus ulcer of left	S9999		

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heel, stage 4, Acute Osteomyelitis of left foot, Decubitus Ulcer of right heel, stage 3. Osteomyelitis of left calcaneus, Continue Levaquin (antibiotic) per Infection Disease, POA decided to keep patient as comfort care with no more surgery.

R3's Progress Note dated on 1/21/2022 at 9:98 AM (as late entry) documented as V10 in facility. Wounds to bilateral heels assessed. Wound to left heel is stage 4 measuring 10.5 cm x 8 cm. Verbal orders received to cleanse area, apply wet to dry dressing with Dakin's, apply heel protector and wrap with Kerlix. Right heel is stage 4, measuring 2.5 cm x 1 cm. Cleanse area, apply Santyl, and foam heel protector, wrap with Kerlix.

On 2/17/2022 at 9:15 AM, V10 (Wound Doctor) stated when he saw (R3)'s heels for the first time it was on 12/10/2021 and both heels were a stage 3 without sign of infection, and he saw them again on 12/16/2021 and they were a stage 3 without sign of infection. V10 stated he was out of the facility for 3 weeks, and when he came back on 1/6/2022 he saw the left heel had worsened to a stage 4 and was more necrotic to the bone and ordered antibiotics and x-ray. V10 stated (R3) did get hospitalized on 1/12/2022 for the infected pressure ulcers. V10 stated once the necrotic tissue is into the deeper subcutaneous tissue and gets to the bone, surgical interventions like debridement, and antibiotics are usually necessary. V10 stated he was not sure why the pressure ulcer went from the stage 3 to stage 4 in 3 weeks unless she was not always wearing the heel protection, but her stage 3 pressure ulcer with comorbid conditions such as diabetes, malnutrition, and poor circulation would contribute to her risk for infection and poor healing of the wounds. V10 stated he had the hospital records

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for (R3), and she did not have any wound debridement, or surgery while in the hospital due to the family wishes for comfort care. V10 stated on 1/20/2022 (R3)'s left heel was full of necrotic tissue to the bone and still a stage 4 which contributes to the increased measurements and sizing, and he did not do debridement due to family wishes. V10 stated he did debridement on 2/3/2022 to clean it up more because it was so necrotic. V10 stated if (R3) could take her heel protection off herself she could develop a stage 2 pressure ulcer in a short amount of time and he feels this would have been an unavoidable pressure ulcer development to her heels, because staff could not be with her 24/7. V10 stated while he was not in the facility for 3 weeks, he would have expected the nursing staff to identify any wound regression on staging, or sign of infection, and report these findings to the doctor in his absence. V10 stated he would review pressure ulcer staging with the nursing staff.

On 2/17/2022 at 12:10 PM, V2 (DON) stated before this survey all the nurses documented weekly skin assessments by exception and there was no written policy for this. V2 stated when the nurses find a skin issue such as skin tear or bruising, they are expected to document the description and measurements on an Event report and weekly on an Event report thereafter. The Wound Management Detail Report is for pressure ulcer documentation. V2 stated they have identified the issues with wound documentation and are following up with the nursing staff to streamline the process. V2 stated he does not get a written wound report weekly of pressure ulcers and he looks up resident change in condition reports daily, which includes residents with new pressure ulcers. V2 stated

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they have access to (V10)'s consult reports online. V2 stated (R3) did not have a change in condition prior to the development of pressure ulcers to her heels, and she may have been able to kick off the heel boots at times. V2 stated he did not see her wear shoes, only the heel protection when she was up. V2 stated nursing should have been documenting (R3)'s boggy/mushy heels on the weekly skin assessments.

2. R1's Resident Face Sheet documents an original admission date of 1/20/2015, with a last return date of 9/17/2021. R1's diagnoses in part include, Chronic Kidney Disease, Local Infection of the Skin, Pressure Ulcer of left hip, unstageable, hypo-osmolality and hyponatremia, Anorexia, and Hypertension. R1's Braden Assessment dated, 9/17/2021 documented score of 16.0 which indicates R1 was at risk for pressure ulcer development and on 2/8/2022 documented score of 14 which indicates R1 was at Moderate Risk for pressure ulcer development.

R1's Minimum Data Set (MDS) dated 11/10/2021 documents in part, Annual Assessment with a BIMS score of 5, which indicates moderate cognitive impairment. Requires extensive assistance for bed mobility with one person, and extensive assistance for transferring and toilet use with 2 persons. Is occasionally incontinent of bowel and bladder. Resident is at risk of developing pressure ulcer/injuries, and none were present at the time of assessment.

R1's Physician Order Report dated 11/1/2021 to 2/02/2022 documents in part, "12/28/2021 Wound Culture, wound to left hip. Start on 1/4/2022-1/14/2022 Amoxicillin-pot clavulante tablet; 875-125 mg; amount 1; by mouth twice a

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day for 10 days and Doxycycline monohydrate capsule; 100mg 1 by mouth for 10 days. [Diagnosis local skin infection of the skin and subcutaneous tissue, unspecified]."

R1's Physician Order Report documented, Treatment Flow Sheet, "Start 12/15/2021 to End 1/18/2021, Cleanse open area to left hip and apply foam dressing daily once a day. Start 1/18/22 to End 1/21/2022, Wound cleanser left hip, Calcium (Ca+) Alginate, and secured with foam dressing daily and as needed. Start 1/21/2022 to open ended, Left Hip cleanse with wound cleanser, apply Santyl to sloughy areas, apply maxorb. Cover with foam dressing once a day."

R1's MAR shows weekly skin checks were completed on 12/17/21,12/24/21, and 12/31/2021, 1/7/2021, 1/14/2021, 1/21/2021, and 1/28/2022 however there is no progress note or Wound Management Detail Report to document the description of the wound (wound size, site, depth, color, drainage, etc.).

R1's Event Report entitled, "Skin Integrity Events-Skin Tear/Laceration I; Event date of 12/15/2021 09:51 PM, Description: Left Hip: Physical Assessment: Skin Tear, Left Hip 1 cm x 1 cm. Depth shallow, Blood Loss-small amount. Representative Notified: No. Treatments: Cleanse open area to left hip apply foam dressing daily 12/15/2021 to 1/18/2021. And Treatments. Wound Cleanser Left hip, Ca+ Alginate and secure with foam dressing daily and as needed dated 1/18/2022 to 1/21/2022. Evaluation Notes: Change in condition."

R1's Progress Notes dated 12/15/2021 at 9:52 PM documented "CNA alerted this nurse to new

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S9999	Continued From page 19 skin area observed while changing resident. Assessment: open area to left hip measuring approximately 1 cm x 1 cm; shallow. Medical Doctor (MD) notified; Treatment cleanse daily and apply foam dressing. Orders processed." R1's Progress Notes dated 12/28/2021 at 4:50 PM documented "Resident's left hip wound is red, swollen, hot and foul smelling. Some areas are sloughed, and edges are necrotic in color. Ok to swab for culture per (MD)." R1's Progress Notes documented on "1/21/2022 at 7:40 AM, (V10) in facility to see resident, wound to left hip unstageable. Wound debrided, resident tolerated well. Measurements are 3-centimeter x 5.5 cm. Treatment orders to cleanse area, apply Santyl, maxorb and cover with foam dressing. Low air loss mattress in place at this time. Wedges ordered. Will continue to monitor." R1's wound culture results collected from left hip on 12/28/2021 and verified on 12/31/2021 documented, Heavy Growth of Staphylococcus aureus. The facility was unable to provide reproducible evidence of a Wound Management Detail Report for R1 up to the time of exit on 2/18/2022. On 2/17/2022 at 12:15 PM V2 stated they did not have any further Wound Management Detail Reports on R1 to provide for the survey. V2 stated they have reviewed their wound care policies and documentation expectations with nursing to streamline their wound documentation. On 1/27/2022 at 2:00 PM, V3 (RN/Treatment Nurse) provided wound care to R1's left hip	S9999		

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pressure area. The left hip pressure ulcer was unstageable, covered with slough tissue and was approximately 1/2 dollar in size but irregular shape. V3 failed to provide a clean barrier for treatment supplies and failed to perform hand hygiene after removal of the old dressing and before application of the new dressing. V3 stated she did not need to do hand hygiene between removal of the old dressing to application of the new dressing because it was not a sterile dressing change.

On 1/27/2022 at 10:00 AM, V3 stated she does all the skin assessments weekly and documents assessments in the Electronic Health Record (EHR) and is expected to notify the doctor and family when new skin issues develop. V3 also stated (R1) had a facility acquired pressure ulcer of her left hip and was currently seeing (V10) the wound doctor weekly.

On 1/27/2022 at 2:15 PM, V2 (Director of Nurses/DON) stated that it is expected of nurses as well as facility policy to perform hand hygiene and don gloves before the removal of the old dressing and repeat before application of a new dressing.

On 2/4/2022 at 9:22 AM, V10 (Wound Doctor) stated he was off for a few weeks before 12/25/2021 to after 1/1/2022 for the holiday. V10 stated he saw (R1's) left hip when he returned from his few weeks off and the left hip pressure ulcer was unstageable. V10 stated (R1) previously had an area on her right hip they healed out and (R1) apparently favored laying on the left side. V10 stated due to her diagnosis of Chronic Kidney Disease and Anorexia and malnutrition, and very little muscle to her left hip area, he thought R1's left hip pressure ulcer was

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unavoidable.

On 2/4/2022 at 3:25 PM, V2 (DON) stated it was facility policy that nursing should notify the doctor and the residents' family when there was a change in resident condition such as a skin tear or pressure ulcers. V2 also stated R1's left hip pressure ulcer started out as a skin tear on 12/15/2021 and developed into an unstageable pressure ulcer on 12/28/2021. V2 stated it was expected of nursing to document wound progress weekly and input wound measurements in the Wound Management Detail Report in the EHR.

Facility Pressure Injury Prevention and Treatment Protocol policy, Revised: 07/16, documents in part, Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury that might develop. A pressure injury is defined as a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Principles: 1. A skin risk assessment is completed on all residents upon admission and weekly for the first four weeks after admission and quarterly thereafter. H. Weekly individual treatment report will be done and put on clinical chart.

Facility Wound Dressing Change (Clean) policy, dated revised on 12/4, documented in part, Objective: 1. To Protect Wound and Promote Healing, 2. To Prevent Irritation, 3. To prevent infection and spread of infection. Procedure: 6. Use towel to establish a clean field. 10. Remove soiled dressing and discard in biohazard bag. Remove gloves, wash hands, and put on new gloves. 13. Cleanse wound with prescribed

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S9999	Continued From page 22 solution if ordered. 14. Remove gloves; wash hands and put on new gloves. Documentation: 1. Date, Time, Dressing Change. 2. Wound size, site, depth, color, drainage, weekly and as needed. 3. Progress of healing (or lack of progress). The Agency for Health Care Research and Quality (AHRQ) Slide Show Presentation titled "Conducting a Comprehensive Skin Assessment" documents in part, "How to Conduct Comprehensive Skin Assessment." A standard protocol for comprehensive assessment should include 5 parameters: 1. Temperature, 2. Turgor (firmness), 3. Color, 4. Moisture level, 5. Skin integrity-skin intact-open areas, rashes, etc. Documentation Results: Think about keeping a unit wide log for each patient. Record whether he/she has pressure ulcers, how many pressure ulcers he/she has, Highest stage of his/her deepest ulcer, and treatment for any existing wounds. " A"	S9999		