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| S 000 | Initial Comments<br><br>Complaint Investigation 2366841/IL163322 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)2)<br>300.1210d)5)<br>300.1220b)3)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as | S9999 | | |

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| S9999 | Continued From page 2<br>indicated by the resident's condition. The plan shall be reviewed at least every three months.<br><br>These Requirements were Not Met as evidenced by:<br><br>Failures at this level required more than one deficient practice statement.<br><br>A. Based on observation, interview, and record review, the facility failed to develop a care plan and interventions for a resident (R4) who is at high risk for developing pressure ulcers and has a history of pressure ulcers. The facility failed to implement pressure relieving interventions, routinely assess resident's skin, identify a pressure ulcer, assess a pressure ulcer upon identification, report a pressure ulcer to the wound nurse and physician, implement a treatment, and ensure open wounds were covered for one (R4) of five residents reviewed for pressure ulcers and repositioning in the sample list of five. These failures resulted in R4 developing a pressure ulcer of the right buttock that deteriorated into a Stage 4 pressure ulcer without treatment nor interventions.<br><br>Findings include:<br><br>a.) The facility's Wound Report dated 8/22/23 documents R4 admitted to the facility with a left hip wound on 6/29/23 that measures 1.4 centimeters (cm) long by 1.2 cm wide by 0.1 cm deep, and R4 has a left inner knee facility acquired Stage 2 Pressure Ulcer that measures 0.8 cm by 1 cm by 0.1 cm.<br><br>On 8/29/23 at 9:59 AM, 11:35 AM, 1:15 PM, 1:21 PM, 1:53 PM, and 2:31 PM, R4 was sitting in a reclining back wheelchair in R4's room. R4's legs | S9999 | | |

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were contracted with R4's knees near R4's chest and R4's heels/feet against R4's buttocks. There was a cushion in R4's wheelchair and an air mattress on R4's bed. At 9:59 AM, R4 stated R4 has a wound on R4's buttocks that has been there a few days and the wound does not receive daily treatments. At 1:53 PM, V10 (Certified Nursing Assistant/CNA) positioned R4 onto R4's right side in the wheelchair, removed the wedge cushion between R4's knees, and placed the cushion between R4's right leg and the armrest of the wheelchair. V10 did not replace a pillow or wedge cushion between R4's knees prior to leaving R4's room. At 2:31 PM, R4 did not have a pillow or wedge cushion between R4's knees.

On 8/29/23 at 3:32 PM, R4 was lying in bed on R4's right side. R4's legs were contracted and R4's heels were near R4's buttocks. R4 was not wearing any pressure relieving boots and R4's heels were not floated. V5 (Registered Nurse/RN) removed a dressing from R4's left hip. There was a large pink, scarred area, approximately the size of a softball, with a small open area near the center. R4's left inner knee had an open red wound that was not covered with a dressing. V5 stated the wound treatment is barrier cream and V5 does not cover it with a dressing. R4's right buttock had an uncovered deep, open wound, approximately quarter size, that contained yellow and red wound tissue. V5 (RN) and V6 (Certified Nursing Assistant/CNA) had to reposition R4's legs in order to observe the wound. V5 and V6 stated they were not aware of this wound and were unsure how long R4 has had the wound.

R4's Diagnoses List dated 8/29/23 documents R4 has Multiple Sclerosis, Multiple Muscle Contractures, and Severe Protein Calorie Malnutrition. R4's Admission Minimum Data Set

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| S9999 | Continued From page 4<br><br>dated 7/5/23 documents R4 is cognitively intact, requires extensive assistance of at least two staff for bed mobility/transfers/toileting, is dependent on two staff for bathing, is frequently incontinent of bowel, has impaired range of motion to bilateral upper and lower extremities, and admitted to the facility with a Stage 4 pressure ulcer.<br><br>R4's Braden Assessments dated 7/4/23, 8/15/23, and 8/22/23 document a score of 11, indicating R4 is at high risk for developing pressure ulcers. R4's Care Plan dated 7/4/23 documents a problem "Wound Management" and interventions to monitor for signs of infection, and administer wound treatment as ordered, but does not identify the type or location of these wounds. This care plan does not document a problem area, goals, or interventions identifying that R4 is high risk for developing pressure ulcers or any pressure relieving interventions.<br><br>R4's Order Summary Report dated 8/30/23 documents orders for pressure-relieving boots when in bed, turn/reposition every 2 hours, float heels when in bed, and a low air loss mattress initiated on 6/29/23, apply barrier cream to bilateral buttocks every shift initiated on 8/8/23, and a wound treatment for the left knee including use of a pillow between knees initiated on 8/23/23. There are no other documented pressure-relieving interventions in R4's medical record. There is no documentation in R4's medical record that the orders for floating heels and the use of pressure-relieving boots were implemented routinely or that R4 refuses these interventions. R4's Treatment Administration Record documents the nurses signed out the treatment for barrier cream to R4's buttocks every shift as ordered. | S9999 | | |

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| S9999 | Continued From page 5<br><br>R4's Wound Assessment and Plans recorded by V4 (Wound Physician) document: On 7/4/23 recorded by V4 (Wound Physician) documents R4's left hip Stage 4 Pressure Ulcer measured 6.5 cm by 4.8 cm by 0.1 cm. On 7/18/23, R4 had a left buttock Stage 2 Pressure Ulcer that measured 0.9 cm by 2.6 cm by less than 0.1 cm deep and notes that R4 has "limited positioning options due to severe bilateral hip and knee joint contractures and current difficult-to heal ulcer left lateral hip (greater trochanter.) On 8/8/23 R4's left buttock wound healed. On 8/22/23, R4's left medial knee Stage 2 Pressure Ulcer measured 0.8 cm by 1.3 cm by less than 0.1 cm and includes orders to use a pillow between R4's knees and a daily treatment for a barrier cream covered with a foam dressing. R4's left hip pressure ulcer measured 1.4 cm by 1.2 cm by 0.1 cm.<br><br>There is no documentation in R4's medical record that routine skin assessments are completed (besides wound assessments), or that R4's right buttock wound was identified, assessed, reported to V3 (RN/Wound Nurse) and V4 (Wound Physician), and treatment orders were administered prior to 8/29/23. R4's Skin Evaluation Note dated 8/29/2023 at 8:21 AM recorded by V3 documents assessment of R4's left hip and left inner knee pressure ulcers. This note does not document that a full skin assessment was conducted and does not identify that R4 has a right buttock wound. Interventions listed are encouraging R4 to frequently shift weight, raise buttocks when sitting in chair, treatments as ordered, and turn/move R4 at least every two hours. R4's Nursing Note dated 8/29/2023 at 5:05 PM documents R4's right medial buttock wound was assessed and | S9999 | | |

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| S9999 | Continued From page 6<br><br>measured 4 cm by 3 cm by 2 cm with undermining from 7 to 12 o'clock, and the deepest part measured 4 cm. The wound contained black eschar (dead tissue) and yellow slough. The wound was cleansed, and a calcium alginate treatment was applied. V3 (RN/Wound Nurse) was notified and will assess R4 in the morning.<br><br>On 8/29/23 at 1:21 PM, V10 (Certified Nursing Assistant/CNA) stated R4 is supposed to be repositioned every two hours and V10 lays R4 down towards the end of dayshift. V10 stated V10 uses a drawsheet and wedge cushion and reclines the back of the wheelchair to reposition R4 in R4's chair. V10 confirmed R4 has been in the wheelchair since around 10:00 AM.<br><br>On 8/29/23 at 3:26 PM, V11 (Regional Clinical Nurse) confirmed care plans should be updated to include current pressure ulcers, pressure ulcer risk, and pressure relieving interventions. V11 stated R4's care plan will be updated today.<br><br>On 8/29/23 at 3:46 PM, V5 (RN) stated, "I'm embarrassed by that" referring to R4's right buttock wound. At 4:14 PM, V5 stated V5 did not apply the barrier cream or assess R4's buttocks yesterday, because R4's left buttock wound had healed. V5 stated no one had reported R4's wound to V5. On 8/29/23 at 4:11 PM, V9 (Registered Nurse/RN) stated R4 has an air mattress, and we turn and reposition R4. V9 confirmed no pressure-relieving interventions for bilateral lower extremities, and stated we tried to use a roll to prevent pressure at one time. V9 stated V9 was not aware of R4's right buttock wound. V9 confirmed V9 worked 8/26/23 and 8/27/23 and did not assess R4's buttocks. | S9999 | | |

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| S9999 | Continued From page 7<br><br>On 8/29/23 at 4:30 PM, V7 (Certified Nursing Assistant/CNA) stated V7 works on R4's hallway and provided care for R4 over the weekend (8/26/23-8/27/23). V7 stated R4 had an open wound to R4's right buttock that was not covered with a dressing. V7 stated the wound should have been covered and V7 had previously reported the wound to the nurses. V7 stated the wound had been there for a few weeks. V7 stated the nurses tell V7 they don't have a treatment for R4's buttock wound, only a treatment for R4's hip wound. V7 stated R4 primarily lays on R4's right side and R4 has never had or used pressure-relieving boots.<br><br>On 8/29/23 at 4:38 PM, V8 (Certified Nursing Assistant/CNA) stated V8 provides care for R4 on evenings and night shifts and last cared for R4 this past weekend. V8 stated that over the weekend R4 had a wound on R4's bottom and hip. V8 described the wound as being a "hole" on R4's right buttock, that was not covered with a dressing. V8 stated we had been applying barrier cream, and V8 was not sure how long the wound had been there. V8 stated there was a sore there a week ago Thursday (8/17/23), but it was not as bad. V8 stated V8 has told the nurses about R4's wound, but they just give cream to apply. V8 confirmed R4 has never had or used pressure-relieving boots.<br><br>On 8/29/23 at 3:51 PM, V2 (Director of Nursing/DON) stated skin assessments are to be completed on shower days and documented on the shower sheets which are not part of the resident's Electronic Medical Record. V2 stated the CNAs are to immediately report any skin issues to the nurses. At 4:01 PM, V2 confirmed V2 was unaware of R4's right buttock wound. V2 stated R4 was listed on today's wound report and | S9999 | | |

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| S9999 | Continued From page 8<br><br>confirmed it does not document a right buttock wound. At 4:26 PM, V2 provided R4's bath sheet dated 8/29/23 and stated that is the only documented shower/skin sheet V2 could find. V2 stated V2 is going to assess R4's wound and implement treatment orders.<br><br>On 8/29/23 at 4:04 PM, V3 (RN/ Wound Nurse) stated R4 had a wound to the left buttock that healed approximately two weeks ago and V3 was not aware that R4 currently has a right buttock wound. V3 stated V3 looked at R4's bottom on Monday 8/28/23 and could have missed the wound, because V3 rolled R4 by herself. V3 stated R4 admitted with an order and still has an active order to wear pressure-relieving boots, but R4 refuses to wear them. V3 stated there is no documentation that heel pressure relieving interventions are implemented. V3 stated R4 has an order for a wedge or pillow between R4's knees.<br><br>On 8/30/23 at 8:09 AM, V3 stated V3 did not document R4's refusal to wear pressure relieving boots, and V3 assumed the order was transcribed to R4's Medication Administration Record (MAR) for the nurses to implement and document. V3 stated staff should have documented refusals in the nursing note or MAR. V3 stated R4 only admitted to the facility with the left hip wound, R4 has a long-standing history of wounds, and has very fragile skin. V3 stated the staff should have told V3 about R4's right buttock wound. V3 stated the nurses should report new wounds to V3 and the physician and measure the wound. V3 stated V3 notifies V4 (Wound Physician) to obtain wound orders, or the primary physician if unable to reach V4. V3 stated the CNAs should be showering the residents and reporting the skin issues. V3 documents in a | S9999 | | |

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progress note when a full body skin sweep is done by V3/V4. V3 confirmed V3 did not conduct a full body skin check on R4 on 8/29/23. V3 stated a treatment order was initiated yesterday for R4's right buttock wound and previously the treatment was for barrier cream, but that would have changed once it was identified to be open. V3 stated R4 is contracted and R4's feet rest there (referring to the location of R4's buttock wound) and refusing to wear the boots. V3 stated R4 likes to wear shoes when sitting in the wheelchair, so it is uncertain if the wound was caused from a shoe or heel. V3 confirmed R4's left knee wound should be covered with a dry dressing.

On 8/30/23 at 10:25 AM, V1 (Administrator) stated V1 was not aware of R4's right buttock wound prior to 8/29/23.

On 8/30/23 at 9:30 AM, V4 (Wound Physician), V3 (RN/ Wound Nurse), and with assistance of V12 (CNA) turned R4 in bed to assess R4's skin and wounds. V4 measured R4's left hip wound and V3 administered the treatment. V4 measured R4's open right buttock wound and stated R4's right buttock wound measures 2.5 cm by 2.7 cm by 1.1 cm deep, with undermining 0.7 cm at 1 o'clock and 3 o'clock. Silver calcium alginate and two by two gauze was packed into the wound and covered with a bordered adhesive dressing. V4 stated R4's right buttock wound is a Stage 4 pressure ulcer since V4 could feel bone. During R4's full body skin check, R4 had scarring from previous wounds to the penis, right heel, right outer foot, sacrum, right hip, and right/left buttocks. R4's right knee wound was not covered with a dressing.

On 8/30/23 at 9:26 AM, V4 (Wound Physician)

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stated V4 has been treating R4 since October 2022 when R4 resided at a former facility. V4 stated R4's muscle volume is very low and due to R4's contractures R4's skin is stretched over R4's buttocks. Wounds can progress quickly for R4. At 10:02 AM V4 stated if R4 had been wearing pressure-relieving boots it may have prevented R4's right buttock wound from developing. V4 stated V4 is not sure if the wound was caused from R4's heel pressure or the chair. V4 last assessed R4 on 8/22/23 when the left knee wound was discovered, and the buttock wound was not there at that time. V4 stated V4 was ashamed that the wound was missed during that assessment and V4 should have done a more thorough skin assessment. It would take probably less than a week for R4 to develop that kind of wound. R4's shoes could have caused pressure to the area as well, and it absolutely would have been better for R4 not to wear shoes. V4 stated therapy could have also helped with R4's mobility and joint flexion. V4 stated V3 and V4 depend on the CNAs to assess skin and report when wounds are found. V4 stated the barrier cream is more for prevention and confirmed this treatment would not be appropriate for open wounds. V4 stated R4's wound being left open puts it at risk for contamination. V4 stated it concerns V4 that the nurses documenting the barrier cream administration should have been looking at and assessing the area. V4 confirmed that if R4's wound had been reported and assessed immediately, monitored, and a treatment implemented it could have prevented R4's wound from deteriorating to a Stage 4. V4 stated in hindsight this wound could have been prevented.

R4's Physician Order dated 8/31/23 documents administer Keflex (antibiotic) 500 milligrams one capsule via gastrostomy tube three times daily for

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| S9999 | Continued From page 11<br>15 days for wound.<br><br>The facility's undated Pressure Ulcer/Skin Breakdown-Clinical Protocol documents the following: Significant risk factors for developing pressure ulcers such as immobility, weight loss, and a history of pressure ulcers need to be identified. Pressure ulcers will be assessed and documented and include wound characteristics and measurements. Treatments and support surfaces will be documented. The physician will order wound treatments including pressure reduction surfaces and the application of topical agents; will help identify medical interventions for wound management; and help staff alter the care plan as appropriate including when new wounds develop despite current interventions.<br><br>The facility's undated Pressure Ulcer Risk Assessment documents the following: "Purpose: The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident." "General Guidelines: 1. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissues." "4. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. 5. Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e. (for example), perspiration, feces, urine, wound discharge, soap residue, etc. (etcetera), decline in nutrition and hydration status, acute illness and/or decline in the | S9999 | | |

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| S9999 | Continued From page 12 | S9999 | | |

resident's physical and/or mental condition. 6. Once a pressure ulcer develops, it can be extremely difficult to heal." "10. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor." "Assessment: 2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring: a. Staff will maintain a "skin alert," performing routine skin inspections daily or every other day as needed. b. Nurses are to be notified to inspect the skin if skin changes are identified. c. Nurses will conduct skin assessments at least weekly to identify changes. 4. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches." "Documentation: The following information should be recorded in the resident's medical record: 1. The type of assessment conducted. 2. The date and time and type of skin care provided, if appropriate." "5. Any change in the resident's condition. 6. The condition of the resident's skin (i.e. (for example), the size and location of any red or tender areas)."

B. Based on observation, interview, and record review, the facility failed to develop and update care plans to include pressure ulcer risk, interventions, and pressure ulcers, complete pressure ulcer risk assessments, implement pressure relieving interventions and preventative treatments for four (R1, R2, R3, R5) of five residents reviewed for repositioning/pressure

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| S9999 | Continued From page 13<br>ulcers in the sample list of five.<br><br>Findings include:<br><br>The facility's undated Pressure Ulcer Risk Assessment policy documents to complete pressure ulcer risk assessments on admission, quarterly, annually, and with significant changes.<br><br>b.1) R1's MDS dated 6/26/23 documents R1 is cognitively intact, requires assistance of one staff person for transfers and bed mobility, and is at risk for developing pressure ulcers. R1's Care Plan dated 1/18/23 documents R1 has impaired skin integrity of the right heel and includes interventions to follow facility protocol for treatment and apply pressure relieving boots.<br><br>R1's Physician Order dated 2/22/23 documents to wear a pressure-relieving boot to the left foot when in wheelchair and offload heel in bed. R1's Physician Order dated 5/17/23 documents to cleanse R1's right heel and apply a skin protectant daily.<br><br>R1's August 2023 Medication Administration Record (MAR) does not document R1's right heel skin protectant was administered on 5 days and R1's left heel boot is documented as applied three times daily except for 6 refusals. The skin protectant entries for 8/1/23 and 8/5/23 refers to the nursing notes.<br><br>R1's Order Administration Notes document: On 8/5/2023 at 2:49, "out of time". On 8/1/2023 at 2:27 PM, "shift over out of time". There is no documentation R1's treatments were administered on the next shift.<br><br>On 8/29/23 at 12:39 PM, 1:08 PM and 2:32 PM, | S9999 | | |

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| S9999 | Continued From page 14<br><br>R1 was sitting in a wheelchair in R1's room and was not wearing a pressure relieving boot. At 12:39 PM, R1 stated R1 used to wear a pressure-relieving boot, but the wounds on R1's feet have healed, and staff told R1 that R1 no longer has to wear the boot. At 2:32 PM, R1 stated they no longer apply the skin protectant to my heels since R1's wounds have healed.<br><br>On 8/29/23 at 10:08 AM, V19 (Licensed Practical Nurse/LPN) reviewed R1's order administration notes and stated V19 did not have time to administer R1's skin protectant treatments on 8/1/23 and 8/5/23, so it fell onto the next shift to administer. At 3:14 PM, V19 stated R1 refuses to wear the pressure relieving boot because R1's wound has healed.<br><br>b.2) On 8/29/23 at 8:11 AM, R2 was sitting on R2's bed wearing a walking boot on the left foot.<br><br>R2's Diagnoses List dated 8/30/23 includes Diabetes Mellitus. R2's Care Plan dated 6/8/22 documents R2 is at risk for skin breakdown and includes interventions to assist with toileting and repositioning. R2's Physician Order dated 8/16/23 documents to wear a short walking boot due to an ankle sprain.<br><br>There are no documented Braden Assessments in R2's electronic medical record after 9/8/22. R2's Census Report documents R2 admitted to the facility on 6/7/22.<br><br>b.3) On 8/29/23 at 8:14 AM, 9:52 AM, 10:43 AM, and 1:58 PM, R3 was sitting in a wheelchair in R3's room.<br><br>R3's Diagnoses List dated 8/30/23 includes Conversion Disorder with seizures/convulsions, | S9999 | | |

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| S9999 | Continued From page 15<br><br>Diabetes Mellitus, COVID-19 (8/21/23) and Dementia. R3's MDS dated 7/12/23 documents R3 has short- and long-term memory impairment, requires extensive assistance of one person for bed mobility, transfers, and toileting, is always incontinent of bowel and bladder, and is at risk for developing pressure ulcers.<br><br>R3's Care Plan dated 6/18/23 documents R3 is at risk for developing pressure ulcers due to decreased mobility, lethargy, and moisture; and includes pressure relieving interventions and monitoring.<br><br>R3's electronic medical record documents R3's last Braden Assessment was completed on 4/9/23. This assessment documents a score of 13, indicating R3 is at moderate risk for developing pressure ulcers.<br><br>b.4) On 8/29/23 at 9:26 AM, R5 was lying in bed with R5's right foot on a foot cradle. R5 states R5 has a wound to R5's right heel. At 11:00 AM, R5 was sitting in the hallway and had a pressure-relieving boot on the right foot. On 8/29/23 at 1:45 PM, V3 (Wound Nurse) administered R5's right heel wound treatment. There was a golf ball sized red/open wound to R5's right heel.<br><br>The facility's Wound Report dated 8/22/23 documents R5 has a right heel unstageable pressure ulcer that developed on 8/1/23 and measured 1.8 centimeters (cm) long by 3.2 cm wide by 0.1 cm deep.<br><br>R5's MDS dated 6/6/23 documents R5 is cognitively intact, requires extensive assistance of two for transfers/bed mobility/toileting, and is at risk for developing pressure ulcers. | S9999 | | |

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| S9999 | Continued From page 16<br><br>R5's Physician Order dated 12/28/22 documents to wear pressure relieving boots at all times. R5's Physician Order dated 8/23/23 documents to cleanse the right heel wound and apply silver calcium alginate and cover with a dry dressing daily.<br><br>R5's Care Plan revised on 4/10/23 documents R5 is at risk for pressure ulcers and includes interventions for skin assessments weekly, provide incontinence care, use pressure relieving cushion and mattress, and float heels under calves when in bed. This care plan has not been updated to include R5's right heel pressure ulcer, foot cradle, and pressure relieving boots.<br><br>There are no documented Braden Assessments in R5's electronic medical record after 1/4/23 until 8/1/23. R5's Braden score was 20 on 1/4/23. On 8/1/23 R5's Braden score was 16, indicating R5 was at risk of developing pressure ulcers.<br><br>On 8/29/23 at 11:26 AM, V3 (Wound Nurse) stated pressure ulcer risk is determined by the Braden Assessment, which is done quarterly by V3 and the MDS Coordinator. V3 stated interventions and risk are documented on the care plan. V3 stated R5 is noncompliant with floating R5's heels and wearing pressure relieving boots.<br><br>On 8/29/23 at 3:26 PM, V11 (Regional Clinical Nurse) confirmed care plans should be updated to include current pressure ulcers, pressure ulcer risk, and pressure relieving interventions.<br><br>(B) | S9999 | | |

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