STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007447	A. BUILDING _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PINECREST	414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview and record review the facility failed to ensure a resident (R12) with a change of condition was assessed and monitored after exhibiting an altered mental status. This failure resulted in R12 being admitted to the hospital with, hypoglycemia and sepsis related to a UTI (urinary tract infection). The facility also failed to ensure a resident received x-ray services without any delay for R57 following a fall. This failure resulted in R57 waiting 18 hours for an x-ray, and the x-ray showed a fractured hip requiring surgical intervention. This applies to 2 of 2 residents (R12, R57) reviewed for quality of care in the sample of 18. The findings include: 1. R12's admission record documents her admission date to be 5/12/23 with a most recent hospitalization of 7/15/23 to 7/24/23. The diagnoses list includes morbid obesity, need for assistance with personal care, and protein-calorie malnutrition. A diagnosis of hypoglycemia (low blood sugar) was added 7/24/23. The 7/13/23 office clinic notes for V15 FNP (Family Nurse Practitioner) documents R12 has had a history of frequent hospitalizations for weakness, hypoglycemia, and unable to care for herself. The same document shows the problem list/Past medical history of ongoing diagnoses includes hypoglycemia. The 7/28/23 facility quarterly assessment documents R12 to be cognitively intact, with no signs of delirium or other mental changes. The same assessment documents she requires extensive assistance with bed mobility and transfers. She is dependent upon staff for locomotion on and off the unit, using a	S9999		

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S9999	Continued From page 3 wheelchair. R12's progress note dated 7/14/23 shows, at 10:00 AM R12 was "acting weird, she will be alert to talk one minute and doze off the next". The MD (medical doctor) was notified and ordered to have her sent out. This note shows no vital signs or assessment of R12, including any oxygen saturation level or blood sugar. This note was authored by V3 LPN (Licensed Practical Nurse). At 10:09 AM, V4 RN (Registered Nurse) documents R12 reported she thinks she has a UTI (urinary tract infection) because her "muscles are jumpy". V4 documented no assessment or vital signs. The vital signs summary sheet was reviewed and shows no results for 7/14/23. The nursing progress notes for R12 were reviewed and show no further assessments or vital signs for 7/14/23. On 08/03/23 at 11:33 AM, V3 said normally R12 does not like to get up for breakfast, so her medications are timed later in the morning as well. V3 said on the morning of 7/14/23, R12 was not acting right, she was not able to hold a glass of water and take her pills, and the CNA's (Certified Nursing Assistants) reported her urine had a strong odor. V3 said that day was not a routine lab day for the facility, so the physician ordered for R12 to be sent out to the ER (emergency room). V3 said R12 refused to go out to the ER, and she notified the physician, and he ordered an antibiotic and labs. V3 said she could not remember doing any vital signs or blood sugar levels as part of her assessment. V3 said she would not check a blood sugar level on R12 because there was no diagnosis of diabetes. V3 said she was unaware R12 had a diagnosis hypoglycemia.	S9999		

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S9999	Continued From page 4 R12's progress note dated 7/15/23 shows at 5:42 AM, V3 documents R12's altered mental status continues, she will awaken to her name but not stay awake to finish the task at hand. The nursing progress note shows no physical assessment, vital signs, oxygen saturation level or blood sugar levels. At 6:51 AM, V4 documented R12 was seeing things that are not there, she is oriented x (times) 2 (normally oriented x 3) but slow to respond when questioned. R12 continued to state she has a UTI. The notes show at 7:18 AM 911 was dialed and R12 was sent to the ER per V15's orders. On 08/03/23 at 10:55 AM, V4 said on 7/14/23, V3 was the primary nurse for V12. She said when she saw her, R12 was at her baseline and responding normal. R12 thought she had a UTI but did not want to be sent out. V4 said the nurses can perform a urine dip to check for a UTI and arrange for a stat pick up if necessary. V4 said R12 was incontinent of urine and would have required a straight catheterization to obtain a clean urine sample. V4 said later that night and into the next morning R12 did continue to decline and ended up getting sent out due to her confusion being more exaggerated, she was rolling her eyes and not making any sense at all and talking weird. V4 said she completed vital signs but did not check a blood sugar since there was no diagnosis of diabetes, and V4 was not aware of any hypoglycemia diagnosis. V4 said R12 had declined to the point of needing oxygen, she was more lethargic and confused. V4 said she called V15 and updated her with R12's condition and received an order for transfer to the ER. R12's weights and vital summary sheet shows on	S9999		

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S9999	Continued From page 5 7/15/23 at 6:54 AM, R12's blood pressure was 98/52, temperature was 97 degrees Fahrenheit, pulse was irregular at 89 beats per minute, oxygen saturation level was 88% on oxygen. R12's nursing progress notes were reviewed and do not indicate when R12 was placed on oxygen, the number of liters, or what administration device was used: mask or cannula. R12's nursing progress notes dated 7/15/23 at 10:24 AM shows V4 received an update from the physician in the ER and reported R12's blood sugar was 34 mg/dl (milligrams per deciliter) upon arrival. The CDC.gov (Centers for Disease Control) documents low blood sugar occurs when the level drops below 70 mg/dl. At 1:18 PM, V4 documented R12 was admitted to the ICU (intensive care unit) with hypoglycemia, hypomagnesia, and sepsis related to UTI. On 08/03/23 at 8:45 AM, V13 LPN said when a resident has any change of condition the nurse should do a full assessment from head to toe, listen to their heart and lungs, check pulses, and perform a neurological check if there is any change in their cognition. The assessment should also include a set of vital signs, completed by the nurse herself, blood sugar check and oxygen level. V13 said if a resident as complaints of a UTI, then a urine dip can be performed by the nurse, and then encourage them to drink some cranberry juice and more fluids. She said all of the assessment and vital signs should be documented, and the resident monitored for further symptoms. On 08/03/23 at 11:12 AM, V15 FNP, stated she	S9999		

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S9999	Continued From page 6 had received a call on 7/15/23 to send R12 out to the ER due to mental status changes. She said for any resident presenting with an altered mental state the nurse should be conducting a head-to-toe assessment, obtain vital signs, neurological check, blood sugar, and evaluate any recent medication changes. On 08/03/23 at 12:00 PM, V2 DON (Director of Nursing) said for a resident with a change of condition, the nurse should perform an overall assessment before contacting provider, include vitals, oxygen saturation levels. V2 said the nurses would not have thought to check R12's blood sugar because she was not on insulin. V2 said the symptoms of hypoglycemia would be similar to hypoxia (low oxygen level), such as lethargy or being not as alert. She said all of this information should be documented in the progress notes. R12 was in the hospital during this survey and unavailable for an interview. 2. R57's Face Sheet showed an original admission date of 9/15/22 with diagnoses to include: Dementia, Parkinson's, history of falling, weakness, and osteoarthritis of the right knee. R57's 6/6/23 Quarterly Minimum Data Set (MDS) showed severe cognitive impairment with a brief interview for mental status score of 1 out of 15. The MDS showed she required extensive assistance of two people for bed mobility, transfers, and toilet use. The MDS showed she did not walk during the assessment period. On 8/01/23 at 9:54 AM, R57 was near the entrance to the nurse's station in the activity/dining room on the locked memory care unit. R57 was in a high back reclining wheelchair.	S9999		

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S9999	Continued From page 7 R57 was non-verbal. R57's Fall Note from 3/10/23 at 8:50 PM showed, "1515 (3:15 PM) Resident sitting at dining room table drinking apple juice. Stood from table with juice in hand and took steps toward nurse's station. LPN (Licensed Practical Nurse) heard "crack" while letting pharmacy staff off of unit. [LPN] returned and resident laying on back, on floor, at nurse's station door...Activity CNA (Certified Nursing Assistant) witnessed incident and stated, "I was only 10 feet from her. She hit her head."...BLE (Bilateral Lower Extremities; both legs) without any shortening or rotation...resident denies head pain, neck and back pain, and hip pain..." (Note was authored by V9 LPN) R57's Nurses Note from 3/11/23 at 12:21 PM showed, "Resident denies pain this shift, but has difficulty with transfers. Able to bear weight on BLE. Offered pain meds (medications), but resident declines. Will continue to monitor weight bearing status." R57's Medication Administration Note from 3/11/23 at 1:22 PM, showed R57 was given one 500 milligram tablet of as needed acetaminophen (non-narcotic pain medication). R57's Nurses Note from 3/11/23 at 4:26 PM showed, "Resident favoring RLE (Right Lower Extremity; right leg). Swelling noted to right thigh and knee. Grimace with palpation (touch). Call to [V7 FNP, Family Nurse Practitioner] about getting mobile x-ray for right hip/knee. Orders received and noted. X-ray ordered and [V8, R57's Daughter and Power of Attorney] notified." (Note was authored by V10 LPN)	S9999		

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S9999	Continued From page 8 R57's x-ray order, from the contracted mobile imaging company, showed a STAT (to be done immediately and without delay) order was entered by V10 on 3/11/23 at 3:40 PM. The order showed her right hip and right knee were to be imaged due to pain and swelling following a fall. The order showed the purpose of the imaging was to rule out a fracture. R57's Nurses note from 3/12/23 at 4:56 AM showed, "Resident has been minimally restless in bed at various times throughout NOC (night) shift. Manipulating blankets with hands often. VSS (Vital Signs Stable). No c/o (complaints of) voiced [incomplete statement], resident nonverbal during assessment, staring at staff during questions." R57's Medication Administration Note from 3/12/23 at 8:16 AM, showed R57 was given one 500 milligram tablet of as needed acetaminophen. R57's Nurses Note from 3/12/23 at 9:45 AM showed, the mobile x-ray company was on site to image R57's right hip and right knee. (Imaging arrived 18 hours after orders were entered.) R57's Nurses Note from 3/12/23 at 10:04 AM showed the x-ray results had been received and R57 had a fractured right hip. The note showed V8 was contacted and V8 requested R57 be sent to the local area hospital; 911 was called. The facility's staff schedule showed V6 CNA worked first shift on 3/11/23. On 8/03/23 at 8:36 AM, V6 stated she recalled the time period between R57's fall and R57 being sent to the hospital. V6 stated R57 was having pain especially during care and repositioning as	S9999		

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S9999	Continued From page 9 evidenced by facial grimacing. V6 stated she noticed swelling to the right hip and reported it to the nurse. On 8/03/23 at 12:06 PM, V10 LPN stated she recalled placing the order for R57's imaging. V10 stated the order was to be done STAT. V10 stated she was notified by the imaging company there may be a delay due to the weather. V10 stated, "...They were going to try and get there that evening but I don't think they got there till the next day. Well, we weren't sure if there was going to be a delay or not, so I didn't call the [NP, Nurse Practitioner] to let them know. Stat x-ray normally should be done within a few hours. I was aware of the fall the day before. If they were not able to come out within that few hours' time frame, I would call the family and see if they wanted her (R57) to be sent out for evaluation then call the NP and let them know what the family wanted to do. I would have handed that over in report that we were waiting on a stat x-ray. I think we left her in bed because she was having pain and we didn't want to move her...In the back of my mind I was concerned she had a hip fracture. X-ray is the only way to really diagnose the hip fracture... " On 8/03/23 at 9:04 AM, V7 FNP stated pain, swelling, and favoring a leg over another can be signs and symptoms of a fracture. V7 said, "I would expect to be notified if it's (STAT x-ray) going to run into the next day or be several hours. I would expect to be notified because the resident is under my care; I want to make sure symptoms are managed; the family is updated; and the resident is getting the care they need. I would want to know if the resident is moving or having limited activity. With a hip fracture they are going to the ER anyway unless they are comfort focused care then it depends..." V7 said the	S9999		

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S9999	Continued From page 10 timeframe from 3/11/23 at 3:40 PM until 3/12/23 at 9:45 AM is too long for a STAT x-ray. On 8/03/23 at 9:29 AM, V7 said she reviewed her documentation regarding R57. V7 stated she was notified of the fall and of the x-ray results. V7 stated she was not notified of the x-ray delay. V7 said, "Had I been notified of the delay in the stat x-ray I would have contacted the POA (Power of Attorney) and given them the option to keep her at the facility and make her comfortable if that was possible; or send her out to the emergency room for the x-ray. " On 8/03/23 at 9:43 AM, V8 R57 POA/Daughter stated, "...If I was given the option between keeping her (R57) there overnight or waiting till the next day for the x-ray, I would have told them to send her out to get the x-ray. I would have said send her out because she is fragile and with her Dementia, we don't really know how she is doing and I want her to feel safe and be comfortable. Sending her to the hospital would have made certain she was safe, comfortable, and getting the prompt care that she needed." R57 ' s Statutory Short Form Power of Attorney for Health Care showed V8 was R57 ' s Healthcare Power of Attorney due to V8 ' s brother had refused the Health Care Power of Attorney role. On 8/03/23 at 11:16 AM, V16 LPN stated a STAT x-ray should be done the same day even if it is ordered in the afternoon. V16 said, "If it's been 4-6 hours, I would call the company and see why the delay and get an ETA (Estimated Time of Arrival) and verify the order was received. If they told me, it couldn't be done till mid-morning the next day, I would call the provider and see if they	S9999		

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S9999	Continued From page 11 want me to send them (resident) out. 3:30 pm till 9:45 AM would not be a stat x-ray." On 8/03/23 at 10:55 AM, V2 Director of Nursing (DON) "If a resident had a fall, then the next day, they were having pain with palpation, swelling, and favoring a leg with transfer my concern would be a hip fracture and the only way to definitively determine that would be with an x-ray so it would be important to get it done as soon as possible. The family may request to keep the resident here if the x-ray could not be done that day but that would be the family's choice. I would have that conversation with the family then notify the NP of the family's wishes to either keep them at facility or send them out. " The facility's Diagnostic Testing Services Policy (Implemented 12/1/22) showed, "In instances where diagnostic testing is not available to be performed on-site...the facility will work the resident and their family to secure appropriate transportation arrangements for such appointments." (A) Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)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	S9999		

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S9999	Continued From page 12 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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	S9999		

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	IL6007447	A. BUILDING. _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PINECREST	414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054

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S9999	Continued From page 13 restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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	S9999		

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S9999	Continued From page 14 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. These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to identify a pressure injury before becoming a Stage 2 or greater and failed to provide initial wound assessments for 2 of 4 residents (R14, R5) reviewed for pressure injuries in the sample of 18. This failure resulted in R14 developing two Stage 2 and one Stage 3 pressure injuries. The findings include: 1. On 8/1/23 (between breakfast and lunch), R14 was in his room in his wheelchair. At 12:22 PM, R14 was self-propelling in his wheelchair after leaving the dining room. On 8-/1-8/3/23, this surveyor had no observations of R14 in any other position than up in his chair. On 08/01/23 at 1:10 PM, V2 Director of Nursing (DON) said the facility could not provide a list of residents with wounds (pressure or non-pressure). V2 said the facility did not have a wound nurse and nobody did wound tracking at this time. "It fell through the cracks during COVID and was to be a focus this August". V2 was unable to provide the date R14's wounds were first noted and any initial wound assessments on the date they were first noted.	S9999		

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S9999	Continued From page 15 On 8/2/23 at 2:25 PM, V2 DON said R14's wound assessments would be in his contracted wound doctor visit notes. V2 said the facility must have known of R14's wounds (sites 3-5) and notified the wound doctor to look at them. V2 was unable to locate any wound assessments done or dates the wounds were identified by staff at the facility prior to the wound doctor evaluation. On 08/03/23 at 9:36 AM, V2 said she would expect a wound assessment to include measurements, a description of the wound, drainage, evidence of redness or edema. It's important to perform an initial assessment to have a baseline to know if a wound is improving/deteriorating and to monitor for signs and symptoms of infection. A resident could have a worsening of the wound, tunneling, undermining and signs and symptoms of infection if there is no baseline assessment to use for reference. Nurses should be doing daily skin checks and weekly wound assessment documentation. Residents should be evaluated for pressure relieving devices. If a wound doctor recommended any interventions, they should go into the resident's orders. The facility's repositioning protocol is every 2-4 hours. V2 said she did not see the wound doctor's recommendations, or she would have care planned them. V2 said she could not find any initial wound assessments for R14's 3 wounds (2-stage 2 and 1- stage 3). V2 was unable to determine the date R14's wound began in the facility due to the lack of documentation. On 08/03/23 at 11:18 AM, V11 facility medical director said he would expect an initial assessment to be documented on any wounds. Assessments should include dimensions, depth, surrounding erythema, vital signs, color, any	S9999		

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eschar, tunneling, odor, and drainage. V11 said if there's no baseline assessment you don't know if it's a new wound or chronic wound. A baseline assessment helps gauge if there's healing or a decline in the wound and provides an opportunity to prevent additional skin breakdown. V11 said offloading, nutritional assessments and barrier creams would be appropriate interventions. V11 said he would expect any wound doctor recommendations to be implemented as interventions.

R14's face sheet showed a 96-year-old male admitted to the facility on 9/29/21. Diagnosis included heart failure, chronic obstructive pulmonary disease, history of Methicillin resistant staphylococcus aureus (MRSA) infection, cardiac pacemaker, and chronic kidney disease.

R14's 5/19/23 pressure risk assessment showed he was at risk for developing pressure injuries.

R14's 6/20/23 wound doctor note showed one wound, non-pressure to the left ear.

R14's 6/27/23 wound doctor note showed a Stage 2 pressure wound of the right medial buttock (site 3) and a Stage 3 pressure wound of the left, upper, medial buttock (site 4). This note showed the doctor recommended to limit sitting to 60 minutes, off load the wound, reposition per facility protocol, and turn side to side in bed every 1-2 hours if able. These interventions are not in R14's care plan.

R14's 7/18/23 wound doctor note showed a Stage 2 pressure wound of the left medial buttock (site 5). This note showed the doctor recommended to limit sitting to 60 minutes, off load the wound, reposition per facility protocol, and turn side to

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S9999	Continued From page 17 side in bed every 1-2 hours if able. These interventions are not in R14's care plan. R14's 7/6/23 facility assessment showed R14 was frequently incontinent of urine and bowel. R14's care plan showed he was totally dependent on staff to provide a bath or shower, extensive to total assistance to turn and reposition in bed, for personal hygiene, requires total assistance by staff for toileting, and extensive assistance of 1-2 staff to transfer. R14's care plan does not include to offload the wound, limit sitting to 60 minutes, turn side to side in bed every 1-2 hours, and to reposition per facility protocol as ordered by the wound doctor. There was no mention of R14's two stage 2 pressure injuries in his care plan and no offloading or repositioning interventions. Facility policies for pressure injury assessment, intervention, monitoring, and tracking were requested. On 08/02/23 at 2:25 PM, V2 said the policy for wound treatment management and pressure injury prevention was all the facility had. The facility's 12/1/22 Wound Treatment Management Policy showed to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Treatment decisions will be based on characteristics of the wound: pressure injury stage, size-including shape, depth, and presence or tunneling and/or undermining, volume and characteristics of exudate, presence of pain, presence of infection or need to address bacterial bioburden, condition of the tissue of the wound bed, and condition of	S9999		

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S9999	Continued From page 18 the peri wound, location of the wound, and goals and preferences of the resident/representative. The National Institutes of Health website showed a wound assessment standard includes evaluation of the depth, length, and width of the wound. Evaluation of the wound bed for exposed bone, vessels, hardware, or subcutaneous fat. Survey for presence, type, and amount of exudate (drainage). Assess surrounding skin tissue for signs of injury. Check the wound margins. Evaluate for warmth, pain, odor, purulence, delayed healing, or other signs of infection. 2. R5's face sheet showed a 64-year-old female admitted to the facility on 6/13/23. Diagnosis included a Stage 4 pressure injury to the back, chronic osteomyelitis, heart failure, high blood pressure, acquired absence of the left leg above the knee, major depressive disorder, morbid obesity, epilepsy, and cerebral infarction. On 8/1/23 at 11:54 AM, R5 was in the dining room seated in her wheelchair. On 8/2/23 after lunch, R5 was in her bed. The head of the bed was upright with her back against the mattress. During observations 8/1-8/3/23, R5 had no pressure relieving interventions to her wound in place. On 08/01/23 at 1:10 PM, V2 Director of Nursing (DON) said she couldn't find an initial wound assessment for R5's infected Stage 4 pressure injury to her back. On 8/2/23 at 2:25 PM, V2 said she put R5's weekly wound assessments in the progress notes once she got the wound vac put on which was the beginning of July 2023.	S9999		

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S9999	Continued From page 19 R5's 6/13/23 admission skin assessment showed a wound to the mid/center back. This note had no description of the wounds shape, color, absence or presence of drainage, odor, slough, dressings, peri wound or wound color description or presence of pain. There were no wound measurements. R5's 6/15/23 at 10:05 PM skin/wound note showed the wound measured 4 centimeters (CM) x 3 cm (no depth). There was no description of the wound bed or peri wound, the type of wound was not indicated nor the stage. R5's 6/22/23 skin/wound notes showed no measurements or description of the wound drainage. R5's 6/20/23 facility assessment showed she was cognitively intact and required extensive assistance of two plus persons physical assistance for bed mobility, transfer, and toilet use. R5's care plan showed a Stage 4 pressure injury to the mid back from a back brace she wore at a previous facility. R5's care plan showed she required 6 weeks of intravenous antibiotics for treatment of osteomyelitis of thoracic region/spine Stage 4 ulcer. R5's care plan had no offloading or repositioning interventions in place. This care plan showed a wound vac was placed on the wound on 7/3/23. (A)	S9999		