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	IL6014781	A. BUILDING: _____ B. WING _____	C 02/24/2023

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SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

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S 000	Initial Comments COMPLAINTS & FACILITY REPORTED INCIDENTS 2289692/IL00154059- F697G 22810225/IL00154642 - F686G Facility Reported Incident of December 05, 2022/IL00154666 - F600G Facility Reported Incident of December 06, 2022/IL00154709 - F689H Facility Reported Incident of December 10, 2022/IL00155154 - F689H Facility Reported Incident of December 30, 2022/IL00155160 - F689H 2380986/IL00156115 - F686G Facility Reported Incident of January 24, 2023/IL00156560 - F689H 2381385/IL00156582 - F689H	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4 300.610a) 300.1010h) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 2 These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect residents right to be free from abuse. This deficient practice affected 4 residents (R5, R6, R21, and R22) in a sample of 28 residents reviewed for abuse. This failure resulted in R5 feeling intimidated and R6 feeling threatened by the facility administrator and R21 and R22 receiving unwanted touching by a facility staff member. Findings include, Facility's Final Incident Investigation Report dated (12/09/22) regarding incident which occurred on 12/05/22 involving R5, R6 and the facility administrator (V43) documents in part: V43 spoke inappropriately and aggressively toward R5 and R6 using profanity. R5 has diagnosis not limited to Unspecified Injury of Face, Subsequent Encounter Assault by Strike Baseball Bat, Insomnia, Major Depressive Disorder, Lack of Coordination, Muscle Weakness, Acquired Absence of Other Specified Parts of Digestive Tract. R5's Brief Mental Status Interview (BIMS) dated 02/03/23 documents that R5's cognition is intact. R5's MDS dated 02/08/23 section GG documents in part R5 uses a wheelchair and/or scooter. R5's document titled, "Screening Assessment for Indicators of Agressive (Aggressive) and/or Harmful Behavior" dated 12/05/22 documents in part total score = 1 with recommendations and outcome that R5 potentially able to integrate into the peer community, minimal risk for aggression.	S9999		

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S9999	Continued From page 3 R5's care plans reviewed. R5 does not have a care plan for abuse or history of aggression. R6 has diagnosis not limited to Driver of Heavy Transport Vehicle Injured in Collision with Two or Three-Wheeled Motor Vehicle in Traffic Accident, Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Quadriplegia, Muscle Weakness, History of Falling, Muscle Spasm, Contracture, Major Depressive Disorder, Hyperlipidemia, Retention of Urine, Anemia, Idiopathic Peripheral Autonomic Neuropathy. R6's Brief Mental Status Interview (BIMS) dated 12/01/22 documents that R6's cognition is intact. R6's MDS section G (Functional Status) dated 12/02/22 document in part R6 requires extensive assistance with two+ persons physical assist with bed mobility, transfer, dressing, toilet use, and personal hygiene. Activity of walking in room and walking in corridor did not occur, R6 uses wheelchair. R6's care plan dated 06/01/22 documents in part R6's medical and psychiatric diagnosis may increase resident's susceptibility to abuse/neglect. R6's care plan dated 06/01/22 documents in part R6 displays socially inappropriate and behavior. R6's care plan dated 06/01/22 documents in part R6 was socially inappropriate by using profane language towards staff members. R6's assessment titled, "Screening Assessment for Indicators of Agression (Aggression) and/or Harmful Behavior" dated 12/05/22 documents R6 has a history of verbal aggression towards staff/peer, resident was involved in an altercation with staff on 12/05/22. R6's score of 4 for recommendations and outcome potentially able to	S9999		

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S9999	Continued From page 4 integrate into the peer community, minimal risk for aggression. On 02/21/23 at 1:36 PM, R5 stated that the previous administrator (V43) lashed out at R5 one day by the 1st floor elevator. R5 stated that R5 did not remember what led up to the altercation but that V43 got hostile with R5 by raising V43's voice and pointing V43's finger in R5's face. R5 stated that R5 was sitting in R5's wheelchair and V43 was standing over R5 looking down at him. R5 stated, "he (V43) just snapped!" R5 denies any issues with V43 prior to this. R5 does not remember specifically what V43 said to R5 but R5 stated that V43 was cursing at R5 a few times. R5 stated that R5 felt disrespected and intimidated. R5 stated that, "I felt like I was going to have to defend myself and fight." R5 stated that the staff intervened and put V43 in the Social Service Director's office to calm down but then when V43 came out of the office "got into it with R6 by the 1st floor elevator." R5 stated that at that point V43 was told to leave the building. On 02/21/23 at 2:01 PM, R6 stated the R6 was sitting in R6's electric wheelchair by the 1st floor elevator and R6 heard V43 and R5 having "words." R6 stated R5 and V43 were "cussing each other out" and that V43 was standing over R5 (who was in a wheelchair) pointing V43's finger in R5's face. R6 stated that V43 went into the Social Service Director's office and then when V43 came out of the office V43 tried to fist pump ("daps") R6. R6 stated that R6 did not return V43's fist pump because R6 was upset at the way V43 had spoken to R5. R6 stated, "I told him to get out of my face." R6 stated that V43 raised V43's voice, got into R6's face and yelled at R6, "what do you want to do? you can't do sh**." R6 stated that V43 was standing over R6 and	S9999		

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aggressively pointing V43's finger in R6's face. R6 stated that this made R6 feel threatened and intimidated. R6 stated, "I didn't know what he (V43) was going to do to me." R6 stated that the Social Service Director told R6 to go back to R6's room but that V43 refused to get out of R6's face and yelled, "yeah, mother fuc**** what do you want to do?" R6 stated at this time the staff intervened and physically removed V43 from the situation and soon afterwards V43 was escorted out of the building.

On 02/21/23 at 3:50 PM, surveyor conducted interview via phone with V43 (Former Administrator) who stated that R5 was a gang member and participating in organized gang-like activities such as trying to sell drugs in the facility and acting inappropriately to female staff. V43 stated R5 was "playing the system to stay in the nursing home by claiming that he (R5) has a psych problem." V43 stated, "everyone was scared of him." V43 stated that on 12/05/22 R5 "threatened my personal safety" by R5 telling V43, "I'll take you out." V43 stated that at this point V43 and R5 went into the Social Service Director's office to allow R5 to explain himself. V43 stated that R5 said, "you're not my father" and "you cannot tell me what to do." V43 stated that R5 tried to stand up from R5's wheelchair so that R5 could punch or fight with V43. V43 stated, "the way he (R5) threatened me rattled me and I lost my cool. I should have known better." V43 stated that when V43 left the Social Service Office R6 was by the office and V43 tried to engage in a conversation with R6. V43 stated that R6 likes to play "gangster music" and is friends with R5. V43 stated that R6 said to V43, "F*** you!" V43 stated that V43 has no memory of swearing back at R6 however other staff said that V43 did do this. V43 stated that the building

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S9999	Continued From page 6 director (V44) called and told V43 to leave the building. V43 has not been back to the facility since this date. V43 stated, "I knew this was going to be written as an abuse case." On 02/22/23 at 11:15 AM, V1 (Administrator) stated that V1 has been the Administrator for the facility since Monday, 02/20/23 and is the Abuse Coordinator for the building. V1 stated that staff should never have any verbal or physical altercation with a resident because that is considered to be abuse and harmful to the resident as it goes against the rights of the resident as a person. V1 stated that the goal of the facility is for residents to feel safe, that their needs are being met, and that they are cared for and happy. V1 stated that the residents should feel that this is their home. On 02/22/23 at 12:15 PM, V10 (Social Service Director) stated that V10 has been working at the facility for 3 years. V10 stated that if an abuse is reported, V10 would immediately inform the Abuse Coordinator who is the Administrator and that once the Abuse Coordinator is informed then V10 and staff make sure the residents are separate physically and by floor if needed. V10 stated, "we don't want any escalation of aggression." V10 stated that the social service staff get the residents statement and then do an "Aggressive Assessment" and document what occurred in a behavior note and update the care plan with the date and modify the interventions. V10 stated that abuse training is done monthly and V10 provide the following examples of abuse: physical, neglect, exploitation. V10 stated that V10 was present on 12/05/22 and in V10's office when V10 heard loud voices by the elevator and went out to check out the situation. V10 stated that based on V10's observations on 12/05/22,	S9999		

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S9999	Continued From page 7 R5 and R6 were both victims of verbal abuse. On 02/22/23 at 1:34 PM, V13 (Admissions Director) stated that V13 was in V13's office and V13 heard loud talking from V10's office and toward the elevator on the 1st floor. V13 stated that V43 was being very loud, and confrontational with 2 of the residents (R5 and R6). V13 stated that one of the residents said something sarcastic to V43 and V43 responded with an inappropriate comment back. V13 stated that heard everyone (R5, R6, V43) using profanity. V13 stated that V43 keep talking loudly to the residents (R5, R6) and these residents were saying for V43 to leave them alone yet V43 keep it up saying something like, "you don't talk to me like that! who do you think you are? Hu? Who do you think you are?" V13 stated that it seemed like V43 was goading R5 and R6 to get more of a response from them. V13 stated that V43 was in the position of authority, and the Abuse Coordinator and it was not appropriate for V43 to talk like that to anyone but especially a resident. V13 stated that this is the residents' home, and they should feel safe and comfortable here. On 02/24/23 at 10:45 AM, surveyor conducted interview via phone with V76 (Psychiatric Nurse Practitioner) who stated that V76 is familiar with R6 but has not seen R5. V76 stated that V76 saw R6 on 12/16/22 and was never made aware of the altercation between R6 and the former administrator on 12/5/22. V76 stated that V76 or the psychiatrist should have been called or notified. V76 stated that it is staff responsibility to calm residents down in a non-threatening manner to help diffuse situation, not fuel it. V76 stated that V43 was the professional and should not have come down to the level of the resident. V76 stated that now R6 may feel R6 cannot trust R6's	S9999		

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S9999	Continued From page 8 surroundings, where R6 lives, and this is a safety concern. V76 stated, "who do they turn to for help?" and that it is creating a hostile environment coming from a person in a position of power and authority. Policy: Abuse Prevention Program - Policy undated, documents in part, it is the policy of the facility to prevent resident abuse, neglect, mistreatment and misappropriation of property. Facility policy titled, "Resident Rights" undated, documents in part, residents have the right to be free from verbal, sexual, physical or mental abuse and the facility must implement procedures that protect (you) from abuse, neglect or mistreatment. R21 has diagnosis not limited to Spondylosis with Myelopathy Cervical Region; Epilepsy; Nicotine Dependence; Low Back Pain; Fusion of Spine; Mastodynia; ETOH (Alcohol) Abuse; Thrombocytopenia; Hyperlipidemia; Overactive Bladder; Problem related to Care Provider Dependency; History of Falls. R21 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. On 02/22/23 at 09:15 AM R21 using a rollator walker, approached the surveyor while standing at the second-floor nurse station and stated "V1 (Administrator) put her hands on me. V1 grabbed my arms with both her hand and put me in the line while I was standing and waiting to go on smoke break. I was off balance. No worker is supposed to put their hands on residents. It happened at 07:45 this morning. V1 want every resident in line outside to smoke on the patio. The whole line and the worker in the red uniform that	S9999		

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S9999	Continued From page 9 was passing out cigarettes saw the incident." On 02/22/23 at 09:21 AM surveyor called receptionist and requested that V1 (Administrator) come to the second-floor nurse station. On 02/22/23 at 09:31 AM V39 (Activity Aide) stated "When I was passing cigarettes at 7:45 AM I grabbed the cigarette cart and material to go to the patio pass out and light cigarettes for the residents. V1 wanted the residents to stand in a straight line. This morning there was lot of confusion, and this was the new administrator first time being here to see cigarette break time. The residents are not always in a straight line so some of them were out of line. V1 (Administrator) was trying to put them in a straight line and trying to tell them to get in a straight line. The administrator put R21 in the line by touching her, I think on her arms. R21 told her that she is not supposed to be touching the residents. R21 hollered you don't have to push me." On 02/22/23 at 09:40 AM V1 (Administrator) arrived on the second-floor nurse station and the incident that R21 reported to the surveyor was reported to the administrator. V1 (Administrator) responded "I am going to have to call my boss so that she can come into the facility." On 02/22/23 at 09:55 AM V1 (Administrator) stated "I was in the first-floor dining room during smoke break observing. I don't know the time; the dining room light was off. V39 (Activity Aide) came in with the smoking cart and was inside the dining room passing cigarettes. I told V39 (Activity Aide) that I need for you to be outside with the residents. V39 (Activity Aide) was upset, and people were jammed up. I was touching the residents as they walked out the door. I said you	S9999		

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have to be outside to supervise the residents. The whole room smelled like smoke. I told the residents to line up outside and get cigarettes. I said we are going to line up and go out the door. I was touching people as they went out the door. R21 said don't touch me. The housekeeping supervisor was there. While the residents were standing outside, I touched a lot of people. I touched several people because I am a touchy-feely person. I can't say I was assisting R21 in anyway. I don't remember any other person saying you don't have to touch me. The housekeeping director was also there. I called my boss so they can come in and take over. V39 (Activity Aide) was upset with me for having her go outside to pass the cigarettes. I told the residents that we were going to paint and strip floors. It is going to take 24 hours and I would give the residents a couple days' notice because the room will be closed down."

On 02/22/23 at 10:30 AM V65 (Housekeeping Supervisor) stated "I was standing in the first-floor dining room. I cut the lights on and walked over to where the smokers were. V1 (Administrator) was talking about the floors being done and the walls painted. V39 (Activity Aide) came with the cigarette cart in the dining room and V1 (Administrator) said she did not want the residents in the dining room. V1 (Administrator) wanted the residents outside and wanted V39 (Activity Aide) to stand outside. I did not see V1 (Administrator) touching the residents."

R22 has diagnosis not limited to Epilepsy; Metabolic Encephalopathy; Non-traumatic Subdural Hemorrhage; Muscle Wasting and Atrophy; Difficulty in Walking; Lack of Coordination; ETOH (Alcohol) Abuse; Cognitive Communication Deficit; Hypokalemia; Weakness;

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S9999	Continued From page 11 Pancytopenia. R22 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. On 02/22/23 at 01:17 PM R22 stated "the administrator was aggressively grabbing people in the smoke break line and saying the line is this way outside. V1 (Administrator) put her hands on my wheelchair. My hands were on the wheels and could have gotten caught in the wheels. I asked V1 can you get your hands off of my wheelchair. V1 aggressively put her hands on R21 and could have knocked her to the ground. I was in my wheelchair behind R21. Initial Reportable dated 02/22/23 document in part: Facility received report from an IDPH (Illinois Department of Public Health) Surveyor on 02/22/23 at approximately 9:00 a.m. that R21 alleged that V1 (Administrator) grabbed/pushed her while resident attended a scheduled smoking break. During initial/preliminary investigation of the alleged incident, it was reported that V1 grabbed R22's wheelchair and pushed R22 chair without permission and bumping the chair into R21 leg. V1 (Administrator) denies the allegation made against her. V1 (Administrator) immediately removed herself from resident contact and has been suspended pending investigation of the alleged incident. Investigation was initiated. Policy: Policy titled "Abuse Prevention Program" revised 01/19 document in part: it is the policy of this facility to prohibit and prevent resident abuse. 1. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm or pain or mental anguish or deprivation by an individual, including a caretaker,	S9999		

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S9999	Continued From page 12 of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. (B) 2 of 4 300.610a) 300.1210b) 300.1210d)2 300.1210d)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 300.1210 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.	S9999		

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	IL6014781	A. BUILDING: _____ B. WING _____	C 02/24/2023

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S9999	Continued From page 13 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure wound care was provided for 2 (R4, R13) of 3 residents reviewed for wound care. The facility also failed to turn and reposition R4 while in bed. This failure resulted in the decline of R4 wounds with exposed bone to the left lower extremity. Findings Include: On 02/21/23 at 03:19 PM V9 (Wound Care Coordinator) stated "R4 has one pressure wound underneath the buttocks to the sacral conjoined, tunneled one to the other and both heels. Both knees lateral side are venous ulcers and both side of the upper and lower leg are venous	S9999		

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S9999	Continued From page 14 ulcers. R4 wounds looked bad, and I have seen a significant improvement in the wounds since I started." R4 has diagnosis not limited to Spondylosis with Radiculopathy, Thoracolumbar Region, Paraplegia, Neuromuscular Dysfunction of Bladder, Type 2 Diabetes Mellitus, Methicillin Resistant Staphylococcus Aureus Infection, Reduce Mobility, Limitation of Activities Due to Disability, Lack of Coordination. Pressure Ulcer of Right Buttocks, Stage 4, Non-Pressure Ulcer of Right Calf with Fat Layer Exposed, Non-Pressure Ulcer of Other Part of Right Lower Leg, Non-Pressure Ulcer of Other Part of Left Lower Leg , Osteomyelitis, Weakness, Acute Embolism and Thrombosis of Unspecified Deep Veins of Unspecified Lower Extremity, Muscle Wasting and Atrophy, Acute Kidney Failure, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity, Major Depressive Disorder, Osteoarthritis, and Essential (Primary) Hypertension. R4 Care plan document in part: R4 is at increased risk for alteration in skin integrity related to incontinence of bladder, incontinence of bowel and impaired mobility status. Interventions: Precautions for prevention of pressure ulcers will be completed: good peri care and drying of the skin. Apply protective barrier cream. Reposition resident frequently when in bed /chair/Geri chair and or wheelchair. Administer Wound Care (Treatment) per MD (Medical Doctor) orders. R4 Treatment Administration Record dated 09/01/22 -09/30/22 document in part: Collagen-Antimicrobial Sheet Apply to Left Lateral Leg every day has 16 out of 31 days with no documented treatments. Collagen- Antimicrobial	S9999		

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S9999	Continued From page 15 Sheet Apply to Right Lateral Leg every day has 16 out of 31 days with no documented treatments. Foam Dressing Pad apply to Right Lateral Lower Leg every Tuesday, Thursday, Saturday has 5 out of 13 days with no documented treatments. Gentamicin Sulfate Ointment 0.1 % Apply to Right Gluteal fold topically every day shift has 7 out of 15 days with no documented treatments. Medi honey gel apply to right gluteal fold has 9 out of 12 days with no documented treatments. Left Lateral Lower Leg: Cleanse with NSS (Normal Saline) apply collagen sheet cover with foam dressing every day shift has 2 out of 4 days with no documented treatments. Right Gluteal Ischial cleanse with ½ Dakin's every day shift has 2 out of 4 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS every shift has 2 out of 4 days with no documented treatments. R4 Treatment Administration Record dated 10/01/22 - 10/31/22 document in part: Calcium Alginate Miscellaneous Apply to Left Lower Extremity and Right Lower Extremity every day has 10 out of 25 days with no documented treatments. Collagen-Antimicrobial sheet apply to left lateral leg every day has 5 out of 6 days with no documented treatments. Collagen-Antimicrobial sheet apply to right lateral knee every Monday, Wednesday, Friday has 4 out 11 days with no documented treatments. Collagen-Antimicrobial sheet apply to right lateral leg every day has 5 out of 6 days with no documented treatments. Foam Dressing pad apply to right lateral lower leg Tuesday, Thursday, Saturday has 7 out of 13 days with no documented treatments. Medi honey Apply to Left Lower Extremity & Right Lower Extremity topically every day has 10 out of 25 days with no documented treatments. Left Lateral lower leg:	S9999		

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S9999	Continued From page 16 cleanse with NSS apply Medi honey and Calcium Alginate every day has 10 out of 25 days with no documented treatments. Left Lateral Lower Leg: cleanse with NSS apply collagen sheet every day has 5 out of 6 days with no documented treatments. Right Gluteal Ischial Cleanse with ½ Dakin's every day has 5 out of 6 days with no documented treatments. Right Lateral Knee: Cleanse with NSS apply collagen sheet or calcium alginate Monday, Wednesday Friday has 4 out of 10 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS apply collagen sheet every day has 5 out of 6 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS apply Medi honey and Calcium Alginate has 10 out of 25 days with no documented treatments. Dakin's ½ strength 0.25 % sodium hypochlorite apply to right gluteal fold every day and night shift has 22 out of 50 wound changes with no documented treatments. Right Gluteal Ischial: Cleanse with Dakin's ½ strength, moisten and loosely insert, every day and night shift have 22 out of 50 wound changes with no documented treatments. R4 Treatment Administration Record dated 11/01/22 - 11/30/22 document in part: Collagen-Antimicrobial Sheet Apply to Right lateral knee topically every day has 5 out of 13 wound changes with no documented treatments. Foam Dressing pad apply to right lateral lower leg Tuesday, Thursday, Saturday has 4 out of 13 days with no documented treatments. Medi honey Apply to Left Lower Extremity & Right Lower Extremity topically every day has 9 out of 30 days with no documented treatments. Left Lateral lower leg: cleanse with NSS apply Medi honey and Calcium Alginate every day has 9 out of 30 days with no documented treatments. Right Lateral Knee: Cleanse with NSS, pat dry, apply	S9999		

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S9999	Continued From page 17 adaptic, cover with foam dressing Monday, Wednesday Friday has 4 out of 9 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS, apply Medi honey and Calcium Alginate every day has 9 out of 30 days with no documented treatments. Dakin's ½ strength 0.25 % sodium hypochlorite apply to right gluteal fold every day and night shift has 14 out of 60 wound changes with no documented treatments. Right Gluteal Ischial: Cleanse with Dakin's ½ strength, moisten and loosely insert, every day and night shift have 3 out of 19 wound changes with no documented treatments. Right Gluteal Ischial: Cleanse with Dakin's ½ strength, pack loosely with iodoform gauze, every day and night shift have 12 out of 41 days with no documented treatments. R4 Treatment Administration Record dated 12/01/22 - 12/31/22 document in part: Calcium Alginate apply to Left Lower Extremity and Right Lower Extremity topically every day has 2 out of 4 days with no documented treatments. Foam Dressing pad apply to right lateral lower leg Tuesday, Thursday, Saturday has 2 out of 4 days with no documented treatments. Gentamicin Sulfate Ointment 0.1 % Apply to Left Lateral lower leg everyday Cleanse with ½ Dakin's apply gentamycin ointment daily and PRN (as needed) day has 9 out of 14 days with no documented treatments. Gentamicin Sulfate Ointment 0.1 % Apply to Left Lateral lower leg everyday Cleanse with ½ Dakin's has 3 out of 10 days with no documented treatments. Medi honey Apply to Left Lower Extremity & Right Lower Extremity topically every day has 2 out of 4 days with no documented treatments. Left Lateral lower leg: cleanse with NSS apply calcium alginate daily and prn has 9 out of 13 days with no documented treatments. Left Lateral lower leg Cleanse with	S9999		

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S9999	Continued From page 18 Dakin's ½ strength apply gentamycin every day has 3 out of 9 days with no documented treatments. Left Lateral lower leg Cleanse with NSS apply Medi honey and calcium alginate every day has 2 out of 7 days with no documented treatments. Right Lateral Knee Cleanse with NSS Monday, Wednesday, Friday has 1 out of 7 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS, apply Xeroform Monday, Wednesday, Friday has 5 out of 10 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS, apply Medi honey and calcium alginate every day has 14 out of 31 days with no documented treatments. Apply Xeroform over any exposed bone, wet to dry with Dakin's solution twice a day has 13 out of 33 wound changes with no documented treatments. Dakin's ½ strength 0.25 % sodium hypochlorite apply to right gluteal fold every day and night shift has 3 out of 7 wound changes with no documented treatments. Gentamicin Sulfate Ointment 0.1 % Apply right gluteal ischial topically every day and night shift for wound care Cleanse with 1/2 strength Dakin's apply gentamicin ointment with calcium alginate Twice a day and prn have 14 out of 29 wound changes with no documented treatments. Right gluteal ischial Cleanse with Dakin's ½ strength pack loosely with iodoform gauze every day and night shift have 9 out of 33 wound changes with no documented treatments. R4 Treatment Administration Record dated 01/01/23 - 01/31/23 document in part: Gentamicin Sulfate Ointment 0.1 % Apply to Left Lateral lower leg topically every day shift Clean with 1/2 Dakin's apply gentamicin ointment daily and PRN shift has 15 out of 18 days with no documented treatments. Santyl ointment 250 unit/gm (gram) apply to left heel every day has 2 out of 2 days	S9999		

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S9999	Continued From page 19 with no documented treatments. Santyl ointment 250 unit/gm (gram) apply to left knee every day has 4 out of 6 days with no documented treatments. Santyl ointment 250 unit/gm (gram) apply to left lateral lower leg cleanse with 1/2 strength Dakin's every day has 2 out of 4 days with no documented treatments. Santyl ointment 250 unit/gm (gram) apply to left lateral lower leg cleanse with NSS apply calcium alginate daily and prn has 4 out of 9 days with no documented treatments. Left Heel cleanse with NSS apply Xeroform Monday, Wednesday, Friday has 7 out of 8 days with no documented treatments. Left lateral knee cleanse with NSS paint with betadine every day has 14 out of 18 days with no documented treatments. Right Heel cleanse with NSS apply Xeroform Monday, Wednesday, Friday has 8 out of 9 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS, apply Xeroform Monday, Wednesday, Friday has 7 out of 8 days with no documented treatments. Right Lateral Lower Leg: Cleanse with NSS, apply Medi honey and Calcium alginate every day has 14 out of 18 days with no documented treatments. Gentamicin Sulfate Ointment 0.1 % Apply right gluteal ischial topically every day and night shift for wound care Cleanse with 1/2 strength Dakin's apply gentamicin ointment with calcium alginate Twice a day and prn have 26 out of 36 wound changes with no documented treatments. R4 Wound Care Note dated 10/20/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 7.4x3.4x0.4. Right Gluteal Ischial Pressure Size in cm (centimeters) 1.5x2.2x3.7. Right Lateral Lower Leg non-pressure Size in cm (centimeters) 11.6x3.5x0.3. Right Lateral Knee non-pressure Size in cm (centimeters) 0.8x0.8x0.1.	S9999		

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S9999	Continued From page 20 R4 Wound Care Note dated 11/10/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 8.5x4.2x0.4. Right Gluteal Ischial Pressure Size in cm (centimeters) 2x1.8x2.3. Right Lateral Knee non-pressure Size in cm (centimeters) 1x0.4x0.1. R4 Wound Care Note dated 11/17/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 9x4.5x0.5. Right Gluteal Ischial Pressure Size in cm (centimeters) 2x2x2.8. Right Lateral Lower Leg non-pressure Size in cm (centimeters) 12x3x0.4. R4 Wound Care Note dated 12/01/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 14x5x1.3. Right Lateral Lower Leg non-pressure Size in cm (centimeters) 14x5x1.2. Left Lateral Knee Size in cm (centimeters) 0.8x0.4x0.1. R4 Wound Care Note dated 12/07/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 16x8.5x1.3. Right Lateral Lower Leg-Proximal Reopen non-pressure Size in cm (centimeters) 1.2x0.8x0.1. R4 Wound Care Note dated 12/21/22 document in part: Left Lateral Lower Leg non-pressure Size in cm (centimeters) 17.3x7.5x1.2. Right Gluteal Ischial Pressure Size in cm (centimeters) 2x3.2x2.5. Right Lateral Knee non-pressure Size in cm (centimeters) 3.2x4x0.1. Right Heel pressure Size in cm (centimeters) 3.5x3x0. Left Heel pressure Size in cm (centimeters) 2.5x3.5x0. R4 Wound Care Note dated 01/18/23 document in part: Right Gluteal Ischial Pressure Size in cm	S9999		

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S9999	Continued From page 21 (centimeters) 8x7.8x2.4. Right Lateral Lower Leg non-pressure Size in cm (centimeters) 15.5x4.2x1.2. Left Lateral Knee non-pressure Size in cm (centimeters) 3.5x3.8x0. Right Heel pressure Size in cm (centimeters) 7x7.4x0.2. Left Heel pressure Size in cm (centimeters) 3.5x7x01. Left Post Knee Size in cm (centimeters) 2x3.7x0.1. Left Anterior Knee Size in cm (centimeters) 2x2x0.1. R4 Wound Care Note dated 02/08/23 document in part: Right Gluteal Ischial Pressure Size in cm (centimeters) 8x7.4x2.8. R4 Hospital Record dated 11/27/22 document in part; Final Hospital Diagnosis: Chronic osteomyelitis of fibula, Pyogenic arthritis of left knee joint, Decubitus ulcer of right perineal ischial region, stage 4. R4 presented to the hospital due to newer wounds on bilateral lower extremities with exposed bone. Initially started as superficial wounds about 2 months prior. R4 came to the hospital from the nursing home facility due to worsening of wounds on both legs. Admitted 11/22/22 with chronic bilateral fibulas (and likely tibial) osteomyelitis with worsening bilateral lower extremity wounds and sacral decubitus ulcer. Wounds on bilateral lower extremities, red granulation tissue with exposed bone. Imaging: X-ray Lower Leg/Tibia-Fibula Bilateral 2 views. Final Result: 1. Soft tissue wounds along the distal bilateral lower extremities, greater on left. Periosteal reaction involving the adjacent bilateral fibula concerning for chronic osteomyelitis. With respect to R4 new bilateral lower extremity wounds, has new findings of chronic appearing lateral ulcerative changes with bone exposure (fistula). This is likely also in the setting of chronic pressure.	S9999		

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S9999	Continued From page 22 On 02/22/23 at 08:37 AM the surveyor entered R4 room. R4 was observed lying in a supine position with a pillow under the lower extremities. R4 stated "the old wound care team walked out when the facility was making its transition and they had no one to do wound care. The old Director of nursing told V41 (Former Wound Care Nurse) that the residents don't have to have wound care every day, and they can miss a day. I still do not get my wound care done daily. The facility tried to make the floor nurses do the wound care, but they don't know how to do it or what medicine go on each leg. My legs got worse. V41 came in and started doing wounds but it was not an everyday thing. V38 (Nurse Consultant) said the facility was getting a wound care team coming in but about the time they came you could see the bone in my leg, and I was sent out to the hospital to get my legs checked out. The Certified Nurse assistant came in at 2 AM this morning to give me some ice water and I have not seen a Certified Nurse Assistant since then. I have never been turned every 2 hours. I have been laying on my back all night." On 02/22/23 at 10:25 AM V9 (Wound Care Coordinator) stated "R4 has daily dressing changes to the buttock and Bilateral lower extremities. R4 has a low air loss mattress, and we recommend and encourage R4 to off load, turn and reposition. R4 is alert and oriented x4 and is compliant sometimes. If a resident is not turned and repositioned it can cause pressure, worsening of the wounds and drainage. I will update the care plan to include turning and repositioning R4 every 2 hours." On 02/22/23 at 10:34 AM the surveyor entered R4 room with V9 (Wound Care Coordinator). V42 (Certified Nurse Assistant) had R4 turned on his	S9999		

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S9999	Continued From page 23 (R4) right side performing incontinent care. V42 (Certified Nurse Assistant) stated "R4 had a bowel movement." R4 was noted with 4 plus pitting edema to the left lower extremity with a large indentation observed to the left lower extremity. V42 (Certified Nurse Assistant) stated "R4 had a pillow under the left leg, under the knee area." A moderate amount of serosanguinous drainage was observed to the left lower extremity dressing and the edge of the dressing near the buttocks was soiled with stool. Dressing and packing to right buttocks was removed by V9. The entire buttocks appeared dark with scattered areas of light pink tissue. V9 cleaned the gluteal wound, applied Santyl/gentamycin, and packed the wound with calcium alginate. V9 stated "the gluteal wound has improved since I started doing the wound care." A small open area was observed to the scrotum. V9 stated "I saw the open area to the scrotum yesterday." R4 left lower extremity outer lateral area was observed with a large open area red in color with slough tissue observe to the top edge of the wound. V9 stated "it was much larger, deeper, wider with a lot of slough tissue, green and yellow drainage. The surgical site to the left knee turned into a wound and has gotten worse." The right outer heel and upper ankle were observed with eschar tissue. The right lower outer lateral leg was observed with a large wound. The wound bed appeared red in color with slough tissue observed to the top area of the wound. A small open area was observed to the right ankle. The wound observed to the right lateral knee area appeared red in color with slough tissue. Open area observed to the right outer heel with eschar tissue. A total of six open areas were observed to the right lower extremity. V9 (Wound Care Coordinator) stated "the right heel wound was facility acquired."	S9999		

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S9999	Continued From page 24 On 02/22/23 at 10:56 AM V40 (Certified Nurse Assistant) knocked on R4 door while V9 (Wound Care Coordinator) was performing wound care. On 02/22/23 at 11:01 AM V42 (Certified Nurse Assistant) stated "the whole wound care department left in September 2022 and the floor nurses would have to do their own wound care. R4 aide has not been in here yet. In September R4 did not have the wounds to the heels and the wounds to the lower extremities were much thinner. R4 had the one wound to the gluteal fold but the area above the gluteal fold that had to get the most packing is the newer wound." On 02/22/23 at 11:55 AM V40 (Certified Nurse Assistant) entered R4 room to perform AM care. R4 was transferred to the wheelchair using the sit to stand with three assistances. On 02/22/23 at 11:59 AM V66 (Licensed Practical Nurse) stated "I saw R4 once at the beginning of the shift. It was after 8 AM when I went in to take R4 blood pressure. No one else has been in R4 room to my knowledge." On 02/22/23 at 12:40 PM V40 (Certified Nurse Assistant) exited R4 room. V40 stated "This is my first day. When they were doing wound care and I knocked on the door, that was the first time that I attempted to see R4. When I start my shift, I do a view of my patients to make sure they are okay. The residents are turned and repositioned at least twice a shift and every 10 - 15 minutes. When I came over it was time for R4 to get up. Before I came over here, I am sure whoever had R4 turned R4." On 02/22/23 at 1:21 PM V38 (Nursing	S9999		

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S9999	Continued From page 25 Consultant) stated "I would have to look at R4 initial assessments. I am not a wound nurse or wound coordinator. R4 has wounds to the bilateral legs and buttocks. On 02/15/23 it is documented R4 left lateral lower leg full thickness, right gluteal ischial stage 4 pressure, left lateral knee non pressure. The facility had a wound care team coordinator, treatment nurse and the Certified Nurse Assistant that rounded with the team. The wound care team did not want to work with the new company that took over in August 2022 and the wound team exited the facility the first part of September. At that time, I would round with the wound doctor until we found a treatment nurse. The wound care doctor come to the facility once a week and the floor nurses did the wounds 6 days a week. I really don't want to describe R4 wounds because it would be based on my memory. R4 was seen by the nurse practitioner on 11/17/22. I reviewed the assessment, and I observed the wounds referred back to the assessment versus what I was objectively assessing with my visual assessment there was a decline in R4 wounds. At that time the orders were daily and prn (as needed). R4 likes to use pillows under the knees that causes pressure. You cannot make the resident do anything; you can care plan. On 01/12/23 R4 most recent BIMS score is 15. R4 is alert oriented to person, place, time, and situation. All we can do is educate preventive measure for the wound care. Pressure is detrimental to the healing of R4 wounds." R13 has diagnosis not limited to Cellulitis, Lack of Coordination, Dysphagia, Non-Pressure Chronic Ulcer of Other Part of Right Lower Leg with Fat Layer Exposed, Non-Pressure Chronic Ulcer of Other Part of Left Lower Leg with Fat Layer Exposed, Sepsis, Pressure Ulcer of Contiguous	S9999		

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S9999	Continued From page 26 Site of Back, Buttock, and Hip, Stage2, Pressure Ulcer of Sacral Region, Stage 4, Weakness, Limited Activities Due to Disability, Reduced Mobility and is no longer a resident at the facility. R13 Braden Scale for Predicting Pressure Sore Risk dated 12/13/22 document in part: 3. Activity: 1. Bedfast. 4. Mobility: Completely immobile. R13 Wound Care Note dated 12/21/22 document in part: Right leg and foot non-pressure size in cm (centimeters) 58x30x0.3. Left leg and foot non-pressure size in cm (centimeters) 59x30x0.3. Back/Buttock/Hip Pressure size in cm (centimeters) 4.5x1.5x0.2. Midback with no documented measurements. R13 Wound Care Note dated 12/29/22 document in part: Midback size in centimeters 3x2x0.2. R13 Wound Care Note dated 01/04/23 document in part: Midback 4x2x0.2. Sacral Pressure reopened size in centimeters 2x2x0.1. R13 Wound Care Note dated 01/11/23 document in part: Sacral Pressure size in centimeters 4x4x0.1. R13 Wound Care Note dated 01/18/23 document in part: Midback 5x1.8x0.2. Sacral Pressure size in centimeters 5x8x0.1. R13 Treatment Administration Record dated 12/01/22 - 12/31/22 document in part: Left leg and foot cleanse with Hibiclens apply gentamycin, collagen, Unna boot every Monday, Wednesday, Friday has 0 out of 3 scheduled dressing change dates with no documented treatment. Right Hallux and 2nd and 3rd toes cleanse with Hibiclens apply gentamycin, collagen every	S9999		

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S9999	Continued From page 27 Monday, Wednesday, Friday has 0 out of 3 scheduled dressing change dates with no documented treatment. Right leg and foot cleanse with Hibiclens apply gentamycin, collagen, Unna boot every Monday, Wednesday, Friday has 0 out of 3 scheduled dressing change dates with no documented treatment. R13 Treatment Administration Record dated 01/01/23 - 01/31/23 document in part: Gentamicin Sulfate 0.1 % (Gentamicin Sulfate (Topical)) Apply to Left leg and foot topically everyday shift for wound care cleanse with 1/2 strength Dakin's apply gentamycin ointment + adaptic cover with abd pad wrap with kerlix and ace wrap daily and PRN (as needed) has 9 out of 31 days with no documented treatments. Gentamicin Sulfate 0.1 % (Gentamicin Sulfate (Topical)) Apply to Right and Left hallux and 2nd to topically everyday shift for wound care cleanse with ½ strength Dakin's apply gentamycin ointment + adaptic cover with abd pad wrap with kerlix and ace wrap start date 01/13/23 has nine out of 19 days with no documented treatments. Gentamicin Sulfate 0.1 % (Gentamicin Sulfate (Topical)) Apply to Right leg and foot topically everyday shift for wound care cleanse with 1/2 strength Dakin's apply gentamycin ointment adaptic abd pad wrap with kerlix and ace wrap -Start Date- 01/13/23 has nine out of 19 days with no documented treatments. Santyl External Ointment 250 UNIT/GM (Gram) Apply to sacral topically everyday shift for wound care cleanse with ½ strength Dakin's apply Santyl calcium alginate cover with foam dressing daily and PRN -Start Date- 01/26/23 with 3 out of 6 with no documented treatments. Santyl Ointment 250 UNIT/GM Apply to mid back topically everyday shift for wound care cleanse with NSS (Normal Saline) apply Santyl/adaptic and foam dressing	S9999		

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S9999	Continued From page 28 daily, and PRN has 13 out of 31 days with no documented treatments. Left Buttocks cleanse with NSS apply zinc oxide cover with foam dressing daily and prn -Start Date- 01/26/23 has 4 out of 6 days with no documented treatments. Left leg and foot cleanse with ½ strength Dakin's apply adaptic abd pad and kerlix and ace wrap everyday shift for wound care -Start Date- 01/01/23 -D/C (Discontinue) Date- 01/12/23 has 4 out of 12 days with no documented treatments. Right and Left Hallux and 2nd toes cleanse with ½ strength Dakin's apply adaptic abd kerlix wrap and ace wrap daily and PRN -Start Date- 01/01/23 -D/C Date- 01/12/23 has 4 out of 12 days with no documented treatments. Right Leg and foot cleanse with ½ strength Dakin's apply adaptic abd cover with kerlix ace wrap daily and prn -Start Date- 01/01/23 -D/C Date- 01/12/23 has 4 out of 12 days with no documented treatments. Right upper buttocks cleanse with NSS apply Medi honey calcium alginate cover with foam dressing everyday shift -Start Date- 01/26/23 has 4 out of 6 days with no documented treatments. Right upper buttocks-site cleanse with NSS apply adaptic cover with foam dressing 3/week and PRN every Monday, Wednesday, Friday has 6 out of 11 scheduled dressing change dates with no documented treatment. Mid Back cleanse with NSS apply Medi honey calcium alginate cover with foam dressing daily and PRN -Start Date- 01/26/23 has 4 out of 6 days with no documented treatments. On 02/22/23 at 05:22 PM V2 (Director of Nursing) stated "R13 was one of the wound patients. I started here on 01/09/23 and V41 (Former Wound Care Nurse) walked out within the first week of me being here. The staff should make rounds on shift arrival to make sure the residents are alive and not on the floor. R4 is alert and	S9999		

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S9999	Continued From page 29 oriented x4 and makes his needs and complaints known. The residents should be repositioned in bed. R4 is on a pressure reducing mattress. The purpose for turning and repositioning is to offload the areas to reduce pressure. If the treatment administration record is not signed or documented, it is not done. If it is not signed, we cannot verify that the treatments were done. R4 wounds were bad when I first started but they are getting better since the new wound coordinator." On 02/23/23 at 10:25 AM V33 (Nurse Practitioner/Infectious Disease) stated "R13 has Chronic wound care following vascular issues preventing the wounds from healing. R13 has been treated for bacteria. I know at the facility I have heard from other residents about the sporadic wound care. At one point not long ago, the wound nurse was not working there anymore. I tried to follow what wound care providers was providing. We want wound care to be done as ordered. If wound care is not done for chronic and slow healing wounds, that does not help the issue and is not in the best interest because it could cause the wounds to get worst. We are trying to keep the wounds from getting infected and to heal. The wound care should be done as frequently as wound care recommend. R4 was the resident I had to discuss with the Director of nursing. When R4 came back from the hospital, wound care was ordered twice daily. If the wound care is not being done and especially if there are pictures and the measurements show that the wounds were getting worse then that is evidence that the lack of wound care is why the wounds got worse." On 02/23/23 at 12:50 PM V64 (Former Wound Care Coordinator) stated "R13 was admitted with a sacral wound that closed and bilateral lower	S9999		

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S9999	Continued From page 30 extremity vascular wounds that were chronic. The dressings were changed as order. R4 had a stage 4 pressure wound to the right gluteal fold that was facility acquired. The Bilateral Lower Extremity vascular wound were improving. The bottom part lateral left leg was larger than right lateral leg wound and was kind of wide. There were no wounds to R4 heels. I left the facility the second week of September. They were cutting staff and wanted the wound nurses to work the floor and wanted the staff nurses to do the wounds." On 02/23/23 at 01:02 PM V41 (Licensed Practical Nurse) stated "R13 bilateral lower extremity wounds were improving to the point where R13 had start growing skin. There was granulation to the lower part of the wound. I was not receiving any assistance from anyone for wound care. There was no wound nurse for a couple of weeks after the wound care team left in September 2022 and the resident wounds were not getting done. V38 (Nurse Consultant) was trying to do the wounds and they wanted the nurses to do the wounds. When the wound doctor came, we could not do the whole building in one day on the wound care rounds. I became the only wound care nurse and they had no one to replace the wound care coordinator. I took a day off on a Monday, it was a couple nurses that did wound care, but they did not touch anyone on that Monday. When I returned to worked on Tuesday, I could tell by R4 bandages that R4 wound care was not done that Monday. In one day, the wound was all the way to R4 bone. I called V38 (Nurse Consultant) to witness R4 wounds. V38 told R4 it is not that bad I see a little bone I don't see any green drainage. I told R4 it was bad your bone is showing and there was green drainage. R4 was sent to the hospital and came back with orders	S9999		

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S9999	Continued From page 31 for dressing changes twice a day. I quit because of the lack of help. R4 had wounds to both lower extremities on the lateral sides, 2 on the knees because they were not turning R4 and another wound on the gluteal fold that was facility acquired." On 02/23/23 at 03:57 V67 (Wound Care Nurse Practitioner) stated "there was a couple of wound care nurses at the facility that quit. R4 has multiple wounds. When I started R4 had one small gluteal wound and it deteriorated from R4 sitting in wheelchair and going out. R4 has multiple wounds on the legs. The wounds to the legs became septic and were not improving. R4 went to hospital because of the septic arthritis. There is a potential for infection, bacterial growth and the wound bed will get worst, deteriorate, and increase in size if the dressings are not changed as ordered. R13 legs were deteriorating." Document titled "Job Description" undated document in part: The Certified Nurse Assistant for the Special Care Unit provides each assigned resident with routine daily nursing care and services in accordance with the resident's assessment and care plan. Policy: Titled "Preventive Skin Care" undated document in part It is the intent of the facility that the facility provides preventive skin care through careful washing, rinsing, and drying to keep residents clean, comfortable, well groomed, and free from pressure sores. Procedure: 4. Residents identified as being high risk for potential breakdown shall be turned and repositioned frequently to prevent redness that does not fade or blanche.	S9999		

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S9999	Continued From page 32 Titled "Activities of Daily Living" undated document in part: ADL (Activities of Daily Living) care is provided throughout the day, evening and night as care planned and/or as needed. ADL care of the resident includes Assisting with movement and ambulation and ROM (Range of Motion) as indicated and care planned. Titled "Turning/Repositioning Guideline" undated document in part: If the resident cannot change position without the help of other(s) or cannot change position due to a splint or brace or other device the risk for skin breakdown is increased. (A) 3 of 4 300.610a) 300.1210b) 300.1210d)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 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 33 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: 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 Requirements were not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow their Fall Prevention and Management Program by (a) not implementing a comprehensive resident centered care plan with goals and interventions to prevent falls, (b) not providing supervision for a wandering resident, and (c) not providing fall prevention interventions for 5 (R7, R8, R15, R16, R11) of 5 in a sample of 28 residents reviewed for falls. These failures resulted in R11 sustaining a right femoral neck fracture. These failures also resulted in R15 falling on the floor directly on her face and sustaining a nasal bone fracture. R7 sustained a left hip (femur) fracture. R8 sustained	S9999		

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S9999	Continued From page 34 a scalp hematoma, forehead laceration that required stitching, and multiple acute pelvic and sacral fractures. Findings Include: On 2/21/23 at 2:48 pm, an interview conducted with R15. When asked about the incident that happened on 1/24/23, R15 stated, "I used to be on the 3rd floor. There was this resident (R16) who walks around and goes to other rooms. I was lying in bed I looked up and saw that resident (R16) in my room. She (R16) was reaching something in my dresser. She (R16) was by herself. There was no staff watching her (R16). I got up and when I got up I guess I moved so fast I lost my balance and fell. I fell on the floor. I was between the dresser and the bed. I felt blood coming from my nose. I never got to touch her (R16). I was going to get her out of there but did not get a chance to because I fell and then she (R16) just left and walked out. That's what she (R16) does she (R16) goes to room to room." On 2/22/23 at approximately 9:45 am to 10:00 am, surveyor observed R16 wandered around the 3rd floor unit. Surveyor did not observe any staff re-directed R16 at that time period. On 2/21/23 at 1:52 pm, V21 (Certified Nurse Aide) stated, V21 worked on 1/24/23 day shift but did not witness R15's fall. V21 was doing patient care with another resident. V21 stated, R16 is confused and wanders around the unit by herself. V21 stated staff should be re-directing R16. At 1:59 pm, interviewed V22 (Certified Nurse Aide) and stated worked on 1/24/23 day shift but did not witness R15's fall. V22 stated, V22 was	S9999		

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S9999	Continued From page 35 doing patient care with another resident. V22 stated R16 wanders to other residents' rooms and staff should be re-directing R16 back to the dining room or where staff can supervise R16. At 2:06 pm, interviewed V14 (Contract Licensed Practical Nurse) who stated, V14 was not the nurse in-charge of R15 on the day of R15 and R16's incident. V14 stated, V14 did not witness R15 falling. V14 stated, R16 wanders in the unit and sometimes to other residents' rooms. V14 stated, R16 should always be supervised when wandering. On 2/22/23 at 11:22 am, interviewed V10 (Social Service Director) and stated that staff should always be re-directing R16 when wandering. V10 stated, "If (R16) walks inside another resident's room they have to re-direct." On 2/23/23 at 9:42 am, a phone interview conducted with V55 (Certified Nurse Aide). V55 stated was in-charge of R15 when R15 and R16's incident happened but did not witness the incident. V55 stated, V55 went downstairs and was not in the unit when the incident happened. V55 stated V55 was not in-charge of R16 that time but V55 saw R16 walking around the unit. V55 stated R15 walks independently, gets up by herself (R15), and toilets independently. V55 stated R15 does not need assistance with transferring or when walking. Surveyor attempted to contact V25 (Agency Registered Nurse) multiple times and left messages to call back to no avail. V25 was in-charge of R15 on 1/24/23 day shift. R15's clinical records indicate an admission date of 6/10/22 with listed diagnoses not limited to	S9999		

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S9999	Continued From page 36 Alzheimer's disease, hypertension, weakness, and other lack of coordination. R15's Quarterly Minimum Data Set (MDS) assessment with assessment reference date (ARD) of 12/16/22 shows R15 has impaired cognition and requires limited one person assistance with activities of daily living and is unsteady with balance during transitions and walking. R15's progress notes dated 1/24/23 at 10:15 am documented by V25 indicates V25 observed R15 sitting on the side of R15's bed with trails of blood on the floor and R15's arms. R15's reported pain on R15's left arm. R15 reported that R15 was trying to get another resident out of R15's room. R15 fell on the floor directly on R15's face. R15 was transferred to the hospital. R15's hospital records show a computed tomography scan of facial bone was performed on 1/24/23 at 1:00 pm with findings that shows displaced fracture at the base of the right nasal bone. R16's clinical records indicate an initial admission date of 5/28/20 with listed diagnoses not limited to dementia, disorientation, and anxiety disorder. R16's Annual MDS assessment with ARD of 1/5/23 shows R16 requires supervision one staff assistance with transfer and walking. R16's comprehensive care plan with date initiated on 6/30/22 shows R16 has a diagnosis of dementia and wanders in and out of peer's rooms. One intervention shows to re-direct R16 when R16 goes to other peer's room. R11's progress notes dated 12/30/22 documented by V26 (Agency Registered Nurse) reads "at 4:00pm, staff heard (R11) calling out for help. Staff responded to (R11's) call immediately.	S9999		

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S9999	Continued From page 37 Staff observed (R11) lying on the floor right side of bed." This note also documents R11 did not know what happened, was sleeping and woke up on the floor. This note also documents R11 stated R11 hit R11's head and was sent out to acute hospital via 911. Facility's final incident reporting on R11's fall reads in part: "Based on a thorough review of (R11's) medical record, the incident was determined to be contributed by (R11) attempting to ambulate out of bed without staff assistance. (R11) was treated at the hospital for the Dx: Right Hip Fracture." R11's hospital records dated 12/30/22 shows X-ray of right femur performed on 12/30/22 at 5:57 pm with conclusion that reads in part, "1. There is evidence of an age-indeterminate fracture of the right femoral neck, possibly acute." R11's clinical record shows an 4/18/22 with listed diagnoses not limited to cerebral infarction, heart failure, dementia, weakness, abnormalities of gait and mobility, diabetes mellitus, and hypertension. R11's Quarterly Minimum Data Set (MDS) assessment with ARD of 10/10/22 shows R11 was cognitively impaired and requires extensive 2 staff assist requires for bed mobility, toileting, transfer. Unsteady with balance during transitions and walking. R11's "Restorative Nursing Review" dated 10/4/22 shows R11 was not steady with balance during transitions. R11's "Fall Risk Review" dated 10/4/22 shows R11 was at risk for falls. R11's comprehensive care plan shows R11's fall care plan was not initiated until 12/31/22, which was after the fall. On 2/21/23 at 2:26 pm, interviewed V23 (Certified Nurse Aide) and stated did not witness R11's fall.	S9999		

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S9999	Continued From page 38 V23 stated R11 needed limited with one staff assistance with transfer, bed mobility, and toileting. V23 stated R11 was at risk for falls. On 2/22/23 at 10:04 am, an interview conducted with V34 (Restorative Director). V34 stated V34 is in-charge of the fall program in the facility. V34 stated R11 fell on 12/30/22 at around 4:47 PM. R11 slipped off the bed and woke up on the floor. V34 stated R11 required extensive 2 staff assistance with bed mobility, transfer, and was incontinent of bowel and bladder. V34 stated R11 was cognitively impaired with diagnosis of dementia psychotic disturbances. V34 stated R11's fall care plan was initiated on 12/31/22 right after the fall. V34 stated prior to R11's fall, R11 had no fall care plan. V34 stated R11 was at risk for falling based on the fall risk assessment dated 10/4/22. V34 stated that if fall care plan is not implemented repeated falls could potentially happen. V34 stated that the fall care plan should be implemented upon admission and updated quarterly, annually, significant changes, or after a fall. V34 stated that fall care plan should have the residents' updated and personalized goals and updated personalized interventions. V34 stated that the purpose of the fall care is to keep the residents safe and to keep the interventions in place to prevent residents from falling. Facility's policy titled; "Fall Prevention and Management" version 080317 reads in part: Fall Prevention Protocol III. Fall Prevention A. Identify risk factors B. Implements individualized approaches/interventions based upon resident risk 1. The Fall Prevention Strategies/Interventions list may be used to identify appropriate	S9999		

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S9999	Continued From page 39 interventions 2. Approaches/interventions should focus on risk factors identified V. Care plan A. Interdisciplinary care plan is implemented for residents at risk and may include 1. Interventions to prevent falls B. Evaluations of the interventions is completed 1. Quarterly 2. Post fall 3. Interventions are modified as indicated based upon evaluated efficacy of the interventions Facility's policy titled; "Standard Supervision and Monitoring" not dated, reads in part: Procedure: 1. When a resident has been assessed either by the staff nurse of Psychosocial staff to have stable physical and psychosocial needs regular rounds will be maitnained to ensure that all of the resident's needs are met. R8's face sheet documents in part diagnoses that include but are not limited to difficulty in walking, weakness, abnormalities of gait and mobility, cognitive communication deficit, history of falling, and Alzheimer's disease. R8's 12/02/2022 Admission Minimum Data Set (MDS) Assessment documents in part that R8 requires supervision and one-person physical assist for locomotion on the unit. R8's Fall Risk Review dated 10/31/2022 documents in part that R8 is a high risk for fall. R8's comprehensive care plan contains a focus initiated on 11/10/2022. It documents in part that R8 is at high risk for falls related to behavioral concerns and history of falls prior to admission.	S9999		

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S9999	Continued From page 40 V7's (Registered Nurse) progress note dated 12/10/2022 02:33 AM documents in part: "Patient [R8] was observed on the floor in the dining area. Patient informed the writer that [R8] slept in [R8's] wheelchair and fell face down from [R8's] wheelchair." R8 had a laceration to forehead. Facility sent R8 to the hospital for evaluation. During a telephone interview on 02/22/2023 at 7:45 AM, V7 stated R8 fell in the dining room on 12/20/2022 around 2:00 AM. V7 stated R8 was sitting up in a wheelchair in front of the television. V7 stated R8 fell asleep and fell from the wheelchair. V7 stated "to my recollection no one was there with her." V7 stated R8 with behaviors of going to the dining room at night without telling staff. V7 stated "we don't tell [R8] nothing. [R8] will fight you to the moon on that. Whatever and whenever [R8] wants to do it, [R8] does it." This was not reflected on R8's comprehensive care plan. V7 stated last seeing R8 in the bedroom about an hour prior to the fall. On 02/22/2023 at 9:59 AM, V1 (Administrator) stated all dining rooms should be supervised when there are residents present. V1 stated this goes for all shifts including night shift. On 02/23/2023 at 12:10 PM, V2 (Director of Nursing) stated a staff member must always be supervising in the dining room when residents are present. V2 stated during night shift staff should be doing rounds at least hourly to make sure everyone is in bed and that no one is on the floor. R8's hospital records from the 12/20/2022 admission documents in part that R8 sustained a +4-centimeter laceration to the forehead which required stitching. R8 also sustained multiple	S9999		

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S9999	Continued From page 41 pelvic fractures and a sacral fracture which required hospital overnight stay with orthopedic consult. Facility's undated "Standard Supervision and Monitoring" policy documents in part: "The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs." "If the resident cannot be guided, supervised, or redirected during regular intervals of rounds, the resident may require 30-minute, 15-minute or 1:1 supervision." Facility's "Fall Prevention and Management Program" policy version 080317 documents in part: "Through an interdisciplinary approach, this facility will provide fall prevention assessment, implement interventions to prevent falls as much as possible, and manage post-fall treatment." R7 was 77 years old, initial admission date 1/17/2022 and discharged date 12/07/2022. R7 brief interview for mental status dated 10/18/2022 scored at 7 that means R7 has impaired cognition. Under functional status bed mobility, ambulation, walk in room and corridor all 1-person limited assistance. On 02/21/2023 at 11:18 AM. V12 (R7's Sister) stated that because of the fall on 12/06/2022, R7 went to hospital on 12/08/2022 and had a hip surgery on 12/10/2022. After R7 left the hospital, he was transferred to a different Long-Term Care facility where he expired on 01/16/2023. Per R7's notes dated 12/06/2022 (04:12 AM) by V8 (Licensed Practical Nurse), in part reads: Approximately 4:00 AM this morning, R7 was	S9999		

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S9999	Continued From page 42 found out of bed. And prior to the incident, R7 was found not acting as usual. Per R7's notes dated 12/06/2022 (01:26 PM) by V8 (Licensed Practical Nurse), in part reads: R7 was observed kneeling by the side of the bed. On 02/22/2023 at 09:56 AM, V8 said that she cannot remember anything to all the questions that were asked by the surveyor. On 02/24/2023 at 09:07 AM, V52 (Former Director of Nursing) stated that she is the nursing consultant for the company and was acting as the DON (Director of Nursing) during that time. V52 said, "I am sorry I cannot remember. I can hardly remember R7 vaguely. And I cannot account to what resident condition at that time." R7's notes dated 12/08/2023 by V6 (Licensed Practical Nurse), documents in part: R7 was unresponsive with oxygen saturation of 78% with labored breathing. 911 was called and R7 was transported to the hospital. On 02/24/2023 at 09:43 AM, V6 said, "I am an agency nurse, but I remember sending R7 out to the hospital on 12/08/2022. I was called by a CNA (Certified Nursing Assistant) who told me that R7 was not responsive. And when I checked R7 oxygen saturation it was low. I took care of R7 in the past beside the time when I sent him (R7) out of the hospital. R7 has altered mental status. And yes, he was walking or ambulating by himself." V6 was informed that per R7's assessment he (R7) needs 1-person to assisting when walking. V6 said, "Was I the one who made that assessment? R7 was walking by himself, he (R7) walks independently." Facility Incident Report Form dated 12/09/2022	S9999		

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S9999	Continued From page 43 marked as initial report, in part reads: Under description of occurrence, documentation reads: Received update from hospital regarding R7's status of left femur fracture. Full investigation initiated. No description was provided as to occurrence of the incident. On 02/23/2023 at 2:34 PM. V2 (Director of Nursing) stated related to R7's report, that there should have been detailed description of the event. V2 said, the present documentation does not account as complete. V2 said after reading (Description of Occurrence), "No that is not complete. It does not amount to complete description." R7's notes dated 12/09/2022 by V5 (Licensed Practical Nurse), documents in part reads: She (V5) spoke with a nurse that R7 was admitted with left femur fracture. R7's notes dated 08/30/2022 by V61 (Physician), in part reads: R7 seen and examined today for follow visit. R7 has reported behaviors at times including attempts to elope. Requires redirection from staff. Care plan for elopement was initiated on 07/18/2022 and was never reviewed. On 02/22/2023 at 09:56 AM. V2 (Director of Nursing) said, "Yes, I don't think that R7 has an updated Fall Risk Assessment before the fall. I will check if R7 has any current fall assessment. But of course, if he does not have any, I cannot give it to you. Yes, care plan for fall must be updated quarterly. After the fall, there must be a head-to-toe assessment done, pain assessment needs to be done related to the fall that must be comprehensive to make sure that R7 has no pain. R7 BIMS score is at 7 that means he is cognitively impaired and may not verbalized how	S9999		

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S9999	Continued From page 44 he felt." Fall Assessment and care plan is needed to have interventions help prevent falls." R7 most recent Fall Assessment was done on 02/01/2022. Fall care plan was initiated on 07/20/2022. Fall interventions for the care plan were also dated on 07/20/2022 and was never reviewed. Per R7's notes dated 09/0/2021, R7 has history of fall that was not care planned. Since fall care plan was only initiated on 07/20/2022. Fall Prevention and Management Program not dated, in part reads: The facility is committed to safety and maximizing each resident's physical, mental, and psychosocial well-being. The purpose of our Fall Prevention and Management Program is to: " Provide our residents with an interdisciplinary approach to assess risk of falls " Provide appropriate interventions to prevent falls " Ensure that in the event a fall occurs, the fall will be investigated, appropriate emergency treatment will be provided, additional interventions will be implemented to prevent another fall from occurring as much as possible. Fall Prevention Protocol not dated, in part reads: Fall Risk Assessment is completed quarterly. Care Plan: Evaluation of the interventions is completed. Review will be done quarterly. Interventions are modified as indicated based upon evaluated efficacy of the interventions. (A) 4 of 4	S9999		

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S9999	Continued From page 45 300.610a) 300.1210b) 300.1210c) 300.1210d)1 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 300.1210 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: 1) Medications, including oral, rectal, hypodermic,	S9999		

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S9999	Continued From page 46 intravenous and intramuscular, shall be properly administered. These Requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain R1's pain levels for 1 of 5 residents reviewed for medications. This failure resulted in R1 being hospitalized due to pain and experiencing pain of 11 on a scale of 1 to 10. Findings include: On 3/1/23 at 9:01 am, R1 said he was in terrible pain during his stay at the facility. R1 said, his pain was 11 on a pain scale of 1 to 10. R1 said, he got no pain medications during his stay and he was withdrawing from opioid as he got no pain treatment at the facility. R1 said, his pain felt like "I want to saw my leg off, I also felt insignificant." R1 said, whenever he would press the call light and staff would come in, they would inform him they already know what he needs (referring to pain medications). R1's face sheet documents in part diagnoses including but not limited to monkeypox, rash and other nonspecific skin eruption. R1's 'Pain Review' dated 12/01/2022 9:37 PM documents in part that R1 experienced pain occasionally in the last 5 days. R1 described it as moderate pain. R1's care plan initiated 12/02/2022 documents in part that R1 has an alteration in comfort secondary to pain related to an alteration in skin integrity. Interventions initiated 12/02/2022 include "Give medications as ordered. Keep the	S9999		

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S9999	Continued From page 47 physician informed of the resident's progress." R1's physician order sheets and Medication Administration Record (MAR) document in part orders for ibuprofen, hydrocodone-acetaminophen, and morphine sulfate for pain as needed (PRN). R1's MAR documents in part that R1 did not receive any pain medications PRN. On 02/21/2023 at 3:25 PM, V18 (Facility's Customer Service Representative) stated R1 called V18 on 12/02/2022 complaining about not receiving pain medication. On 02/22/2023 at 10:55 AM, V31 (Nurse) stated R1 complained of being in pain on 12/03/2022. R1 called V77 (R1's Outside of Facility Physician) repeatedly to report the pain and not receiving medication. V31 stated "the doctor called me and said if you guys aren't able to keep pain down, just send [R1] out." V31 stated "[R1] wasn't saying what [R1's] pain was at from 0-10 but [R1] was saying that [R1] was in excruciating pain. [R1] just said [R1] was in pain 'I'm in pain.' I remember his mood was not stable." V31 stated there was an order in the computer for hydrocodone-acetaminophen and morphine sulfate PRN but pharmacy could not dispense it without a prescription faxed to them. Surveyor asked if there was any documentation that the facility attempted to get a prescription for the medications or if staff followed-up with V69 (Nurse Practitioner) or V70 (R1's Physician) regarding R1's pain. V31 reviewed electronic medical records and stated could not find it. V31's (Nurse) progress note dated 12/03/2022 5:18 PM documents in part R1 does not have any PRN pain medication. R1 sent to the hospital for	S9999		

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S9999	Continued From page 48 pain. When V31 asked V77 (R1's Outside of Facility Physician) what the diagnosis was for hospital evaluation, V77 stated "pain because its Saturday and its not much I can truly do for [R1]." On 02/23/2023 at 12:10 PM, V2 (Director of Nursing) stated during admission, the nurse has to reconcile the medications with the doctor and get clarifications. V2 stated "They have to ask the doctor whether to continue the narcotics. If we don't have a script, the doctor has to give us the script or they contact the pharmacy themselves." V2 stated nurses are supposed to document this conversation with the doctor whether the facility is waiting for the prescription or the doctor is going to call the pharmacy. During a telephone interview on 02/23/2023 at 1:03 PM, V69 (Nurse Practitioner) stated [V69] was not aware of a resident that was admitted to the facility with monkey pox. V69 stated if a resident with monkey pox has open wounds, a provider would be at the facility within 24-48 hours to assess. V69 stated "so we did not get a call. So that was definitely three days of miscommunication. Someone like [R1] would definitely need something more for pain." V69 stated if a resident is reporting pain and requesting stronger medications, the providers would order a pain consult as soon as possible. R1's physician order sheets did not read an order for pain consult. Facility's undated "Management of Pain" policy documents in part: "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014781	A. BUILDING: _____ B. WING _____	C 02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(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
S9999	Continued From page 49 comfort, exercise greater independence, and enhance dignity and life involvement." Policy documents in part that the facility with achieve these goals through "promptly and accurately assessing and diagnosing pain," "monitoring treatment efficacy and side effects," and "Using pain medication judiciously to balance the resident's desired level of pain relief with avoidance of unacceptable adverse consequences." (B)	S9999		