STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002711	A. BUILDING: _____ B. WING _____	03/17/2023

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UNIVERSITY NSG & REHAB CENTER	1095 UNIVERSITY DRIVE EDWARDSVILLE, IL 62025

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations	S9999		

Statement of Licensure Violations

(Violation 1 of 2)

300.610a)
300.1210b)
300.1210d)4)

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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

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:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide resident bariatric equipment/bedside commode needed to promote resident dignity for 1 of 1 resident (R185) reviewed for accommodation of needs in a sample of 35. This failure resulted in R185 having feelings of embarrassment regarding being made to urinate/defecate in an adult incontinent brief instead of toileting.

Findings include:

R185's Undated Face Sheet, documents he was admitted to the facility on 3/1/2023.

R185's Electronic Medical Record, dated

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S9999	Continued From page 2 3/6/2023 at 2:14 PM documents R185 weighed 540.2 pounds and is 5 foot 11 inches tall. R185's Admission Minimum Data Set (MDS) dated 3/10/2023 documents R185 is alert, frequently incontinent of bladder and occasionally incontinent of bowel. R185's MDS documents R185 requires supervision with setup assistance for toileting. On 3/16/2023 at 10:00 AM R185 was sitting in his wheelchair. He stood up, leaned against his dresser and showed an incontinence brief under him. R185 stated, "I have a wound on my buttocks and staff put cream on it several times a day. There isn't a place for me to poop because I can't fit on the toilet in the bathroom in this room, and the facility doesn't have a bedside commode (BSC) that's big enough for me. When I have to poop staff told me to go in my {adult incontinence brief} and they will clean me up. I push my call light after I am done pooping and staff assist to clean me up within 20 minutes. I know when I have to poop and to have to go in my {adult incontinence brief} and have staff clean me up is embarrassing. No staff have offered to take me to the shower room to poop. I wouldn't be able to walk or propel myself to the shower room. I've talked to the facility social worker and nursing about the need to get a bariatric bedside commode, no one is responding to me. I just want to poop like a regular person, on a toilet/BSC." On 3/16/2023 at 1:50 PM V6 *(Certified Nursing Aide/CNA) stated, "I have asked (V28/Maintenance Director), (V27/Housekeeper) and (V12/Social Worker) and they told me to look in the storage room for a BSC for (R185), and I have looked for one in the storage room. There	S9999		

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S9999	Continued From page 3	S9999		

were some there, but not a bariatric one. (R185) has to lay in bed and poop in a {adult incontinence brief} and we clean him up afterwards. (R185) doesn't want to have to poop in a {adult incontinence brief} or even wear a {adult incontinence brief}, but he won't fit on the toilet in his room, and they don't toilet residents in the shower rooms on the halls."

On 3/16/2023 at 3:00 PM V24 (CNA) stated, "(R185) always gets upset when he has to have a bowel movement. He doesn't have a BSC that fits him and (R185) doesn't fit in his bathroom because he is obese, so he has to lay in bed with a brief on, have a bowel movement, then we get him cleaned up." V24 stated R185 told her time and time again that he wanted a BSC that was big enough for him and she told nurses about it (names unknown), but he had to go potty in his brief because there wasn't a toilet/BSC big enough for R185's use.

On 3/16/2023 at 2:30 PM V2 (Director of Nursing/DON) stated at one point R185 had a bariatric BSC but it went missing. V2 stated they have ordered R185 one and put a toilet riser in his bathroom in his room today. V2 wasn't aware R185 was told by staff to have a bowel movement in his pants because the facility didn't have the proper equipment for him.

On 3/16/2023 at 3:30 PM R185 was sitting up in his wheelchair playing a video game. (R185) stated staff put a rise over his toilet but he won't fit to sit on it because he is wider than the toilet riser, and he attempted to sit on it already. R18 stated it wasn't wide enough for him; it poked him on both sides, and he was afraid it would cause skin breakdown on both sides.

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S9999	Continued From page 4 On 3/17/2023 at 9:00 AM V12 (Social Worker) stated no one reported to her that (R185) didn't have a toilet so he could have a bowel movement. V12 stated she ordered a bariatric BSC for him when she became aware of the issue on 3/16/2023. R185's Equipment Invoice, dated 3/16/2023 at 4:39 PM, documents a bariatric commode was ordered. A Written Statement, undated, written by V2 (DON) documents, "(V12) and I spoke with (R185) on 3/16/2023 to inform him we had ordered him a larger bedside commode that could accommodate him. Resident was very pleased. Stated he did have a bedside commode when he arrived in facility, but it was removed because it was not large enough. Stated he tried using that toilet, but it was too close in proximity to the wall. He was also given a toilet riser but said it would be too small and therapy felt a bedside commode would be better. Resident stated he uses bedpan and said he has bedside commode; he will still need help cleaning up because he can't reach his buttocks. At home he used a toilet but there was more room in bathroom, and he still needed help wiping. Resident stated he is actively trying to lose weight so he can do these things himself. He said he is pleased with the care and is very outspoken. He stated, 'If there is a problem with care that I will let you and (V12/Social Worker) know myself.'" On 3/17/2023 at 12:00 PM V28 (Maintenance Director) stated, "(R185) had a BSC when he was initially admitted to the facility. At one point (R185) asked for staff to remove the BSC from his room." V28 stated he didn't know why R185 didn't want the BSC anymore or what size the BSC	S9999		

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S9999	Continued From page 5 was. On 3/17/2023 at 1:10 PM, V27 (Housekeeping Director) stated when R185 was initially admitted he had a bariatric bed and a BSC in his room; she didn't know what size it was but one day it was no longer in his room. V27 stated R185 didn't tell her he needed a bigger BSC commode, and no staff told her he needed one either. On 3/17/2023 at 1:48 PM V23 (Nurse Practitioner) stated, "It is not dignified to tell a resident to have a bowel movement in his pants because the facility didn't have a bariatric BSC to fit the resident." The Facility's Accommodation of Needs policy, revised 1/2020, documents "Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents' wishes. Staff will interact with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains dignity. Staff will help to keep adaptive devices clean and in working order for the resident." (B) (Violation 2 of 2)	S9999		

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S9999	Continued From page 6 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 300.1220b)3) 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:	S9999		

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S9999	Continued From page 7 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor, treat	S9999		

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S9999	Continued From page 8 per standards of practice and implement interventions to prevent the formation and/or worsening of pressure ulcers for 2 of 9 residents (R68 and R282) reviewed for pressure ulcers in the sample of 35. This failure resulted in R282 developing two new unstageable pressure ulcers to bilateral heels. Findings include: 1. R282's Face Sheet, undated, documents diagnoses including Parkinson's disease, pressure ulcer of sacral region, unstageable, dysphagia, oropharyngeal phase, pressure ulcer of left hip, unstageable, mild protein calorie malnutrition, and dementia in other diseases classified elsewhere, severe, with agitation. R282's Minimum Data Set (MDS) dated 3/6/23 documented R282 was moderately cognitively impaired, required limited 1+ person assistance for bed mobility, required extensive 2+ person assistance with transfer, activity of walking activity did not occur over the previous 7-day period, and had one unstageable pressure ulcer that was present on admission. R282's Care Plan last revised 2/28/23 documents, "I was admitted with a pressure ulcer to left hip. My co-morbidities include: malnutrition, repeated falls, atherosclerotic heart disease, dementia." The Care Plan interventions, dated 2/28/23, documented the following: Administer medications as ordered; Administer treatment as ordered and monitor for effectiveness; Assess/record/monitor wound healing, measure length, width, and depth where possible; Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD (Medical Doctor);	S9999		

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S9999	Continued From page 9 Education resident /family/caregivers as causes of skin breakdown including transfer/positioning requirement, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, follow facility protocols for prevention/treatment of skin breakdown; if resident refuses treatment, confer with resident, IDT (Interdisciplinary Team) and family to determine why and try alternative methos to gain complaint; Monitor/document/report to MD PRN changes in skin status such as appearance, color, wound healing, signs and symptoms of infection, wound size and state, obtain and monitor lab/diagnostic work as ordered, and RD (Registered Dietitian) to review and make recommendations PRN. The Care Plan did not include any new interventions for wound care after 2/28/23. R282's Weekly Skin Assessment dated 3/2/23 documented existing skin conditions/wounds to left hip, buttocks, and bilateral heels that were healing. There were no new skin conditions/wounds listed at that time. R282's Progress Note dated 3/5/23 at 3:18 PM documented, "Resident is new to facility. Wound to coccyx. Low air loss mattress with bolsters to help with wound. Areas to skin changed daily. Will monitor." R282's "Specialty Physician Wound Evaluation & Management Summary" dated 3/7/23 documented, "Chief Complaint: This patient has multiple wounds." This summary documented a total of five wounds to include the coccyx, upper left sacrum, right lower buttock, left hip, and left dorsal hand. V22 (Wound Specialist) documented treatment orders and recommended dietary consult, pre-albumin level, and culture of stage 4	S9999		

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S9999	Continued From page 10 pressure ulcer on coccyx. R282's Physician Order dated 3/9/23 documents, "Dietitian to evaluate as needed for nutritional interventions." R282's Weekly Skin Assessment dated 3/9/23 documented resident had existing skin conditions/wounds on left hip, buttocks and bilateral hands that were healing. There were no new skin conditions listed at that time. R282's Progress Note dated 03/14/23 at 10:49 AM documented, "Coccyx pressure ulcer measuring 5cm (centimeters) x (by) 5 x 2cm. left hip pressure measuring 6 x 4 x 0.2. Left upper sacrum measuring 2 x 1 x UTD (unable to determine)." R282's "Specialty Physician Wound Evaluation & Management Summary" dated 3/14/23 documented the resident had previous wounds to coccyx, upper left sacrum, right lower buttock, left hip, and left dorsal hand. In addition, there was a "Focused Wound Exam (Site 6) - unstageable (due to necrosis) of the right heel, full thickness" measuring 2.5 cm (centimeters) x 3.5 cm x not measurable cm and a "Focused Wound Exam (Site 7) - unstageable DTI (deep tissue injury) of the left heel partial thickness" measuring 1.5 cm x 1.5 cm x not measurable cm. R282's Weekly Skin Assessment dated 3/16/23 documented resident had existing conditions/wounds on buttocks, left hip and bilateral hands. There was documentation of new pressure ulcers on R282's bilateral heels. On 3/16/23 at 1:58 AM, R282 was in his wheelchair in the therapy gym wearing tennis	S9999		

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S9999	Continued From page 11 shoes with his shoes on the foot pedals of his wheelchair. On 3/16/23 at 1:25 PM, V3 (Assistant Director of Nursing/ADON) stated, "(R282) stated he will only allow surveyors to observe wound care if they pay him." On 3/17/23 at 8:00 AM, R282 was sitting in his wheelchair in his room wearing tennis shoes with shoes on the foot pedals of his wheelchair. On 3/17/23 at 8:03 AM, V3 (ADON) stated, "(R282)'s pre-albumin is pending. His wound culture is ordered for today. I thought it was done, but the lab said they didn't have it, so it is being done today. It doesn't really look infected, but it has that kind of chronic slough, so I think the doctor wanted to order the culture just to be sure. I could have sworn the heel wounds were here on admission, but it was not on the previous notes, and it was on Tuesday's notes, so I'm treating them as new. I put in orders for the Betadine which is now being treated. Our dietitian usually comes at the end of the month but does work remotely. I will see if she has any documentation for (R282)." On 3/17/23 at 10:00 AM, V23 (Nurse Practitioner) stated, "If a resident came in with wounds and is at high risk for developing wounds, I would expect preventative measures to be in place. This could include floating heels, heel boots, barrier cream, special mattresses, and things like that. I would expect those to be documented in the Progress Notes. Dietitian consults are important because they review the patient and estimate their nutritional needs. Sometimes they will recommend supplements, vitamin C, (arginine supplement), and extra protein to help rebuild	S9999		

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healthy skin tissue. Poor nutrition can cause continued skin breakdown and abscesses. I would expect the dietitian to see the resident on their next visit to facility. If it is going to be a while, I would expect the facility to contact the dietitian, because these interventions need to be implemented right away."

On 3/17/23 at 11:45 AM, V3 (Director of Operations/Infection Prevention Nurse Consultant) stated, "I don't have any documentation that we did anything to prevent (R282's) wounds."

On 3/17/23 at 12:25 PM, V1 (Administrator) stated she would expect facility to take preventative measures to prevent wounds and document all preventative measures.

As of 3/17/23 at 2:00 PM, no Registered Dietitian (RD) documentation was received from Facility.

The Facility's "Nutritional Assessment" Policy revised October 2017 documents, "As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident." "The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition." "The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk for impaired nutrition." "Increased need for calories and/or protein - onset or exacerbation of diseases or

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S9999	Continued From page 13 conditions that result in a hypermetabolic state and an increased demand for calories and protein (e.g., cancer, COPD, liver disease; hyperthyroidism, wounds)."	S9999		
	The Facility's "Pressure Ulcers/Skin Breakdown - Clinical Protocol" Policy revised April 2018 documents, "The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers." "The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions." "The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents." The Facility's "Wound Care" Policy revised October 2010 documents, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." "Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound." "Apply treatments as indicated." 2. R68's Undated Face sheet documents she was admitted to the facility on 1/27/2023. R68's Hospital Discharge Paperwork, dated 1/27/2023 documents, "VRE (Vancomycin -Resistant Enterococci) onset 1/6/2023 in resident's bone on buttocks." R68's Braden Scale for Predicting Pressure Sore Risk, dated 1/28/2023 at 1:58 AM documents, "High risk."			

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S9999	Continued From page 14 R68's Admission Minimum Data Set (MDS), dated 1/31/2023 documents R68 was severely cognitively impaired, total dependence of two persons physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. R68's MDS documents R68 is at risk for pressure ulcers and had a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) present upon admission. R68's MDS documents skin and Ulcer/injury treatments pressure reducing device for chair and bed, pressure ulcer care and application of ointments/ medications. R68's Care Plan, dated 1/31/2023 documents R68 was admitted with stage IV pressure area to coccyx. Goal: pressure ulcer will show signs of healing through the review date. Approaches: administer medications and treatments as ordered, assess/record/monitor wound healing, measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the MD (medical doctor), follow facility protocols for the prevention/treatment of skin breakdown, if the resident refuses treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance, document alternative methods, inform the resident/family of any new area of skin breakdown, observe the (s/s) signs and symptoms of pain or discomfort, pain management as per MD orders PRN (when necessary), observe for s/s of infection or pain, notify MD/NP (nurse practitioner) as needed, obtain lab/diagnostic testing as ordered and	S9999		

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S9999	Continued From page 15 report results to MD/NP, pressure relieving mattress to bed, RD (registered dietitian) to review and make recommendations PRN, sees wound physician wound care specialist and turn and position when providing care as needed or requested. Problem: diagnosis of coccygeal osteomyelitis (VRE) and at risk for medical complications due to this diagnosis. Goal: will have no s/s of complications from my osteomyelitis through the next review." R68's Physician's Order Sheet (POS), dated 1/2023 documents diagnoses included pressure ulcer of sacral region, stage IV. R68's Nursing Progress Note, dated 1/27/2023 at 4:59 PM, documents, "Resident arrived via EMS (emergency medical services) from a local hospital. Alert and oriented x1. Per EMS she knows her name and DOB (date of birth). Assisted from stretcher to bed by nursing staff and EMS. At this time, this nurse assisted CNA (Certified Nursing Aide) in skin check and rolled resident from side to side with little difficulty to remove hospital linens. Resident C/O (complained of) generalized pain. Large sacral wound with slough noted to sacrum. Dressing intact. MD (physician) aware of resident arrival." R68's Focused Observation (admission nursing assessment) dated 1/27/2023 at 6:26 PM written by V3, Assistant Director of Nurses (ADON) documented, "alterations in skin? Yes." No assessment of the Stage IV pressure ulcer on R68's coccyx was documented including location, length, width, depth, and drainage and odor. R68's Electronic Medical Record, documents no skin assessment dated 1/27/2023 through 2/2/2023.	S9999		

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S9999	Continued From page 16 R68's Nursing Progress Note, dated 2/3/2023 at 3:49 PM, documents, "Wound physician here this week to see resident for stage 4 pressure to sacrum measuring 11.5 centimeters (cm) x (by) 12.0 cm x 0.9 cm. moderate serous exudate. 30% necrotic tissue, 20% slough and 50% granulation tissue. post-surgical wound of left lower back measuring 1.0 cm x1.0 cm x 0.6 cm. moderate serous exudate with 100% slough. continue current treatment orders. POA (power of attorney) aware." R68's Nursing Progress Note dated 2/10/2023 at 12:31 PM, documents "Wound physician here this week to see resident. stage 4 pressure ulcer to sacrum measuring 10.0 cm x 13.0 cm x 0.9 cm. moderate serous exudate with 30% necrotic tissue, 20% slough and 50% granulation tissue. all tx (treatment) orders are ssd (silver sulfadiazine) cream mix with collagen particles and apply to wound bed, cover with calcium alginate, and dry dressing. continues on LAL (low air loss) mattress. Hospice, MD and POA aware. wounds present on admission." R68's Nursing Progress Note, dated 3/3/2023 at 12:55 PM documents, "Wound physician here to see resident this week. sacrum wound measures 7.0 cm x 13.0 cm x 0.9 cm with moderate serous exudate, 20% slough and 50% granulation tissue wound has improved." R68's March 2023 POS documents 3/9/2023 cleanse sacral wound daily with wound cleanser and 4 x 4 gauze. Pat dry. Mix compound (streptomycin, flucytosine, vancomycin) capsules with 15 pumps of bassa-gel into mixing container provided. Apply collagen particles to wound bed, cover with calcium alginate, apply silicone	S9999		

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S9999	Continued From page 17 bordered dressing daily. May change as needed. On 3/16/2023 at 10:30 AM there was an isolation sign was on R68's door. V25 (Licensed Practical Nurse/LPN) entered R68's room wearing gown, gloves, booties, and gloves. When V25 entered (R68's) room, no handwashing or hand sanitize was observed. When V6 (CNA) turned R68 to her right hip, there was a large wound dressing on R68's sacrum/coccyx and left buttocks. All dressings were saturated with drainage and were not intact. V25 removed the old dressings and stated she's not good at describing the wound drainage, but it was bloody. V25 stated she's not good at describing wound bed, but that it had blood on it. V25 then removed multiple pieces of 4 x 4 gauze from R68's coccyx wound bed. V25 cleansed R68's coccyx wound bed with wound cleanser and patted dry with gauze. V25 dropped the coccyx foam border dressing on the floor. V25 removed her gloves and left the room. She reentered R68's room with gloves on, touching the door and R68's bedside table, then applied collagen wound filler (powder) to same gloved hands and applied the powder directly to the coccyx wound bed. V25 didn't wash her hands or use hand sanitizer when she reentered R68's room. V25 then applied calcium alginate to the coccyx pressure ulcer bed, then covered it with a large silicone foam dressing. V25 removed the non-intact dressing on R68's left lower buttock that had moderate amount of serous drainage and stated she needed to get the wound treatment clarified. V25 didn't cover the pressure ulcer at that time. This area was approximately the size of a quarter. V25 left the room at that time. R68's Nursing Progress Note, dated 3/16/2023 at 12:11 PM, documents "Resident seen by (V22)	S9999		

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S9999	Continued From page 18 Wound Physician for wound care. Sacral wound measures 8.0 cm x 12.0 cm x 0.9 cm with moderate amount of serous exudate. 30% necrotic 20% slough and 50% granulation. No change to wound. Per MD he believes it is a Kennedy Ulcer. Resident is terminally ill and continues on hospice." There was no assessment of left buttock wound/open area. On 3/16/2023 at 2:00 PM, V6 (CNA) and V25 (LPN) entered R68's room to complete wound treatment. V6 turned R68 to her right hip which showed R68's left lower buttocks pressure ulcer didn't have a wound dressing on it. Observation of the pad under R68 showed serous drainage on it from the left lower buttock open area. V25 cleansed the open area with wound cleanser and gauze. V25 applied SSD ointment, collagen particles mixed in a medication cup and applied it with a q tip applicator. V25 put calcium alginate over the wound bed then applied a silicone foam bordered dressing. The coccyx dressing was lifted on the edges in two sides, and the wound could be seen through the lifted edges at that time. On 3/16/2023 at 2:15 PM, V25 stated she had to get the lower left buttock wound treatment clarified and so she had to wait to get a physician's order for it. When she did the wound treatment on 3/16/2023 morning, the coccyx pressure ulcer and the lower left buttock dressings were not intact, no staff told her the wound dressings were not intact until V6 told her until at approximately 10:30 AM. V25 stated she thinks the dressing aren't intact because of the amount of drainage from the pressure ulcers. V25 stated she noted the wound on R68's left lower buttocks was open but the wound physician would be the one to assess it. V25 stated she	S9999		

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S9999	Continued From page 19 always applies the collagen wound filler (powder) with gloved hands, she changes gloves and either uses hand sanitizer and washes her hands before and after pressure ulcer treatment. She didn't recall entering R68's room with gloved hands and applying the collagen wound filler to the wound bed with the gloved hand without washing her hands or using hand sanitizer first. R68's Electronic Medical Record, dated 3/17/2023, did not include documentation or assessment of the open area on R68's lower left buttocks. On 3/16/2023 at 2:30 PM, V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) were interviewed. V2 stated she expected staff to follow physician's orders for pressure ulcer treatments and to notify the resident's physician if the dressing isn't staying on and intact due to the amount of drainage. If staff found a pressure ulcer's dressing was not on or intact, they expected staff to notify the nurse and the dressing should be redone, so it is intact at all times. V3 stated this is to control the infection, control drainage and benefit wound healing. V3 stated staff are expected to sanitize their hands before entering the resident's room and then wash their hands prior to providing pressure ulcer treatment. V3 stated when staff need to get skin/wound care orders clarified, a dry dressing should be applied to the area and a physician's order should be on the POS within 1-2 hours. V2 and V3 stated they didn't know the initial pressure ulcer dressing was done at 10:30 AM and the resident didn't have a dressing on the lower right buttocks until 2:00 PM today. They also were not aware R68's coccyx wound dressing was not intact on all edges. V3 stated if the pressure ulcer dressing isn't intact, and the correct pressure	S9999		

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S9999	Continued From page 20 ulcer treatment isn't administered per the POS it would ultimately cause the pressure ulcer to deteriorate. On 3/17/2023 at 10:00 AM, V23 (Nurse Practitioner/NP) stated upon admission a through skin assessment should be documented in the resident medical record including pressure ulcer size, tunneling/undermining, pain, drainage, appearance of the wound bed. This skin assessment should be documented in the resident's medical record within 24 hours so the facility has a baseline of what the pressure ulcer looked like on admission and if the pressure ulcer was facility acquired or if it was present upon admission. V23 stated she expected physician's orders to be followed and if a pressure ulcer dressing isn't intact, she expected staff to replace the dressing as soon as possible. V23 stated if the nurse needed to get pressure ulcer treatment clarification, she expected staff to apply a dry dressing over the area until the physician clarification is obtained because if the pressure ulcer was on the buttocks, that would keep feces out of it and help keep infection out. V23 stated she expected staff to wash their hands or use hand sanitizer prior to starting pressure ulcer treatment. V23 stated entering a resident's room with gloves on and touching items along the way, then providing pressure ulcer treatment (putting powder directly on the dirty gloves and applying it directly to the wound bed) is definitely improper infection control technique and can lead to infection to the wound bed because who knows what was on the items the nurse touched prior to applying the powder to the wound bed. The Facility's "Wound Care" Policy revised October 2010 documents, "The purpose of this procedure is to provide guidelines for the care of	S9999		

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S9999	Continued From page 21 wounds to promote healing ...Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound ...Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Apply treatments as indicated." (B)	S9999		