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	IL6014633	A. BUILDING: _____ B. WING _____	04/13/2023

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S 000	Initial Comments Annual Licensure and Certification Survey Investigation of Facility Reported Incident of February 22, 2023/IL157091	S 000		
S9999	Final Observations Statement of Licensure Violations I of III: 300.610a) 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 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent a resident from	S9999	Attachment A Statement of Licensure Violations	

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being verbally abused by a CNA (Certified Nursing Assistant) for one of two residents (R337) reviewed for abuse in the sample of 45. This failure resulted in R337's psychosocial harm as witnessed by R337's increased anxiety and agitation.

Findings include:

R337 was admitted to the facility on 04/04/2023 with diagnosis including but not limited to Malignant Neoplasm of Endometrium, Polyneuropathy, Osteoarthritis of knee, Essential Hypertension, and Acquired Absence of both Cervix and Uterus.

On 04/10/2023 at 01:42 PM Surveyor observed R337 laying the bed, with eyes closed. V16 (R337's husband) sitting at the bedside, indicated R337 is not able to be interviewed at this time.

On 04/10/2023 at 1:45 PM V16 (R337's husband) stated, "On Thursday, 04/06/2023, one of the staff said to R337, "I'm not going to turn you. I don't want to hurt my back. You're going to die anyways". R337 could still talk at that time, and she thought it was a Certified Nursing Assistant but I'm not sure. Later in the day, the same staff came into the room and R337 pointed at her to confirm that this was a person who said that to her. The incident might have happened after lunch time".

On 4/10/2023 at 3:38 PM V2 (Director of Nursing/Abuse Coordinator) stated, "I am not aware of any issues pertaining to R337. No one has reported any abuse allegations to me."
On 04/10/2023 at 3:56 PM V1 (Administrator) stated, "We don't know anything about the incident involving R337. We will start the abuse

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investigation right away."

On 04/10/2023 at 4:03 PM V3 (Assistant Director of Nursing) stated, "I was in my office on Saturday (04/08/2023), and I saw V16 passing by. I spoke to him about R337. I asked if everything is ok, V16 said that when Certified Nursing Assistants turn and reposition R337, should be more careful, but he said, not to worry about it. I didn't ask if there was a particular Certified Nursing Assistant who is not being careful during patient care. V16 stopped me from questioning him further. I told the assigned Certified Nursing Assistant to be careful with repositioning R337. If abuse was reported to me, I would report it to Abuse Coordinator right away but V16 said there was an issue with R337's repositioning, but V16 told me not worry about it". Per record review, Abuse Education Attendance Record reads in part, "Abuse Coordinator, When to Report Abuse, and Types of Abuse" and confirms V3 (ADON) attendance.

On 04/10/2023 at 4:18 PM Surveyor interviewed V16 in presence of another surveyor about the abuse incident that occurred on 4/6/2023. V16 confirmed the incident and R337 nodded her head and said, "Yes". V16 is expressed concerns about staff retaliation and apprehensive about initiated abuse investigation. R377 showed signs of anxiety, agitation, and fear during V16's interview. R337 grabbed V16's hand and said expressed "Take me home, I want to die at home".

On 4/11/23 at 10:43 AM V1 (Administrator) stated, "We were able to determine it is V23 (agency Certified Nursing Assistant) and we were trying to reach out to her, she is yet to respond. We talked to the V16, but he is not willing to talk

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about the incident anymore. We established that V16 reported to V3 (ADON) on Saturday 04/08/2023, V3 denied that there was an abuse allegation that was reported. We assessed R337 and interviewed residents who were assigned to the alleged abuser".

On 4/11/2023 at 11:37 AM V24 (Registered Nurse) stated, "R337 was assigned to me few times. R337 experienced big drop in cognition over the last few days. Even couple of days ago R337 was coherent and today R337 is incoherent and unable to speak. Last week R337 was able to answer some questions, trying to eat, even asked me for a can of ginger ale. I was also able to assess her pain. R337 was alert x1-2. Right now, R337 is not alert, gasping for air; hospice nurse assessed R337 yesterday and placed additional orders for end-of-life care." Surveyor further clarified if V24 was aware of abuse allegations that occurred on 04/06/2023. V24 stated, "I worked last Thursday (04/06/2023), but I was not aware of any incidents involving R337. There is a lot of agency staff that cause problems."

On 4/12/2023 at 9:41 AM and 4/12/2023 at 1:40 PM Surveyor called V23 (agency Certified Nursing Assistant), no answer, voicemail left.

On 04/12/2023 at 12:07 PM Surveyor requested V23's employee file, not provided.
Per record review, Agency Staff Orientation Checklist signed by V23 (agency CNA) on 03/25/2023, reads in part, "V23 oriented to Preventing Abuse, Neglect, Exploitation; Reporting and Investigation".

On 04/13/2023 at 2:26 PM Surveyor interviewed V10 (Attending Physician). V10 indicated that

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statement such as "I'm not going to turn you. I don't want to hurt my back. You're going to die anyways" expressed to a resident who is under hospice care could worsen depression or anxiety, furthermore V10 stated, "I don't know how people who say things like that to residents could work in the healthcare industry".

Per record review, "SG ANE and Investigations" policy dated 11/01/2004 reads in part, "Abuse is the willful intimidation with resulting in pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. IDENTIFICATION: When any allegation or confirmed abuse, neglect, mistreatment, or exploitation of a resident occurs including suspicion, the appropriate state agencies will be notified immediately including Federal Reporting using the Immediate and 5-day Federal reports and the local police or Ombudsman if indicated. The supervisor, Administrator and/or Director of Nursing will be notified immediately. Staff members involved will be removed from the schedule pending investigation."

"B"

Statement of Licensure Violations II of III:
300.610a)
300.1210b)
300.1210d)2)3)6)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall

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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:
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see

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S9999	Continued From page 6 that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to provide necessary care and radiological services in a timely manner, failed to follow the physician order for a STAT/immediate x-ray; failed to follow their diagnostic/labs notification policy and caused a delay in treatment for 1 (R187) of 3 residents reviewed for quality of care from the sample of 45 residents. This failure resulted in R187 waiting over 48 hours to obtain an x-ray that revealed a transverse fracture of the arm causing delayed treatment of the fracture. B. Based on observation, interview and record review, the facility failed to provide effective pain management for a hospice resident with severe cognitive impairment, failed to identify signs and symptoms of pain for 1 (R187) of 5 residents reviewed for pain in the sample of 45 residents. It can be determined that the reasonable person in the resident's position would have experienced pain from the left forearm fracture. Findings include: R187 is blind and cognitively impaired resident admitted to the facility on 2/20/23 for a 5-day hospice/respite stay and with diagnoses of Alzheimer's Disease, atrial fibrillation, obstructive sleep apnea, seizures, anxiety disorder, and cardiac pacemaker. Per facility medical records, R187 cannot communicate her needs and totally dependent on staff.	S9999		

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A facility federal report notification dated 2/27/23, authored by V6 (previous Director of Nursing) reads in part (but not limited to): "Per staff interview, on 2/22/2023, (CNA/Certified Nurse Assistant) dressed resident and reports skin intact and no skin alterations during morning care. Then 2 staff reports assisting resident to transfer using mechanical lift without any issues. Resident was sitting at nurse's station when staff assisted resident with her meals and then transferred to bed for incontinent care by 2 CNAs during AM shift. Resident was assisted with dinner while at nurse's station. Resident noted flailing arms and legs around during meals. No pain indicators noted at that time. Resident redirected with verbal stimuli, and she completed her dinner. At approximately 7:30 PM, 2 CNAs using mechanical lift transferred resident to bed without any issues. As CNA was removing resident's clothing, she noted a skin tear on left forearm and immediately alerted the nurse. Based on staff interview no fall noted or reported as resident was being supervised at nurse's station from change of shift until after mealtime. Resident was then transferred to bed by 2 CNAs for the night.
On 2/23/23, the hospice nurse came in to evaluate the resident and x-ray ordered with results as follows: There are transverse fractures involving the distal radius and ulna; with mild callus and minimal displacement. Left forearm fracture. Hospice and physician collaborated and determined to apply left arm splint, immobilize extremity, pain medication regimen revised, and referral made for orthopedic specialist. Resident admitted to our facility for 5-day respite stay and discharged to home on 2/24/23 with hospice care."

Efforts to contact V6 (previous Director of

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Nursing) during the survey were left unanswered. V2 (current Director of Nursing) indicated V6's agency did not want to provide her contact information and was currently assigned to work in an alternate nursing rehabilitation facility.

Interview with V2 on 4/10/23 at 11:00 AM stated, "I've only been here a month and that incident report was just laying on my desk. I don't know anything about it." Surveyor asked if she reviewed the incident report in anticipation of any investigations from the public health department. V2 stated, "No. I didn't get the chance to do that." Asked later which x-ray company the facility used, V2 indicated she was not certain but would obtain the information for the survey team.

A review of R187's progress notes show the following the timeline of events in the delay of care:
1. On 2/22/2023 22:01, V8 (Registered Nurse/RN) wrote, "CNA reported to nurse that she noted a skin tear on patient's left arm while changing her long-sleeved shirt in bed. Skin tear was noted to be 6 centimeters long ,1.25 centimeters wide on left arm. Scant amount of blood, no swelling, no bruising to surrounding area. Area was cleaned with normal saline, bacitracin applied, covered with dry dressing. Left message with doctor, husband was updated."

2. On 2/23/2023 21:15, V40 (agency RN) wrote, "Note Text: (x-ray/imaging company), "they have no one to take, to come and do x-ray tonight, a tech will be out in the morning to perform the x-ray."

3. On 2/24/2023 at 06:35, V37 (agency RN) wrote, "Note Text: Results of x-ray came in this

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am, resident noted with a left forearm transverse fracture of the distal radius and ulna with mild callus and minimal displacement. MD on-call number was called and a message for MD was left."

R187's radiology results report showed: "Findings: There are transverse fractures involving the distal radius and ulna with mild callus and minimal displacement. Conclusion: Left forearm fractures as described. Addendum: Acute fractures. Electronically signed by M.D. 2/24/23, 3:32 PM."

Efforts to reach V40 (agency RN) and V37 (agency RN) for interview could not be obtained and with no return calls.

On 4/13/23 at 2:15 PM V3 (Assistant Director of Nursing) stated, "I recall (R187), she was sitting by nurses' station a couple of days. She came in respite stay and wasn't here very long. I remember the V6 (previous DON) mentioned in our morning meeting about R187 getting a skin tear. The husband communicated with the staff that he wanted to know about the skin tear, so we followed up an x-ray for a skin tear." I did not look at the skin tear itself but If I recall correctly the nurse working that day was V8 (Registered Nurse/RN) so she must have done the assessment. Surveyor asked if obtaining x-rays for a skin tear was regular practice. V3 stated, "No, I found it odd that he requested an x-ray, but I think he wanted to rule out a fracture because he thought that maybe R187 may have fallen." Surveyor asked if R187 had a fall during her short time she was in the facility. V3 stated, "Not that I am aware of." Surveyor asked if that was a possibility given the number of falls that had occurred within the facility. V3 stated, "It could

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have but I nothing was reported to us." Surveyor asked what the x-ray results revealed. V3 stated, "R187 had fracture transverse on the arm." Asked about x-ray company used at facility. V3 stated, "The only concerns I have is that they (x-ray company) don't come in immediately." Surveyor asked if there was an issue with the x-ray company if she communicated this to administration. V3 stated, "No but I should have and will do so now." Surveyor asked the procedures of her nurses when an x-ray cannot be taken when ordered by the physician. V3 stated, "The nurses should call doctor again and inform the doctor that the x-ray company will not come until the next day. A "stat" order means right away and not tomorrow, so we should be following the doctor's order if he ordered it stat." Surveyor asked what the implications of not carrying out the doctor's order as given. V3 stated, "A delay in treatment can be harmful to the resident I guess because we should find out what's going on with the resident. In this case we found out she got a fracture." Surveyor asked whether she a transverse fracture would be a painful fracture. V3 stated, "I don't have much experience with fractures, but I would think they would be." Surveyor asked whether R187 would be able to communicate whether she had any pain or not. V3 stated, "I think we talked about that in our meeting, and I think the DON assessed her for no pain, but I will check and see if she got anything for it."

Interview with V10 (Physician) at on 4/13/23 at 2:45 PM stated, "I remember that resident was on hospice or respite care, and she was not in the facility very long." Surveyor asked if he was informed of the fracture. V10 stated, "Yes, I recall the facility informing me." Surveyor asked about transverse fractures. V10 stated,

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"Transverse fractures are painful. All fractures are painful." Surveyor asked if R187 should have been provided pain medications if she had a fracture. V10 stated, "The resident should be treated for pain medications if she exhibits any pain symptoms and if she had a fracture which we now know she did, she would definitely be in some pain. Someone who is nonverbal would probably show signs of pain like agitation." Surveyor asked the meaning of STAT orders. V10 stated, "A "STAT" x-ray means immediately. If the x-ray company cannot come immediately, I should have been called and I would have ordered that patient to be sent out to the hospital for evaluation, and x-ray, and treatment. I was not informed that the x-ray company could not do the x-ray, but I should have been because as I said, I would have sent that patient out." Surveyor asked if this delay would have caused R187 to endure any pain while waiting for an x-ray. V10 stated, "Well in hindsight, we know she had a fracture so the sooner we knew that the sooner it would have been treated."

On 4/13/23 at 2:45 PM, V36 (Medical Director) stated, "I am the medical director here. I attended the quality assurance meeting last month, 1 and half months ago. We discussed mainly treatment of Covid patients and readmission to hospital and statistics what's happening in general in the facility." Surveyor asked how the facility staff manage pain for their residents. V36 stated, "Patients have to have their pain controlled. Having minimal pain is the best approach to pain management. Occasionally patients cannot be pain-free but scheduled pain medications should be administered as ordered. Chronic pain should be assessed every two to 3 hours. If the patient is not alert, or if patient has signs for tachycardia

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(rapid heart rate), that would warrant taking pulse, that will warrant looking further into possible pain. Patients with dementia or with dysphagia then we know the non-verbal signs of pain." Surveyor asked whether fractures were painful. V36 stated, "Fractures are generally painful." Surveyor asked specifically about transverse fractures. V36 stated, "Transverse fractures do not normally occur spontaneously. They could happen possibly during a transfer or fall."

A review of R187's physician order sheet does not provide any pain medications ordered or administered during R187's respite stay until being discharged to home on 2/24/23.
A review of R187's MAR (Medication Administration Record) showed that an order for Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) was ordered on 2/24/23 and administered by V35 (Licensed Practical Nurse/LPN) only once upon discharge of the resident. There were no other pain medications prescribed or administered during R187's hospice/respite stay that began on 2/20/24.
On 4/13/23 at 2:06 PM, V24 (RN) stated, "We've had a lot of problems with this x-ray company and management is well aware of it. They (x-ray company) will not come when we order x-rays. They will usually come when there are multiple orders or batches of x-rays they have to do, but if it's only one x-ray they won't come until several days sometimes." Surveyor asked the meaning of a "STAT x-ray". V24 stated, "STAT means within 4 hours, that's the usual guidelines for STAT."

On 4/13/23 at 3:15 PM, V7 (CNA) stated, "I took care of (R187) for a little bit because she wasn't here long. I recall she was in a lot of pain, and she would want to be boosted up a lot and she'd complain when we'd boost her up in bed. Her

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husband came here too and would ask for us to help the resident." Surveyor asked how many staff it took to boost R187 up and/or transfer her from her bed to chair. V7 stated, "It would take two persons, but I never saw her fall or anything like that." Surveyor asked why she mentioned falling as the question wasn't asked. V7 stated, "Sorry, I just thought you were going to ask me if she fell or not, but I never did see her fall or anything like that. I do remember her always agitated when we tried to move her even a little bit." Surveyor asked when she first noticed R187 in pain and whether she mentioned it to the nurse. V7 stated, "She was always in pain, and I did tell my nurse. I just assumed they gave her something for it."

On 4/13/23 at 3:30 PM, V35 (Unit Manager/Licensed Practice Nurse/LPN) stated, "From what I can remember the husband had brought up concern that (R187) expressing pain or wincing at the slightest touch and so normally he was wondering what could have happened. I can recall the husband asking if she (R187) had fallen or anything had happened. I didn't observe anything on my shift so the husband asked on the morning shift and asked the nurses if she fell and that would explain why she would be in pain. No one reported it to me, so I think they did an x-ray, and it showed a fracture. That is why the husband was prompted as to how did she get this fracture. So, I was in touch with hospice to see what we could do with her, and the doctor ordered an orthopedic consult. Hospice was to hold off the orthopedic consult to manage her pain first and we would send orders scheduled pain medication. She was discharged to home then." Surveyor asked what a "STAT" order meant to her. V35 stated, "Stat is a 4-hour turnaround and we are supposed to reach out to

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the doctor if the x-ray company can't do that within that time." Surveyor asked if there were any concerns with the timeliness of the current x-ray company the facility used. V35 stated "Yes, sometimes they do not come." Surveyor asked if this problem was communicated to administration. V35 stated, "I don't know."

On 4/13/23 at 4:15 PM V3 (ADON) presented surveyor with the medication administration record and pain assessment. V3 stated, it was the previous DON (V6) who did this pain assessment, and she wrote that the resident wasn't in any pain, but I see that the resident was given Lorazepam for agitation which is a sign of pain. I see there was PRN (as needed) pain medication, which should have been given instead." Surveyor asked how the facility treats any resident in pain. "V3 stated, Nurses should treat pain as whatever the resident is saying. If the resident is non-verbal, they should look for cues for pain like grimacing, moaning, increased agitation." Surveyor asked if, based on R187's medication record, whether her pain could have been caused by the fracture. V3 stated, "That's what it looks like and we should have identified it and given her pain medication, or at least informed the doctor."

Facility policy revised 3/27/21 titled "Standards and Guidelines: Diagnostic Labs Radiology Notification" reads in part, "Standard: It will be the standard of this facility to provide or obtain timely laboratory, radiology and diagnostic services when ordered by a physician; physician assistant, nurse practitioner; or clinical nurse specialist in accordance with State law, including scope and practice laws. The facility shall promptly notify the ordering physician, physician assistant, nurse

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practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. The facility staff shall further ensure communication with the physician regarding other diagnostics such as vital sign measurements, readings, and EKG's. If the facility is unable to provide the necessary laboratory, radiological or diagnostic services in the facility, the facility shall assist the resident in making transportation arrangements to and from the source of service and file in the resident's clinical record signed and dated reports of laboratory, radiological and other diagnostic services."

Facility policy issued 3/1/2008, revised 3/26/2021 titled "Pain Screening and Management reads in part, "It will be the standard of this facility to screen residents and attempt to provide effective pain and comfort management. Guidelines: Residents will be screened for potential pain on admission. This may be achieved by asking the resident if they have or are experiencing pain, observing for signs and symptoms of pain or by reviewing physician's orders and history and physical. Residents may additionally be screened for pain quarterly, annually, upon change of condition or upon resident report of new pain or newly observed non-verbal signs and symptoms of potential pain. Attempt to obtain physician's orders for pain management, if needed. Administer pain medications according to physician's orders and resident request for "PRN" medications. On-going monitoring of residents receiving interventions should be completed in the clinical record as indicated. Resident's goals and preferences should be considered when developing the pain management regime and

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administration of medication. Implement/update a person-centered plan of care related to pain manage, as is appropriate."

Facility policy issued 2/1/2008, revised 3/27/2021 titled Hospice/Palliative/End of Life Care" reads in part, "It will be the standard of this facility to provide, participate in or collaborate with the provision of dignified palliative, Hospice or End of life care. The physician will order appropriate interventions to help relieve pain and make the resident as comfortable as possible. The facility staff will provide care and services per physician orders and the resident's person-centered plan of care related to palliative, hospice or end of life care."

According to Cleveland Clinic medical journal article dated 5/5/2022 titled "Transverse Fracture" reads in part: "Transverse fractures are almost always caused by traumas like falls or car accidents. Transverse fractures and transverse process fractures are different types of bone fractures. Even though they have similar names, they're very different injuries. Transverse fractures occur when your bone is broken perpendicular to its length. The fracture pattern is a straight line that runs in the opposite direction of your bone. They can happen to any bone in your body, but usually affect longer bones after a trauma like a fall or accident. Transverse fractures can affect anyone. This is especially true because they're caused by accidents and traumas. Symptoms of a transverse fracture include Pain. Swelling. Tenderness. Inability to move a part of your body like you usually can, Bruising or discoloration. A deformity or bump that's not usually on your body. Any impact on your bones can cause a transverse fracture. Some of the most common causes include Falls,

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S9999	Continued From page 17 car accidents or sports injuries." "A" Statement of Licensure Violations III of III: 300.610a) 300.1210b)4) 300.1210c) 300.1210d)2)3)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities	S9999		

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S9999	Continued From page 18 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who 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.	S9999		

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S9999	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the plan of care and procedures for wound care to prevent and heal avoidable facility-acquired pressure ulcers for 2 (R3, R64) of 3 residents reviewed for pressure ulcers in the sample of 45 residents. This failure resulted in R3 and R64 to sustain facility-acquired, clinical stage 4 pressure ulcers that required surgical removal of necrotic tissue. Findings include: On 4/10/23 at 10:00 AM the facility presented survey team with a list of the facility's pressure ulcer list which showed R3 and R64 with facility-acquired stage IV pressure wounds. 1. R3 is cognitively impaired with diagnoses listed in part with hypertension, anxiety state, congestive heart failure, atrial fibrillation, and diabetes. MDS (minimum data set) assessment dated 12/9/22 showed R3 with no pressure ulcers upon assessment but was considered "at-risk" for the development of pressure ulcers. This same assessment showed R3's listed skin and ulcer/injury treatments to have: Pressure reducing device for chair, pressure reducing device for bed, turning and repositioning program, and nutrition or hydration interventions to manage skin problems. A proceeding MDS assessment dated 3/9/23 showed R3 now with a stage 4 pressure ulcer and with listed skin and ulcer/injury treatments as:	S9999		

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S9999	Continued From page 20 Pressure reducing device for chair, pressure reducing device for bed, turning and repositioning program, and nutrition or hydration interventions to manage skin problems, Pressure ulcer/injury care, and application of dressings to feet. This same MDS assessment showed R3 with no behavioral symptoms that interfered with her care. Lastly, this MDS showed R3 required extensive assistance in bed mobility (turning and repositioning) and required a minimum 1 staff person to perform this task. R3's Care plan dated 12/14/22 reads in part, (R3) is at risk for skin impairment/developing a pressure ulcer due to Braden Scale score, diabetes, incontinence, limited mobility, history of healed pressure ulcer, fragile thin skin. Goal: (R3) will have intact skin, free of redness, blisters, or discoloration over a bony prominence through next review. Interventions: Assist with turning and repositioning if resident is unable; Minimize pressure over bony prominences, Offload pressure to heals, Preventative skin care per house protocols, lotion to dry skin, barrier creams to areas affected by moisture as needed; Provide chair cushion; Provide incontinence care after incontinence episodes, apply barrier cream as needed; Provide pressure relieving mattress. A proceeding care plan dated 2/27/23 reads in part, "(R3) has a pressure ulcer on her right lateral foot. Interventions: Assist PRN (as needed) to reposition/shift weight to relieve pressure; Right lateral foot-wound care as ordered by physician until resolved; Minimize pressure over bony prominences; off-load heels; Provide incontinence care after incontinence episodes, apply barrier cream as needed; Provide pressure relieving or reduction device, pressure reduction specialty mattress chair cushion, heel	S9999		

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S9999	Continued From page 21 protectors." On 4/10/23 at 11:10 AM, R3 was observed awake in bed, with her back propped up and watching television. Her bed was made with several sheets and blankets under her body and her feet were exposed and not covered by the blankets. The resident's bed had an air mattress overlay and with the electronic pump laying on the left side of the bed on the floor. Surveyor asked how R3 was doing, R3 stated, "I'm fine, are you a doctor?" Surveyor identified self and asked how her stay was going. R3 stated, "It's fine I just want to get a shower today and I can't seem to get anyone to even come in here. I know who my nurse is it's (V5 Licensed Practical Nurse/LPN). She was in here earlier, but she doesn't do much just gives me my pills and goes. She told me that my CNA (Certified Nurse Assistant) is V15, but they keep changing CNAs around here and you never get the same one. This one today (V15) came in when I used the call light, said he'd be back and never did. What time is it, almost noon and he still hasn't come back. He's one of those agency CNAs they keep using and they're just horrible. They come in and when I think they are going to help me or get me what I need, they just turn off my light and then say they'll be back, but they won't return. This nurse (V15) I have isn't any better, she always says she'll get the CNA, she'll get the CNA. I mean why can't she do anything for me? Surveyor asked if anyone comes in to turn her or to help her reposition in her bed. R3 smiled and said, "You've got to be kidding. I can't get them to even answer my call light." On 4/11/23 at 11:46 AM, R3 was observed lying on her bed in the same position with her back upright and with similar number of bed linens	S9999		

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layered under her body and with her feet atop the air mattress with no pillows or other devices to off-load her feet. The electronic air pump to keep the air mattress inflated remained on the floor and the bed had no foot board. Surveyor asked how she was doing today. R3 stated, "Oh I'm just a bit tired today." Surveyor asked who her nurse and aide were today. R3 stated, "Oh it's V5 (LPN) but it's a different CNA again so don't ask me who that is because it always changes." Surveyor asked when she last saw her aide. R3 stated, "It was around 7 or 8 because he came around the same time I was watching my show but it definitely wasn't V15 (CNA)."

On 4/11/23 at 12:00 PM, V5 (LPN) was asked about R3. V3 stated, "I don't normally work this unit, but I know her. She's always in bed and I give her medications on time in the morning, and she takes it all." Surveyor asked if there was anything special, she did for R3. V5 stated, "No, not really. What do you mean?" Surveyor asked since she had a specialty air mattress if staff did anything different for R3. V5 stated, "Well, I know the wound nurses sees her, but I don't know what else you're asking." Surveyor asked whether R3's number of linens under her body were appropriate to maintain the functioning of the air mattress. V5 stated, "No that shouldn't be that way. There shouldn't be that much under her." Surveyor asked what happened to the foot board on the bed and whether the air pump should be sitting on the floor. V5 stated, "That's been like that awhile but I'm not sure about the pump." Surveyor asked how often R3 needed to be seen during the shift. V5 stated, "Well we try to see everyone frequently." After several questions, V5 failed to mention any turning, repositioning, or offloading of R3's wounds.

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S9999	Continued From page 23 On 4/11/23 at 1:40 PM, surveyor observed wound care being conducted by V19 (LPN/Wound Nurse). Surveyor asked V19 to describe the procedure and wound to surveyor. V19 stated, "R3 has a right lateral pressure ulcer, and it was discovered on 2/20/23 and is facility-acquired. She had boots to elevate the feet, but her family said it made her feet too hot, so we just prop the feet up with pillows. As you can see her legs are twisted outward, so the right lateral foot is always resting against the bed and creates pressure. We do frequent rounds to ensure that her feet are off loaded, and the staff do this when they do incontinence care and whenever they come in the room." Surveyor asked whether the wound was preventable. V19 paused and stated, "Yes sir I think it was but sometimes R3 refuses to she won't ask for help to reposition." Surveyor asked R3 in V19's presence whether what the nurse said was true. R3 responded, "When I call someone for help no one comes. They don't come in at all sometimes. The CNA today hasn't come in since this morning. No one checks on me that is not true." On 4/13/23 Surveyor asked about R3, V38 (Wound doctor) stated, "R3 has had several foot wounds, one was on her dorsal foot which healed and the other was on her lateral foot which I staged at a stage 4. She lays in bed most of the time and does not like to reposition herself. I debrided the eschar (dead skin) to the foot bone. R3 is rigid and bed bound. She was placed on boots to off-load the foot, but I was told she tends to take those off and so the staff use pillows to off-load the pillows." Surveyor asked if R3 had these tendencies to remove the boot and pillows, whether staff should be responsible to ensure these were in place. V38 stated, "Well yes they should but as I said, she is resistive to staff doing	S9999		

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this, so I'm told by the nurses." Surveyor asked if he had any input on the way bed linens should be made atop a specialty air mattress. V38 stated, "There should be minimal linens in order for the air mattress to operate properly. If there are too many linens, it creates pressure points and defeats the purpose of a specialty air mattress. There should be a flat sheet, a draw sheet and blanket and really no more than that."
On 4/13/23 at 2:45 PM, V36 (Medical Director) stated, "I am the medical director here. I attended the quality assurance meeting last month. We discussed mainly treatment of Covid patients and readmissions to hospital, statistics, and generally what's happening in the facility. We discuss fall risk who is fall risk and that has always been a concern, but the numbers were much better recently. We had specific supervisor that really helped for more staff to improve situation in the fall risk. We recommended to do hours visits to the patient to put fall risk to station. They have alarms in place on high fall risk people. There are other devices more frequent visits, padding on the floor, etc." Surveyor asked about R3's wounds and wounds in general. V36 stated, "We do have a wound care team attending to the wounds and we screen the patients; we do air mattresses; we do wound care consult; we have infectious disease consults to make sure the wound is not infected; and we check all the wounds." Surveyor asked about R3's wound, V36 stated, "I know that my patient is being seen by the wound doctor, but I would have to pull up her records to tell you more." Surveyor asked about R3's air mattress and other residents placed on air mattresses. V36 stated, "Most of the time air mattress have feature that can have and rotation every two hours. Some of them have limited abilities but staff still need to physically come in and reposition the patient and

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INVERNESS HEALTH & REHAB	1800 COLONIAL PARKWAY INVERNESS, IL 60067

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not rely totally on the air mattress. We also have paddings on chair if the patient is transferred out of bed. When patients are in chair, it is harder to do, but it is the responsibility of staff to offload on chair. They should shift position and help them to rest in the bed unless patient family is resistant and even still, they should try."

2. R64 is a severely cognitive impaired resident with diagnoses listed in part with aphasia, dysphagia, vascular dementia, hemiplegia and hemiparesis, anxiety disorder and pressure ulcer stage 4.

MDS (minimum data set) annual assessment dated 11/9/23, and quarterly MDS assessment dated 2/7/23 both showed R64 with no pressure ulcers but considered at-risk for the development of pressure ulcers. These same assessments showed R64's with listed skin and ulcer/injury treatments to have: Pressure reducing device for chair and pressure reducing device for bed however R64 did not require a turning and repositioning program, nutrition, or hydration intervention to manage skin problems although R64 was considered at-risk for the development of pressure ulcers.

A proceeding MDS significant change assessment dated 4/12/23 could not be provided as the assessment was in the process of completion.

Care plan dated 3/14/23 reads in part, "(R64) is at risk for skin impairment/developing a pressure ulcer related to incontinence, impaired mobility due to history of CVA, fragile skin, decreased intake with recent weight loss, presence of right ischium wound. Interventions: Minimize pressure

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S9999	Continued From page 26 over bony prominences; Provide chair cushion; Provide incontinence care after incontinence episodes, apply barrier cream as needed; Provide pressure relieving mattress." A proceeding care plan dated 3/14/23 and revised 4/11/23 (the second day of the facility's survey) reads in part, "(R64) has a pressure ulcer on her right ischium. Goal: Pressure ulcer will exhibit sign of healing. Intervention: Assist with turning and positioning if resident is unable. Turn & Reposition every 1-2 hours and as needed (date initiated: 7/15/2020 Revision on 4/11/2023)." On 4/10/23 at 11:00 AM, R64 was observed sitting in her wheelchair asleep in the common area along with several other residents. There were no staff in the immediate area conducting activities or any observed prompting of R64 to off load her buttock while on the chair. On 4/11/23 at 11:20, R64 was again observed in the common area sitting in her wheelchair with her eyes open staring at the ceiling. R64 did not appear to be engaged in any form of activity or movement that off-loaded pressure from her buttocks area. Staff were observed walking past R64 and did not engage with R64 in any manner. On 4/11/23 after R3's wound care, V19 (Wound Nurse) went over to R64's room to initiate the wound care. Surveyor asked V19 to wait until the surveyor came to the room to start the wound care. Upon entering the room at 2:15 PM, R64 was already taken off her chair and transferred on to the bed where bedside care was already in progress. R64's incontinence pad had already been removed and was in the process of being provided incontinence care. Surveyor asked why	S9999		

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the wound care started and did not wait as requested by surveyor. V19 stated, "Oh, I'm sorry. I wanted V12 (CNA) to change her diaper first." Surveyor asked V12 to retrieve the incontinence brief out of the garbage bin to show the surveyor. The incontinence brief was soaked with urine that it was dripping wet when V12 was taking it out of the garbage can. V12 showed surveyor the sweatpants R64 was wearing while seated in her wheelchair. The sweatpants were also saturated with urine all through the buttock area of the pant. Surveyor asked V12 (CNA) if R63 was his resident to take care of today. V12 stated, "No, she's not mine, I'm just here to help V19 (wound nurse) out for wound care. I usually help out during wounds." Surveyor asked V19 to proceed with the wound care. V19 stated, "R64 has a pressure sore on her right ischium, and it is facility-acquired on 3/13/23. I was informed by the nurse and when I came in on Monday morning, the doctor rounded with me and staged it at a stage 4 pressure ulcer." Surveyor asked to describe the wound. V19 stated, "It is a stage 4 and it's about 2.5 inches deep. It is the size of a golf ball. I can see bone and fascia, some redness, and there is no drainage, undermining or tunneling of the wound." Surveyor asked if the wound was preventable. V19 stated, "I think so, it's avoidable." Surveyor asked what measures the facility had in place to prevent the wound, and now heal the wound. V19 stated, "Well she is on an air mattress when she is in bed, and we upgraded her wheelchair cushion to a gel cushion." V12 (CNA) interjected without being asked, "Staff still have to reposition her even if she is in the mattress because it can't do it for her." Surveyor turned to V19 (Wound Nurse) and stated, "Yes that's true but she is resistant sometimes." Surveyor asked if the resident shows resistance to care, as she says, what staff

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should do. V19 stated, "Well they should still keep trying." Surveyor asked how staff would reposition someone when they are in the chair. V19 stated, "I don't know, that's more difficult." Surveyor asked if staff should be prompting the resident to shift her weight if she is unable to do this herself. V19 stated, "Yes you're right. We should be doing that too." After the wound observation, V19 informed surveyor of the exact measurements of R64's wound. V19 stated, "The wound measures 3.9 centimeters long by 2.1 centimeters wide by 3.4 centimeters deep. You were right, it appeared deeper than 2 inches."

On 4/13/23 at 11:46 am, V38 (Wound doctor) stated upon interview, "I was informed about R64's wound. It started out as an unstageable wound at the time, and I debrided the necrotic area and so it was staged to 4. Looking at the records, it appears that I was initially informed of the wound on 3/13/23. R64 tends to sit on her chair most of the day. Staff need to off-load the pressure and I know she has a chair cushion and we upgraded it to a gel cushion. It was a challenge to get her out of her chair all day and to get her back to bed but I then I was informed by the nurses that when she was in bed she tends to climb out of bed, so again R64 has presented challenges for staff. We provided her a special air mattress for that." Surveyor asked if staff should be repositioning R64 while in bed. V38 stated, "Yes, we can't just rely on the special mattress or gel cushion, she needs to be off-loaded by staff. I can tell you she is very resistant however." Surveyor asked whether he considered the wound to be an avoidable wound. V38 paused a moment and stated, "I believe it is unavoidable due to her behaviors from what staff has indicated to me."

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S9999	Continued From page 29 A review of R64's MDS (Minimum Data Set) annual assessment of 11/19/22, MDS quarterly assessment dated 2/7/23, and MDS significant change assessment on 4/12/23 show no behaviors exhibited by R64 that impacted her care, contradicting the information provided to V38 by facility staff. A review of R64's annual MDS assessment dated 12/9/22, showed no behaviors exhibited by R3 that impacted her care. R3's quarterly MDS assessment dated 3/9/23 showed no behaviors exhibited by R3 that interfered or impacted her care contradicting the information provided to V38 by facility staff. Facility policy issued 3/1/2008, revised 3/27/21 titled "Wound Care" reads in part, "It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. A pressure injury risk/skin assessment evaluation will be completed upon admission, with each additional assessment, quarterly, annually and with significant changes in condition. Skin will be assessed evaluated for the presence of developing pressure injuries or other changes in skin condition on a weekly basis at least once each week or as needed by a licensed nurse. Wound care procedures and treatments should be performed according to physician orders. Preventative measure, such as barrier creams, can be employed to help maintain skin integrity as well as utilization of pressure relieving surfaces, floating heels, protective boots and use of positioning devices."	S9999		

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