STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001457	A. BUILDING: _____ B. WING _____	C 06/26/2023

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ACCOLADE HEALTHCARE OF SAVOY	302 WEST BURWASH SAVOY, IL 61874

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2364922/IL160959 Investigation of Facility Reported Incident of 06-13-2023/IL160973	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240b) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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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:

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.

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.

Section 300.3240 Abuse and Neglect

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b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to supervise a resident (R1) with a known history of wandering, evaluate or assess residents' capacity or ability to consent to sexual activity, and identify resident to resident sexual activity as nonconsensual sexual abuse for three of five residents (R1, R2, R3) reviewed for abuse in the sample list of ten. This failure resulted in R1 sexually abusing R3, and R3 sexually abusing R1.

Findings include:

The facility's Initial Report dated 6/13/23 documents the facility reported "physical contact between confused residents (R1, R2, R3)." The section for sexual abuse allegation is not marked. This report documents R1 was seen in R2's room standing beside the bed touching R2's genitals, and it was unclear if this contact was direct or over top of the sheet. R1 was removed from R2's room and later that same day R1 was found in R3's room with R1's shirt pulled up and R3's mouth on R1's breast. R1 was removed from R3's room and was placed on one-to-one supervision. Immediate actions include contacting R1's family about a room change. The time the

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incidents occurred is unidentified. These incidents were reported to V1 Administrator on 6/13/23 at 6:32 PM.

V7 Certified Nursing Assistant (CNA) statement documents: "(V7) was walking down the hall and saw (R1) in (R2's) room with what appeared to be physical contact happening. Resident (R1) had their back to the door blocking a clear view. (V7) asked resident (R1) what they were doing and (R1) stated (R1) was washing (R2's) penis. (V7) approached the residents (R1, and R2) as (V7) could see (R1's) hand appeared to be by (R2's) privates, but by the time (V7) arrived at the bed (R1's) hand was moved. At that point (V7) escorted (R1) out of the room and back to (R1's) room to keep separated from other residents."

V9 CNA written statement dated 6/20/23 documents: V9 walked past R3's room and saw R3 sitting in the recliner. R1 was leaning over R3, R1's dress was low, and R3's mouth was on R1's breast.

R1's Minimum Data Set (MDS) dated 3/24/23 documents R1 is usually understood and sometimes understands, wanders daily, and has severe impairment with daily decision making. R1 transfers and walks with setup assistance and supervision from staff. This MDS and R1's Brief Interview for Mental Status (BIMS) dated 6/15/23 documents R1 has short- and long-term memory loss. R1's Care Plan dated 9/6/21 documents R1 "wanders aimlessly and without regards to needs or safety." R1's Care Plan revised 1/26/23 documents R1 is at risk for abuse/neglect related to diagnoses of dementia with behavioral disturbances and anxiety.

R2's BIMS dated 6/2/23 documents a score of 6,

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indicating severe cognitive impairment. R3's BIMS dated 5/10/23 documents a score of 13, indicating R3 is cognitively intact.

R1's Census documents R1 changed rooms on 6/14/23 at 3:44 PM (almost 24 hours after R1's/R2's and R1's/R3's incidents).

On 6/15/23 at 9:28 AM and at 11:55 AM R1 was in bed in R1's room. There were no staff present in R1's room or stationed outside of R1's doorway. On 6/20/23 at 9:08 AM there were no staff present in R1's room. R1 walked out of R1's room down the hall towards the nurses' station. V37 CNA told R1 to go back to R1's room, and R1 walked back into R1's room independently.

On 6/15/23 at 10:08 AM R3 stated: The other night R1 came into R3's room. R3 was sitting in the recliner. R1 pulled down the top of R1's gown and exposed R1's breasts. R3 touched R1's breast with R3's hand. R1 told R3 to stop, and R3 complied. R1 is confused and did not ask R3 to touch R1. R3 knows R3 probably should not have touched R1, but R3 did. There was a staff person who witnessed the incident from the doorway. The staff did not intervene, but R1 left R3's room.

On 6/15/23 at 10:00 AM V9 CNA stated V9 passed by R3's room at approximately 4:30 PM-4:45 PM on 6/13/23 and witnessed R1 bent forward towards R3 who was sitting in the recliner. R1 pulled R1's gown down exposing R1's breasts and R3's mouth was on R1's breast. V9 stated both residents were not upset by the incident and were actively engaged. V9 told R1 to get out of R3's room and R1 went into the hallway. V9 did not report the incident to anyone. V9 did not consider the incident to be abuse since R1 and R3 were both actively engaged in the

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S9999	Continued From page 6 sexual activity. On 6/15/23 at 9:34 AM V8 Registered Nurse stated: R2 yells out at times, is confused, and alert/oriented to person only. V8 stated R3 is alert/oriented to person, place, time, and situation. V8 stated R1 is confused and wanders into everyone's rooms. On 6/13/23 between 5:00 PM and 6:00 PM V7 CNA reported to V8 that R1 touched R2's genitals. V9 witnessed R1 enter R3's room. V9 went to R3's room and R1 exposed R1's breast and R3 was sucking on R1's breast. After the incident with R1/R2 we brought R1 to the nurse's station to keep a close eye on R1, but R1 "just gets up and goes." After R1's/R3's incident R1 was placed on one-to-one supervision, but not continuous supervision. V8 stated staff checked on R1 frequently and observed R1 in the hallway. On 6/15/23 at 2:46 PM V7 CNA stated on 6/13/23 at approximately 4:30 PM V7 CNA witnessed R1 in R2's room standing over R2's bed. R1 told V7 that R1 was washing R2's penis. V7 did not witness R1 touch R2. V7 redirected R1 back to R1's room which was across the hall from R2's room and left R1 unattended. V7 stated prior to the incident the staff had to redirect R1 from R2's room multiple times. V7 stated there were no staff assigned to provide continuous supervision of R1 on 6/13/23, following the incident with R2. V7 was unsure what interventions were implemented to prevent sexual activity involving R1. On 6/15/23 at 11:55 AM V32 Licensed Practical Nurse stated R1 did not change rooms until after 2:00 PM on 6/14/23.	S9999		

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On 6/15/23 at 10:48 AM V2 Regional Nurse stated V2 received a call from V1 Administrator on the evening of 6/13/23 informing V2 of the incidents involving R1, R2, and R3. V2 stated V2 instructed to implement one to one supervision after R1's/R3's incident. One to one means if R1 is sleeping staff are to sit outside R1's room and if R1 is outside R1's room then a staff person is assigned to be with R1. The staff had initially asked V2 about 15-minute checks for R1 and V2 told the staff that is not enough, because that would allow for periods of time for R1 to be unsupervised. At 3:45 PM V2 stated residents who exhibit a desire for intimate relationships with a BIMS score of 10 or greater have the ability/capacity to consent to sexual activity. V2 stated this type of behavior is not ok in these incidents (R1/R2 and R1/R3). V2 confirmed R1 does not have the ability/capacity to consent to sexual activity. V2 stated R1's one to one continuous supervision is still ongoing at this time.

On 6/15/23 at 11:21 AM V1 stated V8 called V1 at approximately 6:30 PM to report R1's/R2's and R1's/R3's incidents. V1 did not report the incidents to the local police since R2 and R3 are able to consent to sexual activity. Resident's ability to consent to sexual activity is based on the BIMS score and is situational. V1 stated that there is no set BIMS score to identify when a resident is not able to consent. V1 confirmed the facility does not use any other assessment tool to determine residents' ability/capacity to consent to sexual activity. V1 was asked about R1's cognition and ability to consent to sexual activity. V1 stated "That is a good point." V1 stated R1 implied consent because R1 initiated the sexual activity. V1 instructed staff that night to place R1

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on one-to-one supervision and move R1's room. V1 stated V1 would have expected staff to notify V1 immediately after the incident with R1/R2 and implement one to one supervision at that time. On 6/20/23 at 11:02 AM V1 stated the facility does not have a policy for how they determine residents' ability to consent to sexual activity.

On 6/20/23 at 8:58 AM V16 CNA stated following the incidents involving R1, R1 had a room change and we try to keep R1 in R1's room or involved in activities. V16 stated there are no staff assigned to do one to one supervision of R1. On 6/20/23 at 9:08 AM V37 CNA confirmed there were no staff assigned to provide one to one continuous supervision of R1.

The facility's Abuse, Neglect, and Exploitation policy dated 2/28/2023 documents: "The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff

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on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; C. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect".
"Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator."

(B)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210c)
300.1210d)2)5)
300.1220b)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and

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procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

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practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

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,

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S9999	Continued From page 12 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 Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to update resident plans of care for pressure ulcers, failed to document measurements/assessments of pressure ulcers, and failed to document treatments to pressure ulcers were completed as ordered. The facility also failed to implement physician orders for a pressure ulcer wound treatment and notify the facility's wound nurse and/or wound physician of the development of a new pressure ulcer. These failures affect three of three residents (R4, R6 and R7) reviewed for pressure ulcers on the sample list of 10. The facility also failed to ensure identified pressure ulcer prevention interventions were implemented, causing R6's right buttocks	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HEALTHCARE OF SAVOY	302 WEST BURWASH SAVOY, IL 61874

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wound to worsen.

Findings include:

1. R6's Care Plans dated 2/9/23 document the following: "staff will refer to my Physician as needed for skin impairment and issues;" R6 has skin impairments including a Stage 3 pressure ulcer to the sacrum and right upper buttock. These Care Plans document interventions including the following: Assess/record/monitor wound healing measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress. These Care Plans document to report improvements and declines to the physician, monitor/document/report as needed, any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length X width X depth), stage. These care plans also document R6 requires pressure relieving/reducing device low loss air mattress on R6's bed with a date of 9/29/22.

R6's Order Summary Report dated 6/22/23 documents the following: An order dated 2/8/23 documents R6 is to have a Low Air Loss (LAL) mattress and to check function and setting every shift. This Order Summary Report documents an order dated 5/16/23 to clean R6's Stage 2 pressure ulcer to the coccyx with wound cleaner and pat dry. This order documents to apply medical honey gel to the wound and cover with a bordered foam dressing. This report does not document orders for R6's pressure ulcer to the right buttock. There are no orders for a treatment for a Stage 3 pressure ulcer to the sacrum.

R6's Wound Physician notes dated 4/25/23 document R6 had a right buttock skin tear that

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healed. There are no additional wounds documented for R6. These notes document R6 is at risk for reopening previous skin alterations due to: incontinence, limited mobility, poor intake and anemia and that R6 was being discharged from wound care.

R6's Wound Physician notes dated 5/23/23 document R6 had an initial assessment for a Stage 4 right buttock pressure ulcer with full thickness/exposed underlying structure. These notes document R6's right buttock pressure ulcer measurements as 2.8cm (centimeters) length, 1.7cm width, 0.2cm depth with minimal exudate. These notes document orders including preventative wound recommendations including LAL air mattress.

R6's Wound Physician notes dated 6/6/23 document R6's Stage 4 right buttock pressure ulcer with healing status of "healing" and measurements of 3.1cm length, 1.7cm width, 0.2cm depth with minimal exudate. These notes document Additional Notes/Orders including "Wound Improving" and LAL mattress.

R6's Wound Physician notes dated 6/13/23 document R6 was not seen by the wound physician because R6 was not in R6's room. There is no additional documentation in R6's medical records as to where R6 was at that time.

R6's Wound Physician notes dated 6/20/23 document R6's right buttock Stage 4 pressure ulcer "healing status" as "declined" with measurements of 3.4cm. Length x 4.1cm. Width x 0.1 cm. Depth. These notes document "Related to wound status," R6 unable to adhere to offloading and that R6 had a prior stage 4 pressure ulcer to that area in the past. There is

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no documentation R6 had a pressure ulcer to R6's coccyx at this time. These notes document R6's "TREATMENT ORDER: Every three times per weekday(s): Medical Honey Gel - Cleanse wound with normal saline or sterile water - Apply (medical honey gel) to Wound Bed - Cover with Dry Clean Dressing" with "Preventative Wound Recommendations:" LAL Air mattress. This note does not document R6's open pressure ulcer to R6's coccyx.

R6's Order Summary Report dated June 22, 2023, document an order dated 5/16/23 to clean R6's Stage 2 pressure ulcer to the coccyx with wound cleaner and pat dry. This order documents to apply medical honey gel to the wound and cover with a bordered foam dressing. This report does not document treatment orders for R6's pressure ulcer to the right buttock.

On 6/21/23 at 2:05 PM, V32, Licensed Practical Nurse (LPN) completed R6's treatment to R6's right buttock pressure wound with V33, LPN assisting. Upon turning R6 to position R6 on R6's right side, R6's right buttock pressure ulcer was irregular in shape, with an open reddened wound bed. There was no dressing noted to R6's right buttock or coccyx pressure wounds. V32 stated staff cleaned R6 up when they assisted R6 to bed and the dressing was removed at that time. V32 cleaned V32's right buttock and coccyx pressure wounds with wound cleaner. V32 applied medical honey gel to the square bordered foam dressing and used a cotton tipped applicator to move the medical honey gel around on the foam dressing. V32 placed the dressing with the medical honey gel over the top of the right buttock wound. The adhesive portion of the dressing was positioned over the coccyx pressure wound, but not adhered to or covering the coccyx pressure ulcer. The

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coccyx pressure ulcer did not have any medical honey gel treatment or dressing completed as per R6's Physician's Orders. R6 was noted to be on a regular mattress with no alternating air capabilities. V32 confirmed R6's open pressure ulcer to the coccyx area at this time. There were no sacrum pressure ulcers observed at this time, but evidence of scarring over sacral area from previous sacrum pressure ulcers to which V32 confirmed.

On 6/22/23 at 1:40 PM, V29, Wound Nurse stated V29 is the wound nurse for the facility. V29 stated V29 has only been able to come one day a week to round with V30, Wound Physician because V29 is attending school. V29 stated it is probably V29's fault for not making sure R6 was on an air mattress. V29 stated R6 was on an air mattress and had a room change and that R6's mattress "must not have moved" with R6. V29 stated R6's wounds had healed, but R6 was "always on an air mattress." V29 stated V29 and V30 just saw R6 Tuesday 6/20/23, and R6's right buttock pressure ulcer is declining and not having R6 on an air loss mattress will contribute to/cause the decline. V29 stated they should be following the orders for the coccyx pressure ulcer, but V29 was unsure of when the coccyx pressure ulcer had re-opened as it was opened in the past. V29 stated the floor nurse should have entered the new orders for R6's pressure ulcer to the right buttock as ordered. V29 stated V29 would look at the orders and get them updated in R6's medical records so the treatment would be done to the buttock pressure ulcer and the coccyx pressure ulcer. V29 stated the gel is to be placed on/in wound bed and not on the dressing to ensure the entire wound bed has the medical honey gel applied. V29 also stated the facility documents resident treatments were completed on the

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Treatment Administration Records (TAR). V29 stated the treatments should be implemented as ordered and transcribed to the electronic medical records. V29 stated treatments are to be documented when they are completed on the TAR.

2. R7's Order Summary Report dated June 21, 2023, documents R7's Physician's Orders including to apply skin prep to bilateral heels every shift.

R7's Care Plans document R7 is at risk for skin breakdown and that staff will refer to R7's physician for skin impairment and issues. These care plans do not document R7's left or right heel pressure ulcers.

There is no documentation of an assessment by V30, Wound Physician or measurements by the facility for R7's right heel pressure ulcer.

On 6/21/23 at 1:29 PM, V31, Licensed Practical Nurse cleaned R7's heels with wound cleanser and applied skin prep to R7's bilateral heels. V31 stated V31 is unsure of measurements of these wounds or who does them and that V29, Wound Nurse and V30, Wound Physician see R7 weekly and document. V31 stated R7 has had bilateral heel pressure ulcers for a while. V31 completed the treatment to R7's MASD (Moisture Associated Skin Damage) of the sacral area. At this time, R7 was noted to have a darkened circular non-blanchable pressure ulcer to the sacrum of which V31 stated was just smaller than a dime in size and that area had not been there previously.

R7's June Treatment Administration Record (TAR) dated June 2023 does not document R7's skin prep to R7's bilateral heels was completed

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S9999	Continued From page 18 as ordered during the evening shift on 6/1/23, 6/6/23, 6/10/23, 6/20/23. There is no documentation in R7's medical record that V29 or V30 were notified of R7's new pressure ulcer to the sacrum. On 6/22/23 at 1:40 PM, V29, Wound Nurse stated staff should notify V29 and/or V30 for any new skin impairments/pressure ulcer development and document in the nurse's notes. V29 stated V29 was unaware of the dime sized circular pressure ulcer for R7. 3. R4's hospital Discharge Transfer Orders dated 5/12/23 document R4's Wound care orders including "Pressure Injury - Coccyx/Ischial Instructions" including to apply self-adherent bordered foam dressings to the coccyx and all bony prominences. These orders document to peel back and assess skin every shift and change dressings weekly and as needed for soiling, saturation, or slippage to prevent skin breakdown. R4's Order Summary Report dated June 15, 2023, does not document R4's orders for R4's pressure ulcer treatment to R4's coccyx as ordered on 5/12/23. R4's medical records do not document monitoring/treatment of R4's coccyx pressure ulcer. On 6/22/23 at 1:40 PM, V29, Wound Nurse stated the facility documents resident treatments were completed on the Treatment Administration Records (TAR). V29 stated the treatments should be implemented as ordered and transcribed to the electronic medical records. V29 stated treatments are to be documented when they are completed on the TAR. V29 stated V29 did not	S9999		

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S9999	Continued From page 19 evaluate or know of R4's coccyx pressure wound. (B)	S9999		