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S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)2) 300.1210 d)3) 300.1210 d)5) 300.1220 b)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 300.1010 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	S9999		

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

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.

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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 are not met as evidenced by:

Based on interview and record review, the facility failed to implement pressure relieving interventions, assess, monitor, and treat a pressure sore, notify the physician of a reopened pressure sore/worsening pressure sore, and notify the physician of a facility acquired deep tissue injury for two of seven residents (R1, R4) reviewed for pressure sores in the sample list of seven residents. These failures resulted in R1's left elbow pressure sore progressing to an infected stage 4 pressure sore requiring hospitalization, surgery, a wound vacuum, and intravenous antibiotic theray and R4's right heel deep tissue injury deteriorating to an open unstageable pressure sore.

Findings include:

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1.R1's undated Face Sheet documents R1's medical diagnoses as Alzheimer's Disease, Parkinson's Disease, Dementia, Tremors, Presence of Left Artificial Shoulder Joint, Iron Deficiency Anemia, Vitamin D Deficiency, Osteoporosis, and history of Urinary Tract Infections.

R1's Minimum Data Set (MDS), dated 8/3/24, documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring maximum assistance with eating and dependent on staff for toileting, bathing, dressing, personal hygiene, bed mobility and transfers.

R1's Care plan intervention, dated 4/27/22, documents R1 transfers with one person assist, roller walker, and gait belt. This same careplan documents a focus area of R1's left elbow pressure sore, dated 8/15/24. R1's Careplan did not include goal and interventions for R1's left elbow pressure sore until 8/21/24.

R1's Pressure Ulcer Risk Assessment, dated 8/1/24, documents R1 as moderate risk for skin breakdown.

R1's Skin Evaluation, dated 8/13/24, documents R1's Left Elbow has an open wound. This same evaluation documents V14, Physician, and V5, R1's Power of Attorney (POA), were not notified.

R1's Physician Order Sheet (POS), dated August 2024, documents physician orders:
-starting 4/26/24 and ending on 8/8/24 to monitor left elbow for redness, swelling, pain and warmth every shift.
-starting 4/27/24 and ending 8/29/24 to ensure left elbow protection is in place at all times every shift.

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-starting 7/3/24 and ending 8/8/24 to apply border gauze daily to left elbow.

R1's Skin Evaluation, dated 8/13/24, documents an open wound on R1's left elbow. This same evaluation documents V14, Physician, nor V5, R1's Power of Attorney (POA), were notified.

R1's Electronic Medical Record (EMR) does not document an assessment of R1's new left elbow wound noted on 8/13/24.

R1's Skin Evaluation, dated 8/15/24, documents R1 has a new facility acquired unstageable pressure ulcer on her left elbow that shows slough and eschar measuring 1.6 centimeter (cm) long by 1.3 cm deep with no measurable depth. This same evaluation does not document R1's Physician (V14) nor Power of Attorney (POA) (V5) being notified of R1's new pressure ulcer.

The facility provided documentation, dated 8/16/24, documents V14, Medical Director, was faxed notification of R1's left elbow pressure sore.

R1's Nurse Progress Notes dated:

-8/13/24-8/19/24 there were no nurse progress notes addressing R1's left elbow pressure sore during this time period.
-8/20/24 at 3:07 PM, documents, "On 8/16/24 a facsimile was sent to (V14, Physician) to inform of (R1's) left elbow wound. (V14) responded asking if wound physician was following (R1). Response sent to inform (V14) that wound physician no longer follows (R1) due to left elbow wound healing in the past. Awaiting response."
-8/21/24 at 7:26 PM, documents, "(V23, Wound Physician) to follow up on Monday (9/2/24).

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(R1's) Left Elbow wound is open and pin in elbow is exposed. Wet to dry applied, management notified of worsening of wound."
-8/24/24 at 12:05 PM, documents, "Noted that (R1's) left elbow wound is worsening. Wound is red and warm to the touch. Wound is open and has exposed bone and internal hardware present and visible. (R1) sent to the emergency room."

R1's Hospital Record, dated 8/24/24, documents R1 was admitted to the hospital with Cellulitis of the Left Elbow and Altered Mental Status secondary to Left Elbow prosthetic joint infection. This same record documents R1 underwent Left Prosthetic hardware removal and Incision and Drainage (I and D) of Left Elbow followed by a Wound Vacuum placement on R1's left elbow on 8/27/24. This same record documents, "Discussed wet to dry dressings and applying support to avoid putting any pressure on the wound as this occurred from chronic pressure on the left elbow most likely."

R1's Final Report to the State Agency, dated 8/29/24, documents, "(R1) had an area to her left elbow that is a result of an Olecranon fracture with surgical repair with hardware placement prior to her admission to the facility on 4/25/22. From the time of admission, (R1) had a chronic area to her left elbow that will frequently open and resolve. The area to the left elbow most recently resolved as of 7/29/24." This same report documents V21, Registered Nurse (RN), "visualized (R1's) Left elbow and it appeared to be the same as usual, the area was linear and there was a small amount of dried drainage on the dressing, no changes from usual for (R1)." This same report documents R1 had a left elbow wound that required monitoring and dressing changes.

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R1's X-Ray report, dated 8/24/24, documents, "Findings: Post surgical change to the Olecranon noted with a pin and wire construct. There is separation of the hardware from the native bone posterior with protrusion through the skin surface. No significant lucency is noted at the hardware/bone interface. The fracture is healed. The radiocapitellar and ulnar trochlear joints are anatomic in alignment."

On 9/4/24 at 8:00 AM, V5, R1's Power of Attorney (POA), stated, "I saw (R1's) left elbow wound for the first time on 8/24/24 and it was horrible. I could see (R1's) bone. It was just awful. It had a bad odor and yellow/green drainage. I was never informed of (R1's) left elbow wound getting so bad. Now (R1) is on Intravenous (IV) antibiotics for the next four to six weeks. (R1) is in terrible shape now because of this facility."

On 9/5/24 at 10:20 AM, V19, Certified Nurse Aide (CNA), stated R1 had an open wound on her left elbow that was being treated by the nursing staff. V19 stated, "The long-term area where (R1) lived was using agency nurses. Those (agency) nurses did not attend to (R1's) left elbow wound like they should have. The dressing was never on. (R1) like to lean on her Left side when she sat up in her wheelchair. (R1's) left elbow would sit directly on her arm of her wheelchair when it wasn't dressed or padded with anything. That was about half of the time. I told the agency nurses about this, but they didn't do anything."

On 9/5/24 at 11:00 AM, V15, Orthopedic Surgeon, stated R1 had hardware placed in R1's left elbow 10 years ago. V15 stated V15 took over R1's care on 8/24/24. V15 stated R1's hardware removal could have been caused by her pressure

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ulcer or her infection. V15 stated, "It is difficult to tell if (R1's) pressure ulcer or her infection caused the removal of the hardware, but the hardware itself did not cause the infection." V15 stated the facility nursing staff should have notified the Physician (V14) on 8/13/24 when noting R1's left elbow had an open wound. V15 stated R1's infection could have addressed at that time and was not.

On 9/5/24 at 11:30 AM, V1, Administrator, stated the facility staff should have obtained a treatment order and made notifications to R1's Physician and Power of Attorney (POA) on 8/13/24 when R1's open wound on her left elbow had re-opened. V1 stated an open wound would cause an infection. V1 stated the nursing staff treated R1's open wound "off and on" for the entire length of R1's stay. V1 stated the nursing staff did not obtain orders for treatment due to "This was a common problem for (R1). The nursing staff would apply an absorbent pad when her wound would drain off and on. It was the general thought from the nurses that the order to apply elbow protectors meant to provide treatment. (R1's) open left elbow pressure ulcer should have had a separate physician order for treatment."

On 9/5/24 at 1:00 PM, V1, Administrator, stated the facility should have notified V14, Physician, on 8/13/24 of R1's new Left Elbow Pressure Ulcer.

On 9/6/24 at 9:30 AM, V14, Medical Director, stated R1 admitted to the facility with a known medical history of having a left elbow hardware placed 10 years prior to admission. V14 stated after reviewing R1's hospital records from her 8/24/24 admission, R1 did not have a deep infection due to her C-Reactive Protein (CRP)

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level not being extremely high. V14 stated R1's infection was in her left elbow pressure ulcer. V14 stated, "The facility nurses should have been more aggressive in contacting me due to (R1's) wound was open and draining. I would have provided orders until the wound Physician could take over her care. Apparently, the facility sent a fax to my office after hours on a Friday (8/16/24) which was not received until 8/19/24. They (facility) should have called me to get the necessary orders. They (facility) did not give proper care for (R1)." V14, Medical Director, stated the facility should have contacted him on 8/13/24 when R1's left elbow pressure ulcer was first noted as open with drainage. V14 stated, "(R1's) infection in her left elbow pressure ulcer could have been prevented from getting so bad if it would have been treated earlier."

2. R4's undated Face Sheet documents R4 admitted to the facility on 8/13/24. This same Face Sheet documents R4's medical diagnoses of Intertrochanteric fracture of Right Femur, Falls, UTI's, COPD, Iron Deficiency Anemia, Disorders of Bone Density and Structure, and neuromuscular dysfunction of bladder.

R4's Admission assessment, dated 8/13/24, does not include any pressure areas. This same assessment documents R4's skin as intact.

R4's Minimum Data Set (MDS), dated 8/19/24, documents R4 as severely cognitively impaired. This same MDS documents R4 requires maximum assistance with bed mobility, bathing, dressing, personal hygiene and is dependent on staff assistance for toileting.

R4's Pressure Ulcer Risk Evaluation, dated

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8/20/24, documents R4 is a high risk for obtaining a pressure ulcer.

R4's Nurse Progress Note, dated 8/24/24 at 10:46 PM, documents, "(R4's) Right Heel discoloration with discomfort noted. Foam dressing applied to protect the area and heel lifted to reduce pressure, which provided relief. Power of Attorney (POA) and on-call manager were informed. Ongoing monitoring will continue and (V25, Registered Nurse/RN) dayshift nurse will follow up with the (V23) wound Physician for further evaluation and treatment."

R4's Skin Evaluation, dated 8/25/24, documents R4's new facility acquired deep tissue injury (DTI) to R4's right heel. This same evaluation documents R4 had "discoloration and discomfort noted" and measures 1.2 centimeters (cm) long by 1.9 cm wide by immeasurable depth.

R4's Skin Evaluation, dated 8/25/24, documents R4's new facility acquired Deep Tissue Injury (DTI) to R4's right heel. This same evaluation documented R4 had "discoloration and discomfort noted" and measures 1.2 centimeters (cm) long by 1.9 cm wide by immeasurable depth. This same evaluation does not document V14, Physician, as being notified.

R4's Physician Order Sheet (POS), dated September 2024, documents a physician order starting 8/27/24 to apply skin prep and foam every shift and as needed to R4's right heel.

R4's Careplan intervention, dated 8/29/24, documents R4's facility acquired deep tissue injury (DTI). This same careplan, dated 9/11/24, instructs staff to apply heel protectors.

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R4's Initial Wound Evaluation and Management Report, dated 9/9/24, documents R4's Unstageable Full Thickness Right Heel Pressure Ulcer measuring 2.0 centimeters (cm) long by 3.0 cm wide by immeasurable depth due to necrosis. This same evaluation documents R4's Right Heel Unstageable Pressure Ulcer as an open ulceration.

R4's Nurse Progress Note, dated 9/10/24 at 9:45 AM, documents, "(V14, Physician) states to follow up with (V23, wound Physician/(V16), wound nurse) to evaluate and treat coccyx in addition to the (right) heel."

On 9/10/24 at 11:30 AM, R4 was sitting in wheelchair in her room. R4 was wearing non-skid socks with her feet directly on foot pedals.

On 9/10/24 at 12:00 PM, V4, Regional Director of Operations, stated the facility identified R4's right heel Deep Tissue Injury (DTI) on 8/24/24 during a whole house skin sweep. V4 stated R4's the facility nurse should have notified the Physician on 8/24/24 when the new facility acquired right heel pressure ulcer was identified.

On 9/12/24 at 12:15 PM, R4 sitting up in her wheelchair with her feet on the foot pedals by her bed in her room. R4's heel protectors were laying on the opposite side of R4's bed on the floor.

On 9/12/24 at 12:20 PM, V10, Certified Nurse Aide (CNA), stated R4 should have her heel protectors on at all times. V10, CNA, confirmed R4 did not have her heels floated, and was not wearing her heel protectors. V10, CNA, stated, "They (facility) just got those heel protectors for (R4) two days ago. (R4) didn't have them

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before."

On 9/10/24 at 12:00 PM, V4, Regional Director of Operations, stated the facility identified R4's right heel deep tissue injury (DTI) on 8/24/24, during a whole house skin sweep. V4 stated R4's facility nurse should have notified the Physician on 8/24/24 when the new facility acquired right heel pressure sore was identified. V4 stated, "There should have been a skin assessment completed, order obtained, and the Physician should have been notified. We (facility) are working through training our nursing staff on all of these things. There was a delay in treatment for (R4) for three days. That should have never happened." V4 stated the delay in treatment for R4's right heel may have contributed to its deterioration.

On 9/11/24 at 2:00 PM, V25, Registered Nurse (RN), stated V25 was the dayshift nurse for R4 on 8/25/25. V25 RN stated, "I am so sorry. I was endorsed that information and must have forgotten to notify (V14, Physician). I should have called (V14, Physician) to obtain orders for the treatment of (R4's) right heel pressure ulcer."

On 9/11/24 at 2:45 PM, V14, Physician, stated the facility should have notified the on-call system about R4's new facility acquired right heel pressure sore on 8/24/24. V14 stated, "This is the second time in the recent past that this has happened. The nurses need to notify the Physician so that an order can be obtained. (R4's) right heel is now open which could have been prevented. If they (facility) are unable to contact the Physician on call system, then they need to reach out to me as the Medical Director." V14, Physician, stated V14 was notified of R4's right heel pressure sore on 9/10/24, per the nurse progress note documented in R4's Electronic

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S9999	Continued From page 12 Medical Record (EMR). The facility policy titled Wound Assessment, revised 7/1/2019, documents new wounds and/or other skin impairments/abnormalities will be assessed and documented using the skin and wound program in the electronic medical record upon being observed. The designated wound nurse will ensure that all wounds have a weekly assessment completed and monitor all wounds for improvement, deterioration or healing. The undated facility policy titled Change in Condition documents it is the policy of the facility that a licensed staff member will notify the attending physician and responsible party of change in the resident's condition. The physician/responsible party will be notified when there is a marked changed in relations to usual signs and symptoms and/or the signs and symptoms are unrelieved by measures already prescribed. The physician/responsible party notification is to include but is not limited to onset of pressure ulcers. If the physician cannot be reached the Medical Director will be contacted to report the change in condition until the attending physician can be contacted. Calls will be made to the family/responsible party until they are reached. A message may be left on an answering machine that does not give specifics but leaves a request for the community to be called. The nurse will document in the clinical record. Documentation and assessment will be ongoing until condition has stabilized. (A)	S9999		