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S 000	Initial Comments Complaint Investigation 2446636/IL176974	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 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	S9999		

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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

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

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develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not meet as evidenced by:

Based on observation, interview, and record review, the facility failed to assess, monitor, and transfer a resident to the hospital in a timely manner for 1 of 3 residents (R2) reviewed for change in condition and complete treatments as ordered for 6 of 6 residents (R1, R2, R3, R4, R5, and R6) reviewed for wounds in a sample of 6. This failure resulted in R2 being admitted to the hospital with the diagnoses of sepsis (a life-threatening complication of an infection) and acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions).

Findings include:

1. R2's Admission Record, with a print date of 08/27/24, documented R2 has diagnoses of but not limited to chronic respiratory failure with hypoxia, chronic pulmonary embolism, and non-pressure chronic ulcer of right calf limited to breakdown of skin.

R2's Minimum Data Set (MDS), dated 04/30/24, documented R2 was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) of 10 out of 15 and she required partial/moderate assistance with upper body dressing, some of bed mobility, substantial/maximal assistance with toileting

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hygiene, shower/bathe, lower body dressing, personal hygiene, lying to sitting position, transfers, and she was always incontinent of bowel and bladder.
R2's MDS, M section dated 05/01/24 documented she did not have any skin issues at that time including no venous/arterial ulcers.

R2's Care Plan, with an admission date of 12/29/2022, documented R2 is at risk for respiratory infections related to (r/t) COVID-19, chronic respiratory failure, and chronic pulmonary embolism. Interventions are but not limited to monitor for lower respiratory infection (LRI) and temperature. The Care Plan documented SKIN: R2 has developed what is presenting as a venous wound to her right lateral front lower leg. Interventions include but not limited to assess and document of progress of areas weekly, monitor area for signs and symptoms (s/s) of infection: odor, drainage, color, size, notify physician (MD) of abnormal findings, observe, and assess regularly, skin assessment weekly, and treatment as ordered to right lateral front lower leg.

R2's Physician's Orders, dated 08/12/23 at 2:56 PM, documented weekly skin screen (complete skin form if new alteration is present) every day shift every Saturday for prophylaxis.

R2's weekly skin screens for May 2024 were reviewed and documented R2 did not get her weekly skin screen on 05/25/24.

R2's weekly skin screens for June 2024 were reviewed and documented R2 did not get her weekly skin screen on 06/22/24 and 06/29/24.

R2's Wound Care Note, dated 06/18/2024 at

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11:47 AM, documented writer notified by Certified Nursing Assistant (CNA) patient (Pt) had an open area to the right lower extremity (RLE) upon assessment it was observed the Pt had what was presenting as a ruptured blister wound. Wound bed had 100% granulation with no undermining or tunneling. The wound had moderate serous drainage, edges attached, peri wound was intact, no odor or pain, and RLE cool to touch and discolored. V8, Nurse Practitioner was called, and new orders received, and call placed to set up appointment for a doppler.

R2's Skin & Wound Evaluation, dated 06/18/24, documented R2 had a new skin area (blister) to her front right (Rt.) lateral lower leg measuring area: 0.4 square centimeters (cm2), length: 0.9 centimeters (cm), and width: 0.7cm.

R2's Physician's Orders, dated 06/20/24 at 8:25 AM, documented Cleanse right lateral calf with wound cleanser then apply collagen particles to wound bed then apply xeroform and cover with dry dressing daily.

R2's Skin & Wound Evaluation, dated 06/25/24, documented R2's venous wound to her front Rt. Lateral lower leg was deteriorating and now measuring area 12.5cm2, length: 3.0cm, and width: 5.2cm.

R2's Physician's Orders, 06/28/24 at 1:10 PM, documented R2's treatment was changed to the following: Triamcinolone (TMC) Acetonide External Cream 0.1 % (Triamcinolone Acetonide (Topical)) Apply to Right anterior calf topically every day shift to Promote Wound Healing Cleanse right anterior calf wound with wound cleanser then apply TMC mixed with A&D ointment and collagen particles to wound bed

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cover with calcium alginate then apply abdominal (ABD) pad and Kling daily.

R2's Treatment Administration Record (TAR) for the month of June 2024 was reviewed and had no documentation R2 received her daily wound treatments on 06/20/24, 06/23/24, 06/28/24, 06/29/24, and 06/30/24.

R2's Skin & Wound Evaluation, dated 07/03/24, documented R2's venous wound to her front Rt. Lateral lower leg was stable and measuring area: 15.2cm2, length: 3.6cm, and width: 6.5cm. It also documents under evidence of infection there is increased drainage, increased pain, and warmth.

R2's Skin & Wound Evaluation, dated 07/11/24, documented R2's venous wound to her front Rt. Lateral lower leg was improving and now measuring area: 19.7cm2, length: 5.7cm, and width: 4.9cm.

R2's Skin & Wound Evaluation, dated 07/19/24, documented R2's venous wound to her front Rt. Lateral lower leg improving and measuring area: 15.6cm2, length: 3.4cm, and width: 6.5cm.

R2's TAR for the month of July 2024 was reviewed and had no documentation R2 received her daily wound treatment on 07/02/24, 07/14/24, 07/18/24, 07/19/24, 07/20/24, 07/22/24, 07/24/24, 07/25/24, and 07/27/24.

R2's Skin and Wound Note, dated 07/25/24, documented evaluation for venous wound to Right Lower Extremity (RLE) increased edema with erythema, warmth and pain, 2+ edema to RLE toes up to knee, 1+ edema to Left Lower Extremity (LLE). Wound assessment size 6 cm x 8.5 cm x 0.1 cm. Peri wound: fragile, edema,

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erythema, venous, denuded. Exudate: Heavy amount of serosanguineous drainage. Recommend STAT venous doppler to RLE to rule out deep vein thrombosis (DVT), if unable to obtain today then send to emergency room (ER) for evaluation.

R2's Physician's Orders, dated 07/26/24, documented Keflex oral capsule 500mg (Cephalexin) give 1 capsule by mouth four times a day for skin redness for 7 days cellulitis to bilateral lower extremities.

R2's Progress Notes, dated 07/27/2024 at 08:04 AM, documented Nurse's Notes Resident is shaking and very warm to touch. Resident is short of breath, oxygen (O2) saturation (sat) on room air is 85%. Place oxygen to 1 liter (L) and O2 sat is 90%. Place oxygen to 2 Liters (L) and O2 sat is 92%. Resident complains of shortness of breath. Emergency Medical Services (EMS) called at this time. Estimated Time of Arrival (ETA) is at 08:45.

R2's Physician's Order, dated 10/02/23, documented Oxygen at 2L via nasal cannula at bedtime (HS) for sleep apnea.

R2's Electronic Medical Record (EMR)/Vital Signs (v/s) were reviewed and documented on 07/27/24 at 8:11 AM, R2's blood pressure (B/P) was 130/48, temperature (T.) was 98.7, Respirations (resp) were 20, and R2's O2 saturation was 85%. There were no other v/s documented for 07/27/24.

R2's Progress Notes, dated 07/27/2024 at 2:45 PM, documented Nurses Notes resident (Res) transported to the local hospital via ambulance at 2:15 PM.

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R2's Progress Notes, dated 07/27/2024 at 9:11 PM, documented Res admitted to local hospital for sepsis and hypoxia.

R2's Electronic Medical Record (EMR) was reviewed and no documentation regarding continued monitoring of R2's condition including R2's oxygen saturation (SpO2).

On 8/27/24 at 2:00 PM, V14, Licensed Practical Nurse (LPN) was contacted on the phone for an interview. V14 stated she had arrived at the facility at 5:38 AM and was working that morning to cover a few hours until the day nurse arrived. V14 said she was performing a check on her residents and a Certified Nursing Assistant (CNA) had told her R2 was acting different. V14 said she went into the room, and R2 was shaking, and her face was red. V14 stated she obtained R2's vital signs, her (R2) oxygen saturation was low so V14 obtained an oxygen tank and applied oxygen. V14 said she called the local ambulance with the number located on the sign at the nurse's station. She said the ambulance service told her they were on their way and about ten minutes later, the ambulance service called back and said they would be arriving about 8:45 AM. V14 said she let the oncoming nurse know she had called the ambulance and the estimated time of arrival. V14 then left as her partial shift was completed.

On 08/27/24 at 2:45 PM, V15, LPN was called and asked if she could relay the events on 07/27/24, regarding her care of R2. V15 stated that she called the facility to let them know that she would be running a little late that day and they got the night nurse to stay over until she arrived. V15 stated V14, LPN had given her (V15) report and told her she had called the

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ambulance and was sending R2 out because she had the shakes. V15 said she looked in R2's room and staff were getting her dressed and preparing her for ambulance transfer. When V15 checked in the room later, she noted that R2 was eating her breakfast. V15 stated that it was time for the afternoon medications, and she called the ambulance service because they had not yet arrived. The ambulance service told her it would be another hour, so she cancelled the transport and said that if she assessed R2 and she needed to go out to the hospital, V15 would call herself. V15 said later on she assessed R2 and felt that R2 was behaving differently. V15 said she noted a change in R2's condition, and R2 hadn't eat lunch, so she called the emergency ambulance transport and they said they would arrive in five minutes. The ambulance arrived at 2:15 PM to transfer R2 to the hospital. V15 stated that she couldn't find the earlier transfer paperwork that had been prepared, she tried to reprint the paperwork, and had difficulty only receiving one or two of the papers. V15 said the hospital called back asking for the paperwork and once again she had difficulty, and she had the wrong fax number. V15 also stated the hospital staff asked her why she had waited so long to send R2 out. V15 was asked about any additional vital signs for R2 which she stated were not done because her assessment of change in condition did not occur until right before she called the ambulance. V15 stated her charting was in the progress notes regarding transfer by local ambulance at 2:15 PM. V15 stated that her charting again was done later when she charted the hospital admitting diagnosis of hypoxia and sepsis.

On 09/05/24 at 12:16 PM, V20, CNA stated she was at the facility on the day R2 was being sent out to the hospital. V20 said when she first arrives

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at the facility, she will walk down her hallway and check on everyone and the night shift had told her something was wrong with R2 and R2 hadn't been acting right. V20 said R2 didn't eat breakfast that morning, she wouldn't get up out of bed, and that isn't like her at all. V20 stated night shift usually gets R2 up, but she was still in bed when she got to the facility that morning. V20 stated when she checked on R2 that morning she seen R2 was on oxygen, so she asked the nurse why and the nurse told her she was getting ready to send R2 out to the hospital. V20 stated she knew they were sending R2 out, so she kept a close eye on her throughout the day. V20 stated at 11:00 AM she noticed R2 wasn't looking good, so she went and talked with the nurse and asked her about R2 being sent out.

On 09/05/24 at 12:29 PM, V15, LPN was contacted for a follow up interview regarding R2. V15 said she got to the facility about 8:00 to 8:15 AM on 07/27/24 and was told by the nurse covering for her she (V14) was sending R2 out to the hospital. V15 said V14, LPN told her she called the non-emergency ambulance number, and they would be here by 8:45 AM to pick up R2. V15 stated she went down to check on R2, but the CNAs were getting R2 cleaned up and changed so she could go out the hospital and she also seen her breakfast in her room. V15 stated she didn't do any vital signs at this time and R2 did not have any oxygen on, but she said R2 takes it off all the time. V15, said she didn't go down and check on R2 again until a couple of hours later around lunch time after she talked with a CNA. V15 said when she went down to R2's room to check on R2 and she wasn't acting like her normal self. She said she hadn't eaten any of her lunch, she was drowsy, and she was lying off the side of the bed. V15 stated she did

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do v/s on R2 at that time. She said she checked her b/p and her pulse but didn't check her O2 saturation, then she went and called 911, and they (EMS) arrived at the facility in about 5 to 10 minutes after she called them. When questioned about where this surveyor would find the documentation and v/s V15 stated she didn't document the v/s, but she did inform the Emergency Medical Technicians (EMTs) what they were when they came to pick up R2.

On 09/12/24 at 11:13 AM, V15, LPN said she did not ask the CNAs that day to take R2's v/s because she likes to take her own vitals.

R2's Patient Care Report from the local ambulance service, dated 07/27/24 at 2:24 PM, documented R2's chief complaint was altered consciousness: lethargic, R2's v/s were as follows: B/P 134/96, Pulse 88, Respirations 16, SpO2 was 86% ambient air (room air). The Report documents "at 2:27 PM it documented R2's v/s as follows: B/P 137/68, Pulse 94, Respirations 21, and SpO2 87%. At 2:38 PM it documented R2's v/s as follows: B/P 103/52, Pulse 90, Respirations 13, and SpO2 94%.

R2's Hospital Report, dated 07/27/24, documented "Clinical Indicators/Treatments 90 y/o (year old) female presents from her extended care facility with shortness of breath. O2 sat upon arrival 86% on room air. O2 2L (Liters) NC (nasal canula) initially applied up to 6L NC. Patient's respiratory status continued to worsen and BIPAP (bilevel positive airway pressure) was applied. Currently on NC 4L with O2 sats 94-95%." It further documents "Reason for visit, visit diagnoses sepsis, due to unspecified organism, acute on chronic hypoxic respiratory failure, cellulitis of right lower extremity, and acute on

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chronic CHF (congestive heart failure)." It also documented "Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following condition(s): unstable vital signs and end of life care/management/discussion, acute congestive heart failure exacerbation (CHF), hypoxic respiratory failure, and sepsis." It also documented critical care was time spent by providing the following: "Continuous telemetry, continuous pulse oximetry, interpretation of bedside monitors, imaging, and arterial/venous lab draws and several patient bedside exams, supplemental oxygen, and non-invasive positive pressure ventilator management." It also documented some of R2's labs were abnormal. R2's Complete Blood Count (CBC) was high at 19.8 with the normal range being 3.8-9.9. R2's Brain Natriuretic Peptide (BNP) was high at 2,045 with the normal range being <=450 picograms per milliliter (pg/ML). (BNP is a test that gives your provider information about how your heart is working. When your heart must work harder to pump blood, it makes more BNP. Higher levels of BNP can be a sign of heart failure. ClevelandClinic.org)

R2's Hospital Report, dated 08/05/24 at 6:20 PM, documented R2's final diagnoses were but not limited to Sepsis, unspecified organism, Acute on chronic CHF, Acute respiratory failure with hypoxia, and cellulitis of right lower limb.

On 08/27/24 at 09:18 AM, V3, R2's daughter said when she arrived to the hospital R2 was in severe pain and looked like "H***". V3 said later in the evening the doctor came up to check on R2 and told her (V3) he was surprised R2 made it because he wasn't sure if she was going to. V3 said R2 was on oxygen and having issues with

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breathing. They gave R2 some morphine to help with the pain and after that she was kind of out of it for a couple of days. V3 said R2's leg was swollen and looked like it was going to "rot off". She said she (V3) talked with the facility, and they told her they take good care of their residents.

On 08/27/24 at 12:15 PM, V9, LPN said if she had a resident who had a change in condition, she would assess the resident, obtain vital signs, and if abnormal would notify the physician for further evaluation and orders. She would then notify the family and if needed she would then call an ambulance.

On 08/27/24 at 12:30 PM, V13, LPN/Infection control nurse stated if she had a resident who had a change in condition and shortness of breath, she would assess the resident and then phone the physician. She said if the resident was critical, she would immediately call 911.

On 08/27/24 at 1:30 PM, V1, Administrator stated if there was a resident who complained of shortness of breath and had a change in condition, she would expect the nurses to contact the physician, they should chart the situation, background, assessment, and recommendation (SBAR) in the progress notes, and if the situation is urgent the staff should call 911. She said the response time of an ambulance varies and if the call is made on the non-urgent phone number you never know when the ambulance will arrive. V1 stated six hours is too long to wait for an ambulance.

On 08/27/24 at 1:45 PM, V2, Director of Nursing (DON) stated if her nurses had a resident who complained of shortness of breath and had a change in condition, she would expect the nurses

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to first put oxygen on the resident, then call 911, and this should be documented in the progress notes. V2 said six hours is too long to wait for an ambulance.

On 08/27/24 at 12:12 PM, V8, Nurse Practitioner (NP) stated she was not working the day of R2's incident. She said the nurses here at the facility would call the exchange and speak with the on-call provider to get any orders. V8 said the nurses will document in the resident's progress notes that they contacted the on-call provider. V8 said if the nurses were to have a resident who was complaining of being short of breath and their oxygen saturation (SpO2) was 85% she would expect the nurses to assess the resident, place oxygen (O2) on the resident if they didn't already have it on, contact the provider, then send them out. She would also expect them to continue to monitor the resident especially if the resident had interventions in place and there was no change in the resident. V8 was asked if R2 having to wait from 8:04 AM until 2:15 PM to be sent out to the hospital was an appropriate amount of time to which V8 responded "No" that was not an appropriate amount of time for a patient to be in distress if she was still in distress.

On 09/05/24 at 10:30 AM, V16, Wound Care, NP stated she makes weekly rounds on Thursdays, she assesses the wounds, documents on the wounds, takes pictures of the wounds, and makes treatment recommendations for the wound care. She said it is then run past the Primary Care Physician (PCP) and they will say yes or no to the recommendation, but they will generally agree with it. V16 stated the last day she saw R2 she (R2) was having increased edema and showing signs of cellulitis to her wound. V16 stated her recommendation on that

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day for R2 was to get a stat doppler and if they were unable to get the doppler that day to send R2 out to the ER for further treatment. She said she would expect the nurses to put the order in the day it was received and start the order that day or at least within 24 hours of getting the order. V16 stated if she makes a recommendation, and the facility has the supplies in the building she will do the dressing and apply the treatment that day. V16 stated from her understanding V4, Wound Nurse/LPN is to do the dressing changes Monday through Friday unless he is pulled to work the floor and then the floor nurses are to do their own dressing changes. V16 stated when the nurse is changing the dressing, she would expect the nurse to assess the wound. Look for drainage, look at the wound bed, watch for increased warmth, increased pain, and report any signs that are abnormal. V16 said with R2's type of wound (venous) and if there wasn't a clot present the dressing doesn't necessarily have to be changed daily all the time but because of her (R2's) drainage it should have been changed daily as ordered. V16 stated with the signs of cellulitis and the amount of drainage R2 had it could have been detrimental to the wound. She said it was a perfect breeding ground for bacteria. V16 stated if R2's wound was determined to be the source of R2's infection then yes it could have caused the sepsis.

2. R1's Admission Record, print date of 08/27/24, documented R1 had diagnoses of but not limited to Type 2 diabetes, dysphagia, abnormalities of gait and mobility, end stage renal disease (ESRD), heart failure, dependence on renal dialysis, hypertension, chronic atrial fibrillation, and non-pressure chronic ulcer of heel.

R1's MDS, dated 07/06/24, documented R1 was

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moderately cognitively impaired with a BIMS of 10 out of 15. It further documented she has impairment of both upper and lower extremities, treatment as ordered to left lateral mid foot and required use of a wheelchair. observe and assess regularly and protect heels.

R1's Care Plan, last review date of 07/05/24, documented R1 is at risk for skin complications and has a problem listed as an arterial wound to her left lateral mid foot. The goal is that the area to her left lateral mid foot will remain stable/heal throughout the next review. Interventions include but not limited to assess and document progress of areas weekly, educate resident on MD orders for wound care, educate resident on the risks of infection and poor healing related to non-compliance, monitor area for signs and symptoms of infection, odor, drainage, color, and size, notify MD of abnormal findings, protect heals, skin assessment weekly and treatment as ordered to left lateral mid foot.

R1's Physician's Orders, dated 07/04/2024, documented apply wound gel to left heel topically every day shift to promote wound healing. Cleanse left heel with wound cleanser then apply hydro gel mixed with collagen particles to wound bed then cover with calcium alginate then apply dry dressing daily.

R1's TARs, for the month June 2024, shows no documentation that R1 received wound care on 06/13/24, 06/14/24, 06/22/24, 06/23/24, and 06/26/24.

R1's TARs for the month of July 2024 shows no documentation for wound care on 07/02/24, 07/06/24, 07/18/24, 07/22/24, 07/27/24, and 70/29/24.

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R1's TARs for the month of August 2024 shows no documentation for wound care on 08/01/24, 08/02/24, 080/3/24, 08/09/24, 08/15/24, 08/17/24, 08/18/24, and 08/23/24.

On 8/26/24 at 11:15 AM, R1 stated the floor nurses must change her dressing on the weekends because the wound nurse is off on the weekends. R1 stated that last Saturday (08/24/24) her wound care was performed while she was at in-house hemodialysis. During the same time V4, Wound Nurse was observed changing R1's dressing. The date on dressing was 8/24/24 (2 days prior to current observation date). V4 was asked what the date on the dressing was and he verified the date was 08/24/24.

3. R3's Admission Record, print date of 08/27/24, documented R3 had diagnoses of but not limited to non-pressure chronic ulcer of other part of right lower leg, lymphedema, osteoarthritis, schizophrenia, and heart failure.

R3's MDS, dated 06/02/24, documented R3 has a moderate cognitive impairment with a BIMS score of 10 out of 15 and requires use of a wheelchair and a walker, is incontinent of bowel and bladder, and is at risk for developing pressure ulcers.

R3's Care Plan, last review date of 06/04/2024, documented R3 has a problem with a venous wound to his right lateral calf with the goal that the wound will remain stable/heal throughout the next review. Interventions include but are not limited to assess and document progress of areas weekly, educate resident on the risks of infection and poor healing related to non-compliance, monitor areas for signs and

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symptoms of infection, odor, drainage, color, and size, notify MD of abnormal findings, observe, and assess regularly, skin assessment weekly, and treatment as ordered to right lateral calf.

R3's Physician's Orders, dated 04/09/24, documented remove ace wraps from lower legs every night shift. Also, to cleanse bilateral lower extremities (BLE) with soap and water and apply A&D ointment and then wrap with ace wraps every day shift for edema control.

R3's Physician's Orders, dated 08/01/24, documented cleanse right medial calf with wound cleanser and then apply TMC mixed with A&D to wound bed, cover with calcium alginate, ABD pad and Kling daily for 7 days.

R3's Physician's Orders, dated 08/09/24, documented clean left medial calf with wound cleanser and apply TMC mixed with A&D and cover with calcium alginate and dry dressing daily for 10 days.

R3's TARs for the month of June 2024 had no documentation for wound care on the following dates: 06/13/24, 06/22/24, 06/23/24, and 06/29/24. There is no documentation of ace wrap removal on 06/06/24 and 06/12/24.

R3's TARs for the month of July 2024 had no documentation for wound care on the following dates: 07/06/24, 07/18/24, 07/20/24, 07/21/24, 07/22/24, 07/27/24, 07/28/24 and 07/29/24. There is no documentation of ace wrap removal on 07/05/25, 07/10/24, and 07/14/24.

R3's TAR for the month of August 2024 had no documentation on wound care for 8/1/24, 8/2/24, 8/3/24, 8/17/24, 8/18/24, and 8/19/24. Ace wrap

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removal at bedtime was not documented on 8/7/24, 8/13/24 and 8/22/24.

4. R4's Admission Record, print date of 08/27/24, documented R4 had diagnoses of but not limited to multiple sclerosis, acute respiratory failure, metabolic encephalopathy, weakness, chronic pulmonary embolism, cellulitis, and dermatitis.

R4's MDS, dated 05/31/24, documented R4 was moderately cognitively impaired with a BIMS of 12 out of 15, has impairment to both lower legs, is always incontinent of bowel and bladder, and is at risk for developing pressure ulcers.

R4's Care Plan, last review date of 05/31/2024, documented R4 has a wound to his left great toe with the goal that the area to the left great toe will remain stable/heal throughout next review. Interventions include but not limited to assess and document the progress of areas weekly, educate resident on MD orders for wound care, educate resident on the risks of infection and poor healing related to non-compliance, monitor area for signs and symptoms of infection, odor, drainage, color, and size, notify MD of abnormal findings, skin assessment weekly and treatment as ordered to left great toe.

R4's Physician's Orders, dated 05/20/24, documented apply Hydrocortisone (Topical) to buttocks and groin topically every day and night shift to Promote Wound Healing, Cleanse buttocks and groin with soap and water then apply Hydrocortisone, A&D ointment, Calamine lotion and nystatin twice daily.

R4's Physician's Orders, dated 08/08/24 to 08/19/24, documented Triamcinolone Acetonide External Ointment 0.1% topical. Apply to left

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posterior calf topically every day shift to promote wound healing, cleanse left posterior calf wound with wound cleanser then apply TMC ointment mixed with A&D ointment to wound bed then cover with xeroform and cover with dry dressing daily.

R4's Physician's Orders, dated 08/23/24, documented apply hydrogel to left lateral calf topically every day shift to promote wound healing. Cleanse left lateral calf wound with wound cleanser then apply Hydrogel mixed with collagen particles to wound bed cover with calcium alginate and dry dressing daily.

R4's TARs for the month of June 2024 were reviewed and had no wound care documentation for the morning on 06/13/2024, 06/19/2024, 06/20/2024, 06/23/2024, 06/27/2024, and 06/30/2024 and in the evening on 06/18/2024 and 06/29/24.

R4's TARs for the month of July 2024 had no wound care documentation on the mornings of 07/04/24, 07/16/24, 07/18/24, 07/19/24, 07/21/24, 07/22/24 and 07/28/24 and on the evenings of 07/12/24, 07/16/24, 07/17/24, 07/21/24 and 07/22/24.

R4's TARs for the month of August 2024 were reviewed and had no wound care documentation for the mornings for 08/02/24, 08/15/24 and 08/22/24 and no evening documentation on 08/17/24.

5. R5's Admission Record, print date of 08/27/24, documented R5 had diagnoses of but not limited to aphasia following cerebral infarction, brain stem stroke, human immunodeficiency virus, (HIV), diabetes, acute and chronic respiratory

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failure, dysphagia, end stage renal disease, (ESRD), stage 4 pressure ulcer of sacral region, and pressure ulcer of left heel.

R5's MDS, dated 06/25/24, documented R5 has moderate cognitive impairment with a BIMS of 8 out of 15, impairment on bilateral upper and lower extremities, has an indwelling catheter, is always incontinent of bowel, and it also documents R5 is at risk of developing pressure ulcers, and he has a pressure ulcer.

R5's Care Plan, last review date of 08/09/24, documented R5 has a pressure injury to his left heel and sacrum with the goal that the areas will remain stable/heal throughout the next review. Interventions include but not limited to assess and document progress of areas weekly, educate R5 on MD orders for wound care, educate resident on the risks of infection and poor healing related to non-compliance, monitor area for signs and symptoms of infection, odor, drainage, color, and size, notify MD of abnormal findings, skin assessment weekly and to provide treatment as ordered to the left heel and sacrum.

R5's Physician's Orders, dated 06/03/24, documented apply betadine to left heel, then apply ABD pad and secure with Kling daily.

R5's Physician's Orders, dated 06/07/24 through 06/15/24, documented cleanse sacrum wound with wound cleanser then reconstitute 3 capsules of compound of Streptomycin 80mg, Flucytosine 50mg, and Meropenem 150mg and 1 capsule of Levaquin 400mg and 1 packet of collagen particles with 12 pumps of Bassa-gel then apply to wound bed, cover with, and lightly pack with calcium alginate and then cover with dry dressing daily.

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R5's Physician's Orders, with a start date of 06/21/24 and discontinued on 07/26/24, documented Cleanse Sacrum wound with wound cleanser then reconstitute 3 capsules of compound of Streptomycin 80mg, Flucytosine 50mg, and Meropenem 150mg and 1 capsule of Levaquin 400mg and 1 packet of collagen particles with 12 pumps of Bassa-gel then apply to wound bed cover with and lightly pack with calcium alginate.

R5's Physician's Orders, dated 07/09/24, documented apply hydrogel to left heel topically every day shift. Cleanse left heel with wound cleanser then apply hydrogel mixed with collagen particles to wound bed and cover with calcium alginate and cover with ABD and Kling daily.

R5's Physician's Orders, dated 7/26/24, state to apply wound gel to sacrum topically every day shift for to promote wound healing. Cleanse sacral wound with wound cleanser then apply Hydrogel mixed with collagen particles to wound bed cover with calcium alginate then dry dressing daily.

R5's TARs for the month of June 2024 were reviewed and had no documentation of the sacrum wound treatment being completed on 06/22/24, 06/23/24, 06/27/24, and 06/30/24.

R5's TARs for the month of July 2024 were reviewed and had no documentation of the sacral wound treatment being done on 07/04/24, 07/18/24, 07/22/24, 07/23/24, 07/25/24 and 07/26/24.

The August 2024 TAR showed no documentation on the sacral wound on 8/2/24, 8/7/24, 8/12/24,

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8/21/24 and 8/22/24.

R5's July 2024 TAR showed no documentation his wound care was completed on the left heel wound on 7/14/24, 7/18/24, 7/22/24, 7/23/24.

R5's August 2024 TAR showed no documentation R5's wound care was completed on the left heel on 8/2/24, 8/7/24, 8/12/24, 8/21, and 8/22/24.

6. R6's Admission Record, print date of 08/27/24, documented R6 had diagnoses of but not limited to type 2 diabetes, dependence on renal dialysis, congestive heart failure, (CHF), transient cerebral ischemic attack, (TIA), dependence on renal dialysis, essential hypertension, peripheral vascular disease, non-pressure chronic ulcer of other part of right foot with other specified severity, non-pressure chronic ulcer of right heel and midfoot with other specified severity.

R6's MDS, dated 08/04/24, documented R6 was severely cognitively impaired with a BIMS of 6 out of 15. R6 however is alert and oriented to place, time, and person. It also documented R6 has impairment on both sides and requires the use of a wheelchair, has a diabetic foot ulcer and is at risk for developing pressure wounds.

R6's Care Plan, last review date of 08/02/24, documented R6 was admitted with a diabetic foot ulcer to her right heel with the goal that the heel will remain stable and heal. Interventions include but not limited to assess and document the progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours, educate R6 on MD orders for wound care, educate R6 on the risks of infection and poor healing related to non-compliance, monitor area for signs and symptoms of infection, odor,

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drainage color and size, notify MD of abnormal findings, skin assessment weekly and treatment as ordered to right heel.

R6's Physician's Orders, dated 06/08/24, documented cleanse right heel with wound cleanser and then apply hydrogel mixed with collagen particles to wound bed and cover with calcium alginate and dressing daily.

R6's TARs were reviewed for the month of June 2024 and there was no wound care documentation on the following dates: 06/04/24, 06/13/24, 06/14/24, 06/23/24, 06/26/24, and 06/29/24.

R6's TARs for the month of July 2024, were reviewed and there was no documentation wound care was done on the following dates: 07/02/24, 07/06/24, 07/20/24, 07/27/24, and 07/29/24.

R6's TARs for the month of August 2024, were reviewed and there was no documentation wound care was completed on the following dates: 08/02/24, 08/03/24, 08/17/24, 08/18/24, and 08/25/24.

On 08/26/24 at 11:30 AM, R6, stated she had daily wound care dressings ordered. She also stated did not receive a new dressing over the weekend. During the same time V4, wound care nurse, was observed performing wound care to her (R6) right heel. The dressing on her right heel was observed to be dated 8/23/24 (3 days ago).

On 08/27/24 at 10:34 AM, V4, Wound Nurse said skin checks are to be done weekly on the resident's shower day. He said the Certified Nursing Assistant (CNA) will fill out the shower sheet and then the nurse is to sign off on it. If

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BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

there are any issues, they will bring it to him. He said the only time they must fill out a skin assessment in Point Click Care (PCC) is when the resident actually has an issue. V4 said he would expect the nurses to do just like any other place and be responsible for their own dressings when he isn't at the facility.

On 08/27/24 at 1:30 PM, V1, Administrator stated she expects the floor nurses to perform their own treatments on days when V4, Wound Nurse isn't at the facility.

On 08/27/24 at 1:35 PM, V2, Director of Nursing (DON) stated if V4, Wound Nurse wasn't at the facility she would expect the nurses to perform their own treatments.

On 09/05/24 at 1:10 PM, V17, LPN stated V4, Treatment nurse is the one who is responsible for treatments Monday through Friday, if he isn't in the facility, they will sometimes have someone who picks up a day and comes in and does treatments, and if there isn't anyone to do that then the floor nurse is responsible for their own treatments. When V17 was questioned about the TARs not being signed off that treatments were completed she said she will usually sign them off. She said sometimes the nurse who is doing treatments that day will forget to sign them off also. V17 said on days where she is really busy and has to send residents out to the hospital treatments are hard to get to so she will report it to the nurse who comes in to replace her that she wasn't able to complete the treatments.

On 09/05/24 at 1:18 PM, V9, LPN stated V4, Wound nurse is responsible for all the treatments and if he isn't here the hall nurse is to do their own dressing changes. She said it can be a little

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	IL6005474	A. BUILDING: ______ B. WING ______	C 09/12/2024

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BRIA OF BELLEVILLE	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

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bit of a struggle to get the treatments done when V4 isn't here. V9 stated she will just prioritize what she needs to do. She also stated sometimes agency will pick up a shift and they will forget to sign off the TAR.

On 09/05/24 at 1:20 PM V18, Registered Nurse (RN) stated the wound nurse (V4) is responsible for the treatments during the week. She said if he isn't at the facility and there isn't anyone to replace him or if he is pulled to work on the floor, then each nurse is responsible for their own treatments. When questioned about the TARs not being signed off, she said sometimes she isn't able to get the treatments done but she will pass it on to the next nurse so they can complete them.

The facility's Change in Resident Condition, review date of 09/2023, documented "General: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician, and resident's responsible party of a change in condition." It further documented "Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: b. There is a significant change in the resident's physical, mental or emotional status." It also documented "e. It is deemed necessary or appropriate in the best interest of the resident. 2. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issues and any physician orders. 3. Communication with the resident and their responsible party as well as the physician will be documented in the resident's medical record or other appropriate documents.

The facility's policy Wound Cleansing and Dressing, with a revised date of 01/05/24,

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S9999	Continued From page 26 documented "Policy: It is the policy of this facility to cleanse all wounds and clear exudates, bacterial contamination, and debris from the wound bed. Optimal wound healing cannot proceed until inflammation-producing substances are removed from the wound bed. Wound cleansing is completed as indicated in the provider's order by the licensed nurse. It is the policy of this facility to perform wound dressing changes as ordered by the provider using clean technique on all chronic or contaminated wounds. A moist wound environment is most favorable for optimal wound healing." It further documents "IV. Documentation A. Documentation of the dressing change is completed on the Treatment Administration Record (TAR) B. Additional documentation may be completed in the nurse's notes as indicated." (A)	S9999		