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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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.	S9999		

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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	S9999		

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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.

These requirements were not met as evidenced by:

Based on interview, observation and record review, the facility failed to identify, treat, monitor and provide pressure reducing interventions for 3 of 3 residents (R1, R2, R3) reviewed for pressure ulcers in the sample of 11. This failure resulted in R2 and R3 sustaining unstageable necrotic pressure ulcers while in the facility.

Findings include:

1. R3 Admission Record, print date of 1/10/24, documents R3 was admitted on 10/26/23 and has diagnoses of Dementia, fracture of right femur, coronary artery disease and Type 2 Diabetes Mellitus.

R3's Minimum Data Set (MDS), dated 10/29/23, documents R3 is severely cognitively impaired, requires substantial maximum assistance from staff for bed mobility and transfers and is at risk for pressure ulcers.

R3's Admission Assessment, dated 10/26/23, documents R3's does not have any pressure ulcers.

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R3's Braden Assessment, dated 10/26/23, documents R3 is at high risk for pressure ulcers.

R3's Alert Note, dated 11/10/23 at 2:43 PM, documents, "New skin condition will evaluate." This Alert Note fails to document what the new skin condition is.

R3's Wound Summary Report, print date of 1/10/24, documents a Deep Tissue Pressure Injury on R3's left heel was identified on 11/11/23, measurements were taken on 11/14/23 of 7.00 cm x 6.0 cm x unknown depth.

R3's Wound Summary Report, print date of 1/10/24, documents a Deep Tissue Pressure Injury on R3's left heel measurements on 12/27/23 and 1/3/24 were measured at 3.0 cm x 2.5 cm x unknown depth.

R3's Specialized Wound Doctor Wound Evaluation and Summary Report, dated 12/26/23, documents, "Unstageable (Due to Necrosis) of the Left Heel Full Thickness. Etiology Pressure. Wound Size (L (length) x W (width) x D (depth): 3.2 x 2.5 x not measurable cm (centimeters). Thick adherent black necrotic tissue (eschar) 100%. Dressing Treatment Plan: Betadine once daily. Recommendations: Pressure Off- Loading Boot, Off Load wound."

R3's Specialized Wound Doctor Wound Evaluation and Summary Report, dated 1/8/24, documents, "Unstageable (Due to Necrosis) of the Left Heel Full Thickness. Etiology Pressure. Wound Size (L (length) x W (width) x D (depth): 3.5 x 2.5 x not measurable cm (centimeters). Thick adherent black necrotic tissue (eschar) 100%. Dressing Treatment Plan: Betadine once

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daily. Recommendations: Pressure Off- Loading Boot, Off Load wound."

R3's December 2023, Treatment Administration Record (TAR), documents, "Skin prep to left heel and apply heal protector. every day shift for wound care - Start Date 11/11/2023 0600 -D/C Date 12/13/2023 1419."

R3's December 2023, TAR, documents, "Cleanse left heel wound with wound cleaner, pat dry, apply xeroform, cover with Abd (abdominal) pad and kerlix. every day shift for Wound Care - Start date 12/14/2023 0600 - D/C Date 12/26/2023 1243."

R3's December 2023, TAR, documents, "Apply Betadine to left heel and offload area with protective boot. every day shift for Wound Care -Start Date 12/27/2023 0600 -D/C Date 12/27/2023 0956."

R3's December 2023 and January 2024 Physician Order and TAR's fails to document a treatment order, or a treatment being done for R3's left heel between 12/27/23 and 1/9/24.

R3's January 2024, TAR, documents, "cleanse l (left) heel with wound cleanser, bad dry, paint with Betadine, cover with Abd, wrap in kerlix daily and prn (as needed) for wound care -Start Date 01/09/2024 1015".

R3's Care Plan, dated 11/11/23, documents, "I have a pressure ulcer to left heel. Intervention: Administer treatments as ordered and monitor for effectiveness - Skin prep to left heel and apply heal protector every day shift. At times I am noncompliant with allowing staff to administer wound treatment as ordered. Education provided on importance of compliance to keep wound

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clean and dry to promote wound healing and increased risk for possible wound infection, if I continue to refuse my choice will be honored. Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (Medical Doctor). Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate."

On 1/9/24 at 11:49 AM, R3 was sitting in his room in his wheelchair. R3 was wearing house slippers. The heels of the house slippers have been folded forward and his heels are resting on. R3's left heel dressing observed to be a dry dressing.

On 1/10/24 at 11:30 AM, R3 was sitting in his wheelchair watching TV. R3 was wearing tennis shoes on both feet.

On 1/9/24 at 11:55 AM, V3, Certified Nurses Aide (CNA), stated R3 was working with therapy earlier and is why he has slippers on instead of his pressure relieving boot.

On 1/9/24 at 12:48 PM, V6, Licensed Practical Nurse, (LPN), stated, "I did his dressing already this morning. I did Betadine and a dry dressing. The area is totally necrotic."

On 1/10/24 at 1:30 PM, V1, Administrator, stated, "On 12/27/23, the old wound nurse entered orders for R3's heel of Apply Betadine to left heel and offload area with protective boot every day for Wound Care but then instead of implementing the order she accidentally hit resolved and the order was discontinued."

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On 1/10/24 at 1:55 PM, V10, stated the dressing order was just changed yesterday to have a foam dressing or an Abd (abdominal) pad and then wrap with Kerlix.

On 1/11/23 at 11:05 AM, V1, Administrator, stated R3's heel pressure ulcer should have noticed and treated before 11/11/23 since it got to the size of 7 cm x 6 cm.

2. R2's Admission Record, print date of 1/10/24, documents R2 was admitted on 9/29/23 and has diagnoses of Periprosthetic fracture around internal prosthetic right knee joint, infection and inflammation reaction due to internal fixation device, Dementia.

R2's MDS, dated 11/20/23, documents R2 is severely cognitively impaired, dependent on staff for bed mobility and transfers, frequently incontinent of bladder.

R2's Braden Observation, dated 1/9/23, documents R2 is a moderate risk for pressure ulcers.

R2's Care Plan, dated 10/17/23, documents, "I have the potential for impairment to skin integrity r/t (related to) impaired mobility, incontinence. Intervention: Follow facility protocols for treatment of injury."

R2's Nurses Note, dated 1/9/24, documents, "during routine wound vac change this nurse noted an open area to l (this should be right) foot small toe approx. 1.0 x 1.5 bed is necrotic in color with moderate serosanguinous drainage. No odor noted. This nurse cleansed and dressed and notified NP (Nurse Practitioner) and obtained new orders."

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On 1/10/24 at 2:55 PM, review of R2's Wound Summary Report fails to document the right foot 4th and 5th toes, lateral middle of foot and bottom of right foot necrotic pressure ulcers.

On 1/10/24 at 3:00 PM, R2's Physician Orders, dated January 2024, failed to document treatment for the right foot 4th toe, lateral middle of foot and bottom of right foot necrotic pressure ulcers.

On 1/17/24 at 12:49 PM, R2's Physician Orders, dated January 2024, failed to document treatment for the right foot 4th toe, lateral middle of foot and bottom of right foot necrotic pressure ulcers.

R2's Wound Summary Report, dated 1/17/24, documents a facility acquired pressure ulcer was identified on 1/17/24. The tissue is necrotic and firm. The pressure ulcer measures 12.50 x 4.00 x Unknown.

On 1/9/24 at 3:30 PM, R2's right leg and foot was observed during a wound vac dressing change. R2's 5th toe (pinky toe) appeared necrotic with a black hard appearance and the peri-wound was red. The top of the 4th toe appeared to be necrotic, in between the 4th and 5th toe was necrotic and red, the middle of the outside foot had a necrotic area was the approximate size of a quarter, and under the necrotic area went to sole of the foot. V2 cleansed the 5th toe and in between the 5th and 4th toe with normal saline. The gauze had slight bloody drainage to it after cleansing. V2 (Director of Nurses) then applied a calcium alginate strip in between the 4th and 5th toes, sprayed the outside of the 5th toe with Betadine and covered the areas with a dry dressing. V2 failed to treat the middle lateral pressure ulcer of the R2's foot or the sole of R2's

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foot.

On 1/9/24 at 3:30 PM, V2, Director of Nurses and V14, Licensed Practical Nurse (LPN), entered the room to change R2's wound vac dressing. V2 completed the wound vac dressing change. V2 was questioned if she had a treatment for the lateral (outside) of R2's foot and toes. V2 stated she has not done R2's treatment in a long time and she was unsure if there were orders for treatment to the pressure ulcers, but she would treat them.

On 1/17/24 at 11:30 AM, R2's room was entered with V2. V2 observed the 4th and 5th toes, lateral middle of the foot and bottom of right foot pressure ulcers. R2 also had 2 new necrotic pressure ulcer areas on the side of the heel and up towards the toes on the side of the foot.

On 1/10/23 at 11:45 PM, V10, Registered Nurse (RN) / Wound Nurse, stated she saw R2's toes and lateral right foot this morning for the first time. V10 stated the areas are pressure ulcers, and the areas are all necrotic. V10 stated R2 would benefit from some type of pressure relieving device for the right foot.

On 1/10/23 at 1:35 PM, V2, stated, "R2's lateral foot pressure ulcer and toes did not just happen. Yesterday (1/9/24) was the first time I have seen her in a long time, from reviewing her records, the necrotic areas had not been documented on. I did not measure them yet. I have put in an order for a treatment to it. I have also ordered a pressure relieving boot for her."

On 1/16/24 at 11:50 AM, V15, Assistant Director of Nurses, ADON, stated, "After the wound nurse left, I did wound assessments in wound rounds. I

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stopped doing last Friday. Some residents I would treat some I would not. I did change her (R2's) dressing once or twice. I never noticed her necrotic toes."

On 1/17/24 at 12:05 PM, V2 stated she sent R2 to the hospital because she can no longer wait for (V17, Doctor) to call her back. V2 stated, "She needs somebody to look at leg and foot." V2 stated the new areas were not there yesterday when she looked at her foot. V2 stated R2's 4th toe, lateral middle foot and bottom of the foot should have been noticed before 1/9/24 and should have assessments done and treatments ordered.

On 1/17/24 at 1:30 PM, V18, Nurse Practitioner, stated, "I think R2's wounds are pressure wounds because she lays with the outside of her foot on the bed because of the exposed hardware in her leg. She does have pain and is why she lays that way."

3. R1's Admission Record, print date of 10/10/24, documents R1 was admitted on 5/16/23 and has diagnoses of Osteomyelitis of vertebra, sacral and sacrococcygeal region and Adult Failure to Thrive.

R1's MDS, dated 12/14/23, documents R1 is cognitively intact, requires substantial / maximal assistance from staff for toileting hygiene, dependent on staff for bed mobility and transfers and R1 is always incontinent of bowel and bladder.

R1's Care Plan, dated 6/1/23, documents, "I have a pressure ulcer to my sacrum, right outer ankle and to right heel, I have skin impairment to my right posterior thigh and left upper back d/t (due

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to) progression of disease process, immobility, incontinence and fragile skin. Interventions: Encourage and assist with offloading pressure from BLE (Bilateral Lower Extremity) with the use of heel boots or pillows while in bed as allowed and tolerated."

R1's Physician Order, dated 11/23/23, documents, "Air Loss Mattress, bilateral heel protectors, and cushion to w/c (wheelchair)."

R1's Wound Summary Report documents on 1/4/23, R3's right heal measurements were 3.0 cm x 3.50 cm x 0.2 cm.

On 1/9/24 at 11:52 AM, R1 is lying in bed on his back. His bilateral heel protectors are in the chair in the room.

On 1/9/24 at 1:46 PM, R1 was uncovered by V3 CNA for incontinent care. R1's bilateral heels were directly on a pillow. V3 stated, "After care we will put his boots on."

The Pressure Ulcer Prevention policy, dated 1/18/18, documents, "Inspect the skin several times daily during bathing, hygiene, and repositioning measures. Turn dependent resident approximately every 2 hours or as needed and position resident with pillow or pads protecting bony prominences as indicated. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction / shearing from heels, toes, and malleoli as indicated."

The Pressure Injury and Skin Condition Assessment, dated 1/17/18, documents, "1. A skin condition assessment and pressure ulcer risk assessment will be completed at the time of admission / readmission. 2. Residents identified

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S9999	Continued From page 11 will have weekly skin assessments by a licensed nurse. 3. A wound assessment will be initiated and documented in the resident chart when pressure and / or other ulcers are identified by licensed nurse. 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment." It continues, "7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes." It continues, "11. A wound assessment for each identified open area will be completed and will include: a. site location. b. size (length x width x depth). c. Stage of pressure ulcer. d. odor. e. drainage. f. Description. g. Date and initials of the individual performing the assessment." It continues, "The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection." (A)	S9999		