Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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S 000	Initial Comments Complaint Investigations: 2329924/IL167188 23210063/IL167378 23210268/IL167614	S 000		
S9999	Final Observations Statement of Licensure Findings (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to conduct a fall risk assessment and implement fall interventions for two of three residents (R1 and R4) and failed to ensure a resident (R2) was properly transferred with a mechanical lift. This failure resulted in the mechanical lift tipped over while R2 was in the sling resulting in fracture of the right distal tibia and required a surgical repair. Findings include: The facility's (mechanical lift) Owner's Manual (dated 2017) documents the following: "Please	S9999		

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S9999	Continued From page 2 note that the (mechanical lift) is designed to perform all types of lifts. It can be used as a bath lift in many situations. When used as a bath lift, we recommend using a (mechanical lift mesh bath sling)." This same manual also documents, "Lift Legs Position. Legs should be opened at the following times: To allow access around chairs, toilets or other impediments; To increase stability particularly with heavier patients; So, it is recommended to have legs open when lifting or lowering if possible though not required except as set forth below; Legs must be opened at the following times: For use with a walking harness; For patients who are active or swing around in the lift". The facility's Fall Prevention policy (revised 11/10/18) documents to conduct a fall risk assessment on the day of admission, quarterly and with a change in condition. Identify, on admission, the risk for falls. All staff must observe residents for safety. If a resident with a high-risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. Assessment of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be high risk at the time of admission for up to 72 hours. The admitting nurse will determine the temporary risk category. 1. R2's current medical record documents R2's current diagnoses to include: Hemiplegia and Hemiparesis following cerebral infarction affecting right non-dominant side; and Muscle Weakness. R2's current care plan documents the following focus: "Alteration in transfer ability. Unable to transfer independently related to diagnosis of	S9999		

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S9999	Continued From page 3 CVA (stroke) with right-sided Hemiparesis as evidenced by dependent on staff for all transfers. Resident Specific Information: (R2) requires the use of (mechanical lift) and staff assist of two to complete all transfers." On 12/11/23 at 02:40 PM, V3 (Certified Nursing Assistant) stated she was present during the 12/06/23 transfer when R2 was injured. V3 stated, "We had just given (R2) a shower, and we were transferring (R2) from the shower bed back into her bed. She transfers with a (mechanical lift), and we just left the sling underneath her during her shower, so it was really, really wet. (R2) was moving when she was lifted, and the entire lift tipped over in the middle of the transfer. She did hit her head and the entire right side of her body struck the wall pretty hard. The position of the sling was not centered, and it was very, very wet since she just had the shower." V3 stated the mechanical lift's legs were not opened to increase stability at the time of R2's fall. V3 added R2 has a deficit on her right side, and R2's right arm lost positioning during the transfer. V3 stated, "She (R2) cannot hold her right arm across her chest for the entire transfer, so her arm did slide down, but she remained still enough for me to guide the sling." On 12/11/23 at 04:05 PM, V4 (Certified Nursing Assistant) stated she was one of the staff members present when R2 sustained an injury during a mechanical lift transfer on 12/06/23. V4 stated, "(V3, Certified Nursing Assistant) and I had just given (R2) a shower. We had transferred her to a shower bed for the shower, and we were transferring her back into her bed once her shower was completed. We did leave the mechanical lift sling underneath (R2) while we gave her the shower. It was not a shower sling,	S9999		

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S9999	Continued From page 4 so it absorbed a lot of water, and there was water everywhere. I operated the controls, and (V3) was guiding (R2) while she was lifted in the sling. I had to leave the (stabilizing) legs closed because there just wasn't enough room to open them. When I pushed the mechanical lift toward (R2's) bed, the sling began swinging and then the entire lift tipped over. The top of the lift struck the wall. (R2) hit her head and her body struck the wall pretty hard. At that point, (V2, Director of Nursing) came in and took over. We put her back in bed once lifting help arrived. (R2) has a strong right sided deficit. She was adjusting her arms during the transfer because she cannot maintain her right arm positioned across her chest for very long. She was not flailing around. She was still enough for us to transfer. What made the lift fall was the momentum created from us moving the lift. I think they called 911 for additional lifting assistance. She was still in the facility when I left at the end of my shift." R2's Incident Investigation (dated 12/06/23) documents the following: "(R2) in (mechanical lift) following shower. (R2) was active in (mechanical lift) sling causing the (mechanical lift) to sway. Water dripping from sling during the transfer. The momentum and legs were not fully extended, caused the (mechanical lift) to tip over. 911 activated to assist with returning resident to bed. Again, assessed for injury by staff nurse. Neurological checks intact. Pain 3/10 in lower back. Later in shift resident noted to have increased swelling of extremity. V14 (R2's Physician) made aware and orders received for X-ray. (Local mobile X-ray provider) at facility to perform X-ray (fracture observed). Resident transferred to (local hospital) for evaluation. X-rays there confirmed closed fracture of the proximal fibula." This same investigation	S9999		

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S9999	Continued From page 5	S9999		

documents, "Resident scheduled for surgery at this time. During surgery an open reduction internal fixation using intramedullary nail in distal tibia, and five screws to secure the fibula. Root Cause: Resident moving around in the (mechanical lift). Interventions: Resident will be educated about behavior in the (mechanical lift) upon return from the hospital. Nursing staff will be in-serviced on proper use of the (mechanical lift), which (mechanical lift) slings are appropriate for the transferring situation, weight limits for (mechanical lifts), and resident behavior in a (mechanical lift)."

R2's (local hospital) medical record (dated 12/07/23) documents the following: R2 had an X-ray of her right tibia and fibula with the following impression: Distal Right Tibial Fracture. These same records document R2 had surgery on 12/08/23, and an intramedullary nail with five locking screws were inserted into R2's right tibia to stabilize R2's fracture.

On 12/12/23 at 03:50 PM, V2 (Director of Nursing) stated, "The only correct thing that occurred with (R2's) transfer (on 12/06/23) was the correct (mechanical lift) was utilized, it was appropriate for her weight. The legs of the (mechanical lift) should have been fully expanded and locked for stability, and they were not. Never take the center of gravity away, or someone is going to get hurt. (V3 and V4, Certified Nursing Assistants) did not use the correct sling for the situation. Using a regular sling in the shower is going to absorb excess water weight, and water was dripping everywhere creating a fall hazard. They (V3 and V4) knew to use a shower sling but did not because they could not locate one." V2 then confirmed R2 has right-sided weakness and may not be able to maintain her arm across her

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S9999	Continued From page 6 chest for the duration of a mechanical lift transfer. V2 verified the newly implemented intervention of, "Resident Education" was not an appropriate intervention to implement for R2's mechanical lift transfers and indicated the failure came from the two staff members transferring R2. V2 stated, "(R2) initially reported her pain at 3/10 around 04:00 PM on 12/06/23. At 06:00 PM, increased swelling was noted R2's right leg, and she was reporting increased pain. We ordered a mobile X-ray, and they were at the facility around 06:30 PM. As soon as the X-ray was taken, you were able to see an obvious break, so (R2) was sent to (local hospital) at 06:40 PM and is still hospitalized. She has not yet returned to the facility. The hospital identified a fracture in her right tibia. She had to have surgery to repair the fracture, and she had some hardware to stabilize the fracture." (A) Statement of Licensure Findings (2 of 2): 300.610a) 300.696a) 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 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	S9999		

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S9999	Continued From page 7 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 300.696 Infection Control a) Each facility shall establish and follow policies and procedures for investigating, controlling, and preventing infections in the facility. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. Each facility shall monitor activities to ensure that these policies and procedures are followed. 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. 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:	S9999		

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S9999	Continued From page 8 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, 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 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, assess, report	S9999		

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S9999	Continued From page 9 and treat a facility-acquired pressure ulcer for one resident (R6); failed to administer wound treatment as ordered using proper infection control technique; failed to develop and implement pressure relieving interventions or care plan; failed to conduct a pressure ulcer development risk assessment for a resident identified as high risk for pressure ulcer development; and failed to develop a pressure ulcer care plan after a pressure ulcer developed for three of three residents (R1, R4, R6) reviewed for pressure ulcers in the sample of nine. Findings include: The facility's Skin Care-Wound Care- Teaching Protocols dated 4/07 document, "CNAs (Certified Nursing Assistants): Skin check with ADLs (Activities of Daily Living) and 100% (percent) Skin check with bath/shower. Report any changes in skin to the charge nurse. Report problems noted with wound or treatment coverings to charge nurse. Float heels while in bed. Document interventions on CNA Flow Sheet. Read care plan-Report interventions not on care plan to Care Plan Coordinator. Charge Nurse: Complete Interventions as listed for Prevention Protocols: Report wound area to physician during same shift discovered whenever possible. Obtain order for treatment of wound. Order to include: Method of Cleansing, type of treatment, specific location of area to be treated, type of dressing or "leave open to air", frequency of how treatment is performed, treatment ending date. Assess for pain, notify physician as necessary and intervene as necessary to minimize pain, Initiate daily skin check on TAR (Treatment Administration Record) per score risk, Complete weekly assessment of wound to include wound locations, size in cc	S9999		

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S9999	Continued From page 10 (centimeters), shape, color, depth, and presence of drainage, necrotic tissue granulation present, Initiate nursing intervention and place on TAR as necessary (Door Flag, specialty mattress, specialty chair, float heels, elevate legs, apply lotion, barrier cream..), Communicate new interventions and orders obtained to nursing office via the New Acquired Skin Condition Report, Document on Nurses' Note notification, interventions and current condition/wound description, Notify the physician of any changes in skin integrity or lack of progress. MDS (Minimum Data Set) Coordinator: Ensure Braden completed on newly acquired wound and PRN (as needed), Ensure care plan completed for presence of wound and new interventions including treatment, Ensure CNAs and nurse understand C/P (Care plan) interventions and documentation supports MDS and C/P. Director/Assistant Director of Nursing: Ensure inclusion of necessary interventions for prevention and treatment based on standards of practice and P&P (Policy and Procedure), Ensure completion and documentation of daily skin checks on TAR, Insure completion of weekly progress note includes wound location, size in cc, shape, color, depth and presence of drainage, necrotic tissue, granulation present, Ensure treatment completed as ordered, Ensure proper infection control technique is observed, Ensure physician notification of changes in skin integrity, presence of signs and symptoms of infection and/or lack of healing progress, Ensure completion of care plan and coordination of care by interventions listed. Administrator: Ensure above parties listed complete tasks as delegated, Review TARs to determine compliance with above tasks, Review MDS, Care Plans and charting to determine compliance with regulation".	S9999		

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S9999	Continued From page 11 The facility's Skin Care Prevention-Teaching Protocols, dated 04/07, documents to complete Braden Risk Assessment on admission. Inspect skin head to toe first three shifts after admission-document results in nurse's notes. Complete Nursing Admission Assessment. Obtain order for prescriptions as needed for prevention (Vitamin/Mineral Supplements, antibiotic creams/ointments, prescription creams...) The facility's Treatment Protocol Guidelines Policy undated documents, "Always maintain a clean field- Sterile if ordered, Wash hands after removing old dressings, cleansing and before applying new dressings, Sanitizer should be rubbed in for at least 30 seconds, Document the treatment on the TAR immediately upon completion, Document treatment progress at least weekly, Notify the Physician if a treatment is not producing progress within 2 weeks of starting." This protocol also documents to follow the Treatment Administration Record for all cleansing, medication application and dressings. 1. R1's TAR, dated 9/17/23, documents a new order to cleanse R1's left gluteal wound, then apply Santyl External Ointment (debridement ointment) topically, cover with calcium alginate (medicated dressing) and secure with a border gauze every day and night shift. This treatment is not signed out as being completed on 9/23/23. This treatment was not signed out as being done 9/28/23 through 10/8/23. R1's TAR, dated 10/8/23, documents to cleanse R1's right and left buttock wounds with normal saline, dry the wound, then apply Santyl ointment, cover with calcium alginate and a dry dressing. This treatment is not signed out as being done on 10/11/23, or from 10/16/23 through 10/27/23.	S9999		

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S9999	Continued From page 12 R1's Weekly Wound Tracking, dated 9/17/23, documents both R1's left and right buttocks wounds are stage III facility acquired wounds. R1's right buttock wound measuring 5.2cm (centimeters) x 3.7cm x 0.1cm (no treatment ordered for the right buttocks wound) and left buttock wound 5.5cm x 5.0cm. On 9/26/23, R1's right buttock wound measured 6.0cm x 6.0cm x 0.0 cm and left buttock wound 5.5cm x 5.0cm x 0.0cm. On 10/5/23, R1's right buttock wound measured 6.0 cm x 5.5. cm x 1.0 cm and R1's left buttocks measured 5.5 cm x 4.5 cm x 0.5 cm. Both wounds documented as increasing in size. R1's Weekly Wound Tracking, dated 10/10/23, documents R1's right buttock wound measured 6.0cm x 6.0cm x 1cm and left buttocks wound 6.0cm x 6.0cm x 2cm. R1's right buttocks wound measured 6.0 cm by 6.0 cm by 3.0 cm on 10/17/23, and his left buttocks wound measured 6.0 cm by 6.0 cm by 3.0 cm. On 10/24/23, R1's right buttocks measured 6.0 cm by 6.0 cm by 5 cm and the left buttocks wound measured 6.0 cm by 6.0 cm by 4 cm. Both wounds increasing in size. R1's Progress Notes, dated 10/27/23 at 6:06 PM, document R1 has a temperature of 102.2 degrees Fahrenheit, 117 heart rate, and was sent to hospital for suspected sepsis. R1's Re-admission order sheet, dated 11/22/23, documents R1 was being treated for lower extremity paralysis, history of opioid abuse, infected ulcer of the skin, undifferentiated connective tissue disease, normocytic anemia, acute osteomyelitis of calcaneus, osteomyelitis of left side of pelvis, positive blood culture,	S9999		

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CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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S9999	Continued From page 13 hyponatremia, hypoalbuminemia. R1's admission orders document to cleanse R1's right and left gluteal/ischial wounds with normal saline and gauze, protect the perineal wound with a no sting barrier spray, then apply Sodium Hypochlorite moist gauze to the wound bed, cover with an ABD (abdominal gauze) and bordered dressing. Change twice a day and PRN (as needed). On 12/11/23 at 1:00 PM, R1 stated the facility does not have the Sodium Hypochlorite (Dakin's) solution for his wound care. R1 stated his wounds on his bottom are not being done twice a day as ordered. R1 stated he just returned from a hospital stay because of his wounds being infected. R1 stated he is now on a long term intravenous antibiotic treatment because of the wound infections. R1 stated his wounds on his buttocks had to be surgically debrided. On 12/12/23 at 1:15 PM, V17, Registered Nurse, washed her hands, then applied gloves. V17 un-taped R1's incontinent brief, soiled with a small amount of soft mushy BM (bowel movement). V17 removed the dressing from R1's right ischial wound. V17 sprayed the wound bed with wound cleanser, then used a gauze pad to wipe the inside of the wound. V17 soaked a roll of gauze in a glass of sterile water. V17 took the end of the sterile water-soaked gauze and packed it into R1's wound. V17 covered R1's wound packing with a calcium alginate and a foam dressing. V17 did not change her gloves or perform hand hygiene during this part of R1's wound care. V17 left, removed her gloves, then went to the bathroom to perform hand hygiene. V9, Licensed Practical Nurse/Wound Nurse, was assisting R1 to roll over on his side. V9 left R1 lying on the side of the bed and R1 rolled out of bed to the floor. V17 and V9 assisted R1 back to	S9999		

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bed with the mechanical lift. V17 applied gloves and pulled back on R1's soiled brief. V17 attempted to place the calcium alginate dressing back in place, after it was out sitting on the soiled brief. V17 discarded the soiled calcium alginate dressing, applied a new calcium alginate to R1's wound, then covered the wound with a foam dressing. V17 performed hand hygiene then applied clean gloves. V17 removed the dressing on R1's left ischial wound. V17 cleansed R1's wound with wound cleanser, then wiped the wound out with gauze. V17 then soaked a roll of gauze in a cup of sterile water. V17 packed R1's wound with the sterile water-soaked gauze and covered it with calcium alginate, then a foam dressing. V17 and V9 then cleaned R1's BM covered buttocks.

On 12/12/23 at 2:10 PM, V17 verified she did not perform hand hygiene when moving from a soiled area to clean. V17 stated incontinence care should have been done prior to the wound care. V17 stated she did not do R1's wound care as they were ordered. V17 verified the facility has been out of Sodium Hypochlorite for some time. V17 stated V9, Assistant Director of Nursing/Wound Nurse, told her to apply the calcium alginate over the gauze packing.

On 12/13/23 at 3:00 PM, V2, Director of Nursing, verified the only wound R1 had on admission was the burn to his left lateral lower leg. V2 also verified the facility is unable to get Sodium Hypochlorite (Dakin's) solution. V2 stated sterile water is not a substitute for the Dakin's solution. V2 stated all the Sodium Hypochlorite orders were to be changed to normal saline but were not. V2 verified R1's wound is to be cleansed with wound cleanser then the Sodium Hypochlorite-soaked gauze is to be packed in the

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S9999	Continued From page 15 left and right buttocks wounds, then covered with an ABD (Abdominal Pad). V2 stated she does not know where the calcium alginate or sterile water came from. V2 stated R1's incontinent care should have been done, prior to wound care being started. V2 stated hand hygiene is to be done when going from a dirty area to a clean area. 2. R4's Admission Skin Assessment, dated 11/30/23, documents upon admission to the facility (11/30/23) an unstageable pressure injury to her coccyx, measuring 4.8 cm (centimeter) by 7.2 cm and a depth of 0.3 cm. The wound bed has slough with purulent drainage, with an odor. R4's admission orders, dated 11/30/23, documents to cleanse R4's right gluteal wound with Sodium Hypochlorite (Dakin's) 0.125% solution, apply moist to dry gauze dressing using 0.125% Sodium Hypochlorite (Dakin's) solution. R4's TAR (Treatment Administration Record), dated 11/30/23, does not have any pressure ulcer treatments documented as ordered. R4's TAR, dated 12/1/23 through 12/6/23, does not have wound care or pressure ulcer orders transcribed or documented as being done as ordered. R4's Skin Check weekly, based on Braden, one time daily every Tuesday and Friday was not completed on 12/5/23. R4's TAR, dated 12/7/23, documents to cleanse R4's left buttock wound with Dakin's (1/2 strength) then cover with a wet normal saline gauze and a dry dressing.	S9999		

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S9999	Continued From page 16 R4's Progress Notes, dated 12/8/23, at 12:05 PM, R4 was lethargic and vomiting, blood pressure is 69 (systolic)/59 (diastolic) and a pulse of 120 beats per minute. R4's Progress Notes, dated 12/10/23, documents R4 is being admitted for wound debridement, intravenous fluids and unable to eat. R4's hospital admission diagnosis, dated 12/8/23, documents sepsis secondary to infected sacral ulcer/urinary tract infection, urothelial metastatic cancer, physical deconditioning and encephalopathy. On 12/13/23 at 3:00 PM, V2, Director of Nursing, stated R4's skin assessment was completed on admission, but the pressure ulcer and fall risk assessments were not completed as required. V2 stated R4 did not have an interim pressure ulcer care plan implemented. V2 also stated R4's admission wound care orders were not transcribed onto the TAR's. V2 verified R4's wound care was not done from 11/30/23 through 12/7/23. V2 stated if the TARs are not initialed, then the wound care is considered to not be done as ordered. V2 verified the wound measurements are not being done weekly as required. V2 stated she was not aware the skin issues were so bad until the state agency came in to investigate. On 12/14/23 at 9:20 AM, V9, Assistant Director of Nursing/Wound Care, stated she is having a hard time keeping up with the wound care duties because she is getting pulled to the floor to work all the time. V9 verified the floor nurses are responsible for doing treatments expect for when V19, Wound Physician, is in the building.	S9999		

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S9999	Continued From page 17 3. On 10-17-23 R6's Initial Wound Evaluation and Management Summary signed by V19 (Wound Physician) documents R6 presented with a wound on R6's left heel and a rash. A stage III (three) pressure wound of the left, medial heel full thickness. Wound size 2cm x 3.5cm x 0.2cm. Exudate: Light Serous-Sanguineous. Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater depth today. Relevant conditions including infection considered and address through treatment changes or investigations. Dressing treatment plan: Primary dressing(s)- Xeroform gauze apply once daily for 30 days. Secondary dressing(s) ABD (Abdominal Pad) apply once daily for 30 days; Gauze roll (kerlix) 2.25 inches apply once daily for 30 days. Recommendations: Float Heels in Bed; Off-Load Wound; Reposition per facility protocol; (heel protector). Other Diagnosis: Cellulitis of the left foot. Duration: At least 1 day(s). Additional treatment information: Recommend Tetracycline 500 mg (milligrams) PO (by mouth) BID (twice a day) for 14 days. Probiotics daily for 30 days. Clinical data and material reviewed: Deep swab technique performed on stage three pressure wound of the left, medial heel on 10-17-23. R6's current POS (Physician Order Sheet) documents R6 has diagnoses of, but not limited to, Type Two Diabetes Mellitus without Complications, Hypertension, Major Depressive Disorder, Cerebral Infarction, Paralytic Ileus, Muscle Weakness, Heart Failure, Chronic Congestive Heart Failure, and other lack of coordination.	S9999		

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S9999	Continued From page 18 R6's most recent completed MDS (Minimum Data Set) Assessment dated 08-22-23 documents R6 had no pressure ulcers and is at risk for pressure ulcers. This same assessment documents R6 requires extensive assistance with one staff member for bed mobility, and dependent assistance with two staff members for transfers and toileting. R6's Braden Scale for Predicting Pressure Ulcer Risk (completed prior to pressure sore development) dated 5-15-23 documents, "Activity: 2. Chairfast- Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. Mobility: Very limited- Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Skin Treatment Review: Indicate all used in last 7 days: Float Heels- No." This same assessment documents R6 has a score of 14 (high risk for developing pressure sores). R6's Current Care Plan last revised 11-21-23 does not include a skin management or wound care management plan of care prior to wound development (to prevent pressure wound) with interventions. This same plan of care does not include the wound development with interventions (to prevent wound from worsening). R6's MAR (Medication Administration Record) dated 10-01-23 to 10-24-23 documents an order for Tetracycline 500 mg capsule by mouth two times a day for wound infection until 11-2-23, with a start date of 10-19-23, two days after V19 Wound Physician recommended the order for an infection to the left heel on 10-17-23.	S9999		

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S9999	Continued From page 19 R6's TAR (Treatment Administration Record) dated 10-01-23 to 10-24-23 does not document a treatment to apply xeroform gauze daily for 30 days, ABD pad daily for 30 days, or kerlix daily for 30 days to R6's left heel as ordered per V19 Wound Physician on 10-17-23. On 10-24-23 R6's Wound Evaluation and Management summary signed by V19, Wound Physician, documents R6 had a stage III pressure wound of the left, medial heel full thickness. Wound size 2cm x 3cm x not measurable cm. Peri-wound radius: Odor. Exudate: Moderate Serosanguinous. This same summary documents a diagnosis of Cellulitis to the left foot. Progress: Not improved. Recommend d/c (discontinue) Tetracycline and start Bactrim DS (Double strength) BID (twice daily) for 14 days. Levaquin 500 mg PO (by mouth) daily for 14 days. Probiotics daily for 30 days (based on culture report). Deep swab technique of stage III pressure wound of the left, medial heel demonstrates Pseudomonas Aeruginosa and MRSA (Methicillin-resistant Staphylococcus aureus) on 10-24-23. Dressing treatment plan: Add Gentamicin ointment daily for 30 days, Alginate Calcium daily for 30 days, ABD pad daily for 23 days, and Kerlix daily for 23 days. Discontinue Xeroform Gauze. On 11-7-23 R6's Wound Evaluation and Management summary signed by V19 Wound Physician documents (R6's) pressure sore of the left medial heel has now worsened from a stage III to a stage IV. R6's TAR dated 10-24-23 to 11-7-23 documents an order to apply Gentamicin Ointment BID to left heel, calcium alginate- silver BID to left heel and cover with an island dressing. These same	S9999		

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S9999	Continued From page 20 orders were not started and signed off in the TAR until 10-25-23. From 10-25-23 to 11-07-23, five treatments were not signed as completed on R6's pressure ulcer, causing it to worsened from a Stage III to a Stage IV. R6's TAR dated 11-16-23 to 12-12-23 documents an order to apply Gentamicin Ointment every night to left heel, calcium alginate-silver every night to left heel and cover with an island dressing. From 11-16-23 to 12-12-23, ten treatments were not signed out as completed. R6's TARs dated 10-1-23 to 12-13-23 does not document an order for a daily skin check per policy despite having a facility acquired left heel pressure ulcer and a high-risk Braden Assessment score. R6's progress notes dated 10-1-23 to 12-13-23 does not include any documentation of R6's facility acquired left medial heel pressure sore including size, appearance, signs and symptoms of infection, etc. R6's MARs and TARs dated 10-1-23 to 12-13-23 does not include an order to monitor left heel pressure sore for signs and symptoms of infection. R6's Weekly Wound Tracking documents left heel wound measurements on the following dates: 10-17-23, 10-24-23, 10-31-23, 11-7-23, 11-14-23, 11-21-23, and 11-28-23. No further measurements to R6's left heel wound were documented after 11-28-23. On 12-13-23 at approximately 9:55 AM, V5 Agency LPN (Licensed Practical Nurse) prepared treatment for R6's facility acquired left heel	S9999		

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wound. R6 was lying in bed with both heels elevated on a pillow. V5 LPN removed R6's dressing to the left heel with gloves. R6's left heel had a quarter-size pink area with a scant amount of light pink drainage and slight redness around the wound. V5 took off his soiled gloves and without sanitizing his hands put on new gloves before applying R6's treatment. V5 verified he did not use hand sanitizer or wash his hands between glove changes. V5 stated, "I should have applied hand sanitizer in between glove changes." V5 stated he does not document any assessment anywhere on the wounds he only initials in the TAR that the treatment was completed. Immediately after R6's treatment R6 stated, "My left heel has caused me severe pain. I have told the staff that I am in pain, but they won't come back to give me anything. Occasionally, they will bring me back a Tylenol, but it's not often."

On 12/13/2023 at 1:30 PM, V2 DON (Director of Nursing) confirmed there was no skin assessment completed for the month of October 2023 upon identification of wound of the left heel.

On 12-14-2023 at 9:20 AM, V14 (R6's Primary Physician) verified R6's facility acquired left heel pressure sore could have been avoidable if prior wound interventions were put into place and could have been avoidable from worsening if facility would have followed V19's Wound Physician orders, provided the treatment as ordered, and implemented/followed wound interventions. V14 stated if the facility is not following their wound care protocol and a resident's wound treatment is not completed as ordered the wound can worsen.

On 12-14-23 at 10:54 AM, V9 Assistant Director

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S9999	Continued From page 22 of Nursing/ Wound Nurse stated, "I am unsure of the exact date R6's left heel pressure sore had developed. I know it was approximately one week prior to the (V19) Wound Physician seeing (R6). (V20, CNA) found the area to the left heel when the CNA was getting (R6) dressed and reported it to an Agency Nurse (V21) that no longer works at the facility, around 10-11-23. I can't remember who the CNA was that found it. I did not see (R6's) left heel pressure wound until that Saturday 10-14-2023. I looked at the wound but did not document on the wound or fill out any papers regarding (R6's) left heel pressure sore. (V21) who was initially made aware of (R6's) newly identified skin issue should have filled out an initial skin report, measured the wound, assessed/documented on the wound, initiated a daily skin check treatment, and notified (V14/R6's Primary Physician)." V9 verified that an initial skin report had not been filled out, the wound was not initially measured, assessed/documented on, a daily skin check was not put in place, and the physician was not notified. V9 also stated that R6's left heel pressure sore was facility acquired and no treatment orders or interventions were put in place when R6's pressure wound was identified until the V19 (Wound Physician) evaluated R6 on 10-17-23. V9 stated, "(V19) Wound Physician wrote treatment orders on 10-17-23 but the order did not get processed, and no treatments were performed on (R6's) left heel pressure sore during that time until (V19) Wound Physician came back on 10-24-23 and wrote new orders. We (the facility) sometimes have a delay with processing (V19's, Wound Physician) orders because we are too busy. I did wound measurements on (R6's) left heel pressure sore from 10-17-23 to 11-28-23 but have not measured (R6's) left heel wound since that date. I have been too busy over the past two weeks to	S9999		

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S9999	Continued From page 23 keep up, sometimes I can't even get the wound physician notes and new orders processed until a week or two later." On 12-14-23 at 3:30 PM, V2 DON verified R6's had missing treatments on the TARs dated 10-1-23 to 12-13-23. V2 verified no care plan was in place with interventions for skin breakdown and after R6's pressure sore was identified. V2 stated, "The staff should always wash/sanitize their hands between glove changes." (A)	S9999		