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| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br>1 of 1 Violation<br><br>300.610a)<br>300.1210b)<br>300.1210d)5)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>resident to meet the total nursing and personal care needs of the resident.<br><br>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:<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)<br><br>These Requirements are not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure that a pressure | S9999 | | |

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sore did not increase in size/decline; failed to follow interventions in preventing deterioration of pressure sore related to repositioning and failed to ensure proper functioning of low air loss mattress for one (R4) of four residents reviewed for pressure ulcers. These failures resulted in worsening of R4's Stage 4 pressure ulcer on the sacrum and Unstageable pressure ulcer on the left buttock.

Findings include:

R4 is a 90 year - old, female, admitted into the facility on 7/24/13 with diagnoses of Other Sequelae following Unspecified Cerebrovascular Disease and Pressure Ulcer of Sacral Region, Stage 4.

Per facility's census report, R4 was transferred to the local hospital on the following dates:
03/31/18 - transferred to hospital
04/03/18 - return date to facility
07/10/18 - transferred to hospital
07/22/18 - return date to facility

R4's MDS (Minimum Data Set) dated 07/31/2018 documented:

Sec. C - has memory problem for short and long-tern memory; severely impaired cognition for daily decision making
Sec. G - needs extensive assistance from two persons physical assist during transfer; extensive assistance from one person physical assist during dressing, toileting, hygiene and totally dependent from one person physical assist during eating and bathing
Sec. H -has nephrostomy tube and incontinence of bowel
Sec. M - M0300: Current Number of Unhealed

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| S9999 | Continued From page 3<br>Pressure Ulcers at each stage - Stage 4 is one; Unstageable slough and/or eschar is one<br>Sec. M1200: Skin and Ulcer Treatments - pressure reducing device, turning/repositioning program, pressure ulcer care<br><br>R4's Wound notes documented:<br>MD (Medical Doctor) notes 05/11/18: Stage 4 pressure wound Sacrum - measuring 4.5cm (centimeters) x 4.2 cm x 0.4cm<br>Treatment plan: Primary dressing: Calcium alginate apply once daily for 30 days, dry protective dressing apply once daily for 30 days, santyl apply once daily for 30 days, mupirocin-apply once daily for 30 days<br>Recommendations: off-load, reposition per facility protocol<br>MD notes 05/25/18: Stage 4 pressure wound sacrum - measuring 4.0cm x 4.2cm x 0.4cm<br>06/04/18 - progress notes documented that R4 went to hospital for tube feeding replacement and came back to the facility the same day<br>MD notes 06/15/18: Stage 4 pressure wound sacrum - measuring 3.5cm x 4.2cm x 0.4cm<br>MD notes 06/29/18: Stage 4 pressure wound sacrum - measuring 6.5cm x 4.5cm x 0.4cm;<br>Wound progress: Deteriorated<br>Shear wound of the Left buttock - measuring 2.0cm x 2.0cm x 0.1cm<br>Primary dressing: dry protective dressing, apply once daily for 30 days, santyl apply once daily for 30 days<br>Recommendations: off-load wound, reposition per facility protocol<br>07/05/18: Hospitalized due to tube feeding malfunction and returned to the facility the same day<br>07/10/18: sent to hospital due to lethargy, increased congestion, tachycardia<br>07/22/18: Readmission into the facility | S9999 | | |

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07/23/18: Per R4's progress notes on skin assessment - readmission head to toe skin assessment done, R4 non-verbal, bedbound, there is a nephrostomy tube at the right flank area, in place and draining well, there is a 7.5 x 5.5 x 2.5cm Stage 4 pressure injury at the coccyx area, with moderate serosanguinous discharge, wound bed clean with 50% granulation tissue, noted to have a 1.0 x 2.0 x 0.1cm Stage 2 pressure injury at the left buttock, with minimal serous discharge, wound bed with 50% slough, there is a 1.0 x 1.5cm DTI (deep tissue injury) at the left heel.
MD notes 07/27/18: Stage 4 pressure wound sacrum - measuring 8.5cm x 5.5 x 1.0cm;Wound progress: Deteriorated
Unstageable (due to necrosis) of the Left buttock - measuring 1.5cm x 1.5cm x Not measurable
08/03/18: Nursing notes - R4 seen today by V10 (Wound Care Nurse) and V11 (Wound Physician). V12 (Licensed Practical Nurse, LPN) was unable to change the left wound on buttocks, R4 was uncooperative.
MD notes 08/10/18: Stage 4 sacrum - measuring 7.5cm x 5.5cm x 1cm
Unstageable(due to necrosis) of the Left buttock - measuring 2.0cm x 2.0cm x not measurable cm.; Wound progress: Deteriorated

R4's POS (Physician Order Sheet) documented:
07/27/18 Coccyx/Sacral wound: apply santyl to wound bed, pack with sterile foam, cover with transparent tape, attach to wound vacuum at 125 mm Hg every Mon-Wed-Fri.
07/27/18 Left buttock: clean with NSS (normal saline solution), apply santyl, cover with calcium alginate and dry dressing daily.

R4's current care Plan dated documented:
Skin: Potential for breakdown due to (e.g. history

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breakdown/incontinence/decreased mobility/poor nutrition/poor circulation/terminal illness.
Status: Active
Interventions: use moisture barrier cream; use specialty pressure relieving equipment (mattress); use pillows, pads, or wedges to reduce pressure on heels and pressure points. Turn/reposition every two hours.

On 08/13/18 at 11:54 AM, R4 was observed in bed, asleep, with oxygen inhalation treatment at 2 liters per minute (lpm) via nasal cannula; on low air loss (LAL) mattress. The mattress was covered with a fitted sheet. On top of the fitted sheet, an underpad was placed. R4 was wearing an incontinent brief. The pressure pump for the LAL mattress was observed off.

At 2:00 PM, V10 is about to do wound care on R4. It was observed that the pump for the LAL mattress which R4 was using was still off. V10 was asked if the pump was supposed to be off. V10 stated, "The pump should be turned on at all times." V10 turned on the pressure pump on R4's LAL mattress. Wound care was provided by V10 assisted by V13 (Resident Care Assistant, RCA). V10 with gloved hands removed the old dressing on R4's left buttock wound and started cleaning it.

Afterwards, V10 removed the dressing on R4's sacral wound. The sacral wound is connected to a wound vacuum. V10 disconnected the wound vacuum to the wound and started cleaning R4's sacral wound. R4's sacral wound appeared to be like pear-shaped which extends to the coccygeal area. The wound bed appeared to be dry and pinkish in appearance.

On 8/14/18 at 9:40AM, R4 was again observed in bed, awake but unable to verbalize needs, with

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oxygen inhalation at 2lpm via nasal cannula. R4 was lying on her back with a pillow placed under right shoulder. The following were observed on R4's position while in bed:
9:45 AM - lying on back, awake, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
10:00 AM - lying on back, awake, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
10:15 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
10:30 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
10:45 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
11:00 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder. V7 (RCA) was observed in R4's room putting some towels in R4's cabinet.
11:15 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
11:30 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder
11:45 AM - lying on back, asleep, with oxygen inhalation at 2lpm via nasal cannula, with pillow placed under right shoulder

At 12:45 PM, V7 (RCA) and V8 (RCA) was observed providing incontinence care on R4. It was observed that R4's low air loss mattress is covered with a fitted sheet. A white blanket folded into 4s was placed under R4's lower back. R4 was wearing incontinent brief. V7 and V8 were

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asked on the number of sheets used for low air loss mattresses. V7 stated, "we need to cover the mattress with two sheets which is a flat sheet and an underpad. V8 stated, "only one flat sheet should be covering the low air loss mattress."

V7 and V8 were also asked regarding R4's pressure sores. V7 stated, "I'm first time with her (R4). She (R4) needs to be changed very often like three times per shift or when needed. She (R4) also need to be reposition to sides every two hours because she (R4) has wound on the back." V8 stated, "I have worked with her (R4) before but now I have a different wing. She (R4) needs to be changed every two hours and be turned from left to right every two hours.

After the provision of incontinence care on R4 by V7 and V8, R4 was turned to the left side. A pillow was placed under R4's right shoulder covering the upper and lower back. The sacral area was also observed resting on the pillow.

At 1:05 PM, V10 was interviewed regarding ways to prevent further decline of pressure sores. V10 stated, "We do repositioning every two hours, keep the sacral area dry and dressing intact, provide pillows or cushion in between legs to protect bony prominences and the use of low air loss mattress. For the low air loss mattresses, there should be one sheet covering the mattress, that one sheet is the top sheet which ideally is the fitted sheet to keep it in place. At this time also, surveyor showed V10 the position of R4 in bed. V10 stated, "Oh, she (R4) should be turned a little bit more to the left side. The pillow should be placed before the sacral area making sure the sacral area is not resting on the pillow.

On 08/16/18 at 12:17 PM, V10 was asked to

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clarify exactly on R4's pressure ulcer. Wound MD notes documented Stage 4 pressure wound sacrum and V10 documented in her (V10) notes coccyx wound. V10` stated, "Her (R4) wound is on the sacrum but because it extends to the coccyx, I wrote coccyx, but it is on the sacrum area."

On 08/16/18 at 1:42PM, V9 (Medical Director) was interviewed regarding pressure ulcer.V9 stated, "I've been working in the facility as the Medical Director for 4 - 6 months now. Yes, one of the issues in the facility that we talked about during quality assurance meetings are pressure ulcers. I expect that staff do a team approach in preventing and treating pressure ulcers. There is a wound care nurse and a Wound doctor seeing residents with pressure ulcers. And nurses and aides should also help in implementing ways to manage pressure ulcers. I expect staff to ambulate residents and if residents are unable to get up and stay in bed, there should be off-loading, repositioning on a consistent basis based from the protocol."

Facility's policy titled "Skin Management Program", revised date 05-2016, stated in part but are not limited to:
Policy: (Facility name) will have in place a skin management program that promotes identification of residents at risk for skin breakdown and utilizes interventions that minimize that risk. If breakdown occurs or is present at the time of admission, a systematic approach and monitoring process will be in place for managing pressure ulcers to promote healing and maximize function and quality of life and minimize risks, complications, and functional decline."

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| S9999 | Continued From page 9<br><br>Facility's policy titled, "Prevention of Pressure Ulcers" undated documented:<br>Interventions and Preventive Measures: General<br>2. For a person in bed:<br>a. Change position at least every two hours or more frequently if needed.<br>Interventions and Preventive Measures: Residents with Risk Factors<br>3. Risk Factor - bed fast<br>a. Change position at least two hours and more frequently as needed.<br><br>The Operation Manual on the low air loss mattress currently used by R4 stated in part:<br>2.0 Safety Precautions<br>Bed Linens: This device incorporates a waterproof cover that is moisture vapor permeable; therefore it is recommended to limit bed linens to one sheet in order to maximize the system's performance.<br><br>(B) | S9999 | | |