IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 25, 2019

VCorp Agent Services, Inc., Registered Agent
Aperion Care Cairo, LLC
208 S. LaSalle Street, Suite 814
Chicago, Illinois 60604

RE: Complaint #: IL 106992
Survey Date: November 28, 2018
Docket #: 19-C0024
Violation Type: A Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Aperion Care Cairo.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Aperion Care Cairo/November 28, 2018/19-C0024/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: APERION CARE CAIRO COMPLAINT #: 0106992
LIC. ID #: 0054692
DATE COMPLAINT RECEIVED: 10/31/18 09:34:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
130	MENTAL ABUSE	2
205	INSECTS, RODENTS, PESTS	1
212	PHYSICAL PLANT PROBLEMS	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. APERION CARE CAIRO, LLC, D/B/A, APERION CARE CAIRO Respondent.	)))))))))	Docket No. NH 19-C0024

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on November 28, 2018 at Aperion Care Cairo, 2001 Cedar Street, Cairo, Illinois 62914. On January 24, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Aperion Care Cairo, 2001 Cedar Street, Cairo, Illinois 62914 on July 24, 2018. The Facility's current license number is 0054692. The term of the conditional license shall be from February 24, 2019 to August 23, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 24, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

- **Type A violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)2), 300.1210d)3), 300.1210d)5) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)5) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 25th day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. APERION CARE CAIRO, LLC, D/B/A, APERION CARE CAIRO Respondent.	))))))))))	Docket No. NH 19-C0024

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Required; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	VCorp Agent Services, Inc.
Licensee Info:	Aperion Care Cairo, LLC
Address:	208 S. LaSalle Street, Suite 814 Chicago, Illinois 60604

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 25th day of January, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

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
	IL6010342	A. BUILDING: _____ B. WING _____	C 11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAIRO	2001 CEDAR STREET CAIRO, IL 62914

(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
S 000	Initial Comments Complaint Investigation 1857139/IL106992 - F580, F584, F686, F712 are cited. Complaint Investigation 1857166/IL107062 - No deficiencies are cited. Complaint Investigation 1857290/IL107160 - No deficiencies are cited. A partial extended survey was conducted - F712, F727, F773, F838 are cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)d)2)3)5) 300.3240a) 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2)All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5)A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 2	S9999		

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET EVIDENCED BY:

Based on observation, interviews, and record review, the facility failed to recognize the development of pressure ulcers, initiate, and implement measures to promote healing, accurately document the correct location, description, and progress of these pressure ulcers, report a decline to the physician, and seek timely medical treatment for 2 (R3 and R7) of 3 residents reviewed for pressure ulcers in a sample of 8. The facility also failed to follow their policy and notify resident's family and/or representative, and primary physician when there was a significant change in the resident's condition for 1 (R3). The facility also failed to ensure timely physician visits for (R3 and R7), resulted in R2 to undergo an emergency right through the knee "guillotine" amputation on 10/18/2018 with a subsequent above the knee amputation and closure of the surgical site on 10/22/2018.

The Braden Scale for Predicting Pressure Sore Risk Assessments reviewed, documented all 73 residents residing in the facility are at risk for skin breakdown. V3 (Regional Nurse Consultant) verified in an interview on 11/28/18 at 1:00 pm, all 73 residents residing in the facility are at risk for skin breakdown.

Findings include:

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S9999	Continued From page 3 A Facility Diagnosis Report documents R3 was admitted to this facility on 07/09/18 with the following diagnoses in part - muscle weakness, chronic obstructive pulmonary disease (COPD), malignant neoplasm of colon, colostomy status, essential hypertension, and unspecified severe protein-calorie malnutrition. There is no documentation of pressure wounds or a contributing underlying condition upon R3's admission. Review of R3's clinical record documents V21 (family member) is POA (Power of Attorney) over R3's medical care. According to R3's Minimum Data Set (MDS) entry tracking record dated 07/09/18, R3 has no pressure ulcers, however, is at risk. There is no documentation of R3 having a pressure wound until a Skilled Charting note on 07/26/18 at 1:55 PM documents a new skin concern of "... right heal (sic). Resident has treatable wounds". There is no documentation of physician notification or treatment initiation found. There is no documentation of physician notification or treatment initiation found. There is no further documentation of a pressure wound on the heel on this date or any other date prior to R3 being sent to the hospital on 08/01/18 (nurses note). There is no documentation in R3's record of any physician's visit or physician progress notes during R3's stay at the facility. R3's Admission Assessment on 07/16/18 documents a Brief Interview for Mental Status (BIMS) of 9, indicating moderate cognitive impairment.	S9999		

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S9999	Continued From page 4	S9999		

Facility Braden Observation dated 07/09/18 documents R3 is at moderate risk for skin breakdown with a score of 13.

Local hospital admission records dated 08/01/18 document R3 presented with the following wounds: Wound buttocks right Stage III; Wound buttocks left suspected deep tissue injury; Wound buttocks sacrum Stage III; Wound coccyx suspected deep tissue injury; Wound heel right unstageable; Wound ankle right suspected deep tissue injury.

R3's hospital wound care reporting dated 08/07/18 at 11:05 AM documents R3 is being discharged back to facility with the following: Wound buttocks right; Wound buttocks left; Wound sacrum right; Wound coccyx - surrounding tissue red - dressing foam. Wound heel right; Wound ankle right - site black - surrounding tissue clean, dry and intact - open to air.

Upon R3's re-entry to the facility, a Nurses Note dated 08/07/18 at 2:50 PM documents R3 returned to the facility with the following wounds: Stage II wound to bilateral coccyx and area of eschar to right heel. There is no facility documentation of the other pressure areas identified on the wound care reporting document from the hospital on 08/07/18.

Changes to R3's right heel were first documented in a Skilled Evaluation note dated 09/15/18 at 9:29 PM indicating R3's right heel has an odor and tissue is painful. R3's Skilled Evaluation notes dated 09/20/18, 09/22/18, 09/25/18, and 09/26/18 document R3's right ankle/heel wound has an odor, and tissue remains painful and mushy. There was no documentation that V15

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(R3's primary care physician) was notified of the significant changes.

R3's care plan documents focus of, "I have pressure ulcer to my right heel unstageable due to eschar and moisture associated skin damage to bilateral buttocks noted upon readmit to facility from recent hospital stay. Date Initiated: 08/07/18."

Goal: "My right heel pressure ulcer will show signs of healing and remain free from infection through review date. Date Initiated: 08/07/18. Target Date: 08/25/18."

Interventions: "Report improvements and declines to the medical doctor (MD). Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs and symptoms (s/sx) of infection, wound size (length x width x depth), stage."

R3's August 2018 Medication Administration Record (MAR) documents zinc oxide 10% apply to coccyx topically every 72 hours for Stage II wounds with a start date of 08/07/18.

An Orders-Admission note dated 08/07/18 at 7:54 PM documents telephone orders for Santyl ointment 250 U/mg (units per milligram), apply to right heel topically two times a day for area of eschar. "No Santyl in yet."

An Orders-Admission note dated 08/10/18 at 8:23 PM documents, "Santyl not sent from rx (prescription) yet."

The facility was unable to provide reproducible evidence of when R3's Santyl was received from the pharmacy and initiated.

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R3's Weekly Skin Observation dated 8/13/18 does not document a measurement for R3's right heel wound. The weekly skin observations dated 08/27, 09/04, and 09/10 document measurements with no location/description of a wound.

It was not until, a nurse's note dated 10/02/18, documents a treatment change for skin prep bid (twice a day). R3's nurses notes do not document what area the skin prep is to be applied to. V2 (DON) confirms on 11/08/18 at 9:00 AM this treatment change is not documented on R3's October Medication Administration Record (MAR) or Physician's Order Sheet (POS) and R3 continued to receive the same treatment with the Santyl ointment until 10/18/18.

The facility Pressure Ulcers/Wounds logs for August, September, and October 2018 for R3 document inconsistent measurements as follows: Right heel wound on 09/04/18 measures 5.8 x 5.2; 09/10/18 measures 3.7 x 4.4. The last documented right heel measurement dated 10/15/18 indicates partial improvement measuring 4.4 x 9.3.

The facility was unable to provide reproducible evidence R3's physician was notified of R3's decline in condition.

The local wound clinic screening dated 10/18/18 at 10:30 AM documents R3 presented for, "right foot and heel ulcer that is (sic) been there since he came to the nursing home 3 months ago so the initial history of the ulcer is unknown. However they are saying it got worse lately." R3's physical exam includes a skin inspection documenting decreased turgor, right foot

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...gangrenous skin on the heel and sole of the foot with bluish skin of toes. Foul smell, mostly dry gangrene with some fluctuation. Pale, shiny skin on the right lower leg." "Findings consistent with ischemic limp (sic) with advanced gangrene and infection." At this time, V26 (local wound doctor) transferred R3 to a higher level of care due to his need for intravenous (IV) antibiotics and as soon as possible amputation. There is no documentation in R3's record indicating a necrotic right big toe and middle toe wound is present.

On 10/18/18 at 1:37 PM, R3's local hospital emergency room disposition records document, "Patient's condition represent a certified medical emergency." R3 was transferred at this time for surgical intervention in a higher level of care facility on this same date. R3's diagnoses upon transfer are - Gangrene and Sepsis. R3's local hospital operative report dated 10/18/18 documents a right through the knee guillotine amputation was performed on this date.

On 10/18/18 at 1:41 PM a nurse's note for R3 documents, "patient (pt) taken to wound clinic today, physician had him taken to emergency room (ER) for area on right (R) foot."

On 11/02/18 at 11:12 AM, V16 (Registered Nurse - RN) at V15's (R3's primary care physician - PCP), stated R3 was not seen at V15's office. There are no documented appointments from 08/07/18 to 10/18/18. V15 usually sees residents once a month in his local office, as he does not generally do facility onsite visits any more.

On 11/02/18 at 1:03 PM, V14 (Medical Director) stated R3 was not one of his patients so he never saw him in person. V14 stated someone from the

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S9999	Continued From page 8	S9999		

facility called him on 10/02/18 about a "heel issue" and requested a new prescription for treatment for better results, so he prescribed skin prep to the right heel.

On 11/02/18 at 3:32 PM, V15 (R3's primary care physician) stated he had not seen R3 and did not know anything about a wound on his heel. V15 stated he was never told anything about this.

On 11/08/18 at 9:00 AM, V2 stated R3's first wound clinic appointment was scheduled for 10/11/18. V2 stated the wound clinic called the facility and cancelled R3's appointment stating there was a scheduling conflict. No documentation of this cancellation could be provided. V2 stated R3's wound clinic appointment was rescheduled for 10/18/18.

The facility documentation did not include any of this description or the magnitude of the condition of R3's heel, toes, foot, or lower leg that was identified at the local wound clinic.

The facility was unable to provide reproducible evidence that R3's physician was notified of R3's right heel wound and decline in condition.

On 11/08/18 at 9:00 AM, V2 (Director of Nursing/Wound Nurse - DON) confirmed in an interview V15 (R3's primary care physician) never saw R3 in the facility or in his local office.

On 11/08/18 at 11:00 AM, V26 (Wound physician) states the first time he saw R3 was on 10/18/18, and was in bad shape when he arrived. The condition of R3's toes would typically take a long time to develop, and his foot condition did not develop overnight. V26 states he is not aware of R3's history, but can say he would have stood a

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better chance if treatment had been sought earlier, because by the time he got to me it was too late. I referred him to the local emergency room and he had an amputation. We would have done initial testing to find a source if he would have come here regularly. I don't know what they were doing for the wound. Transport staff had no information.

The Facility Physician-Family Notification-Change in Condition policy dated (last revised 11/13/18) documents the following in part: "Purpose - To ensure that medical care problems are communicated to the attending physician or authorized family/responsible party in a timely, efficient, and effective manner; Responsibility - Licensed Nursing Personnel; Guidelines - The facility will inform the resident, consult with the resident's physician...notify the resident's legal representative...when there is - B) A significant change in the resident's physical, mental, or psychosocial status...such as "Clinical complications....development of a stage II pressure sore...; D) A decision to transfer or discharge the resident..."

The local regional hospital center documents R3 is admitted on 10/18/18 with a chief complaint of - "transferred from outside hospital with gangrenous right lower extremity in sepsis." Hospital Course, - "75-year old male with advanced peripheral vascular disease, chronic hypoxemic respiratory failure, chronic indwelling urinary catheter was brought to this (name of hospital) for treatment of non-healing right heel pressure ulcer stage IV with resultant wet gangrene. Patient underwent guillotine amputation through his right knee. Postoperatively it was decided that he return to the operating room (OR) for a more proximal

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above knee amputation (AKA). He was treated aggressively with IV antibiotic therapy." Discharge Summary dated 10/26/18 documents under Final Diagnoses in part - Gangrene of right lower limb due to atherosclerosis (resolved 10/20/18); Ulcer of right foot (resolved 10/19/18).

An Occupational Therapy Evaluation note dated 10/22/18 from this same local hospital documents R3 was living at home in a senior apartment. He fell and had hip pain and was transferred to a nursing home 2-3 months ago for rehab. He then became non-ambulatory resulting in multiple pressure ulcers and gangrene of right lower extremity (RLE).

R3's local hospital operative report dated 10/18/18 documents a right through the knee guillotine amputation was performed on this date. V30 (Vascular Surgeon) documents in part - "I offered to the patient to take him to the operating room for urgent through the knee amputation tonight. Benefits, risks, and potential complication, including but not limited to, death, heart attack, stroke ...were discussed at length with the patient. Alternative, including but not limit to, comfort care measures - hospice care, second opinion with a different vascular surgeon, etc. were offered to the patient. He voiced understanding and wanted to proceed with the proposed surgery in our institution."

On 11/08/18 at 9:00 AM, V2, Director of Nursing/Wound Nurse (DON) confirmed in interview there is no documentation in R3's record of a physician being notified regarding R3's right heel wound prior to 10/02/18.

On 11/08/18 at 11:43 AM, V21 (family member) stated he and his siblings visited R3 at the

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nursing home, but never thought to look at his feet because they assumed the facility did that. V21 states R3 usually had socks on and was covered with a blanket. V21 states the first time he was told something was wrong with R3's right foot was when he was taken to the local wound clinic on 10/18/18.

On 11/08/18 at 4:10 PM, R3 was observed in another facility where he currently resides. R3 states he never knew his foot was that bad until he was at the hospital being told he needed an amputation. R3 states he does not really remember much about the other nursing home and they, "never did anything for me."

On 11/09/18 at 10:30 AM, V2 stated if wounds are reported to her, she completes a full wound care assessment on the computer. When asked about R3's wounds to the right great toe and middle toe, V2 stated, "those were not there on 10/15 when I measured his right heel!"

R7's transfer/discharge report dated 11/09/18 documents R7's diagnoses include; anemia, chronic obstructive pulmonary disease, hypertension, pressure ulcer right buttock, type 2 diabetes mellitus, end stage renal disease, pressure ulcer left buttock.

R7's quarterly MDS (Minimum Data Sets) dated 10/12/18 documents R7 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates she is cognitively intact.

R7's progress notes dated 8/6/18 and 8/7/18 document R7 returned to the facility from a hospital stay with a Stage 3 pressure ulcer to her coccyx and right buttock. On 11/09/18 at 11:00 AM, V2 (Director of Nurses-DON) stated R7

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S9999	Continued From page 12 acquired the pressure ulcer to her coccyx and buttock during her hospital stay. R7's wound notes from the regional wound clinic dated 10/31/18 document R7 has a stage 3 pressure ulcer on the right buttock that was acquired on 7/18/18. R7's regional wound clinic note documents an order for a "wound vac to wound continuously ...black foam to wound bed, cover with drape ...change wound vac dressings three times per week and PRN (as needed) for dislodging of the drape or loss of seal ...turn and reposition every 2 hours, only up for meals, no more than 1 hour at a time, reposition every hour while sitting up ..." On 11/08/18 at 10:40 AM, R7 stated the wound (pressure area) on her buttocks was supposed to be checked every shift and staff were not checking it. R7 stated her wound (pressure area) was checked on 11/06/18 and her wound vac was removed when she went to dialysis on 11/07/18 and had not been reapplied. R7's wound vac was not connected with the tubing draped over the right side of R7's bed. On 11/08/18 at 1:50 PM, V20 (Registered Nurse) was observed providing wound care to R7's right buttock with V30's (Certified Nursing Assistant) assistance. R7 was in bed. V20 (RN) and V30 (C.N.A.) assisted R7 in rolling to her left side. R7's wound to her right buttock was open with no dressing or wound vac observed on the pressure area prior to initiation of wound care. V20 (RN) stated R7's wound vac was not in place when she arrived to work on the morning of 11/08/18. V20 (RN) was observed cleaning R7's pressure area wound on the right buttock.V20 (RN) removed her gloves, put on clean gloves, and then put a black sponge dressing inside R7's pressure area	S9999		

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wound. V20 (RN) then took her gloves off and used scissors to cut a small notch in the top of the black sponge in R7's wound. V20 then put on clean gloves and applied a clear dressing to R7's wound. V20 removed her gloves and applied a second clear dressing to R7's wound. After providing this care to R7, V20 (RN) then left the room, and went to the nurse's station, went through the treatment cart for more supplies to continue the wound treatment for R7. V20 returned to R7's room and applied a clear dressing to R7's wound and then applied the wound vac. V20 (RN) did not wash her hands prior to exiting the room, touching and removing treatment supplies from the treatment cart. Upon returning to R7's room , V20 (RN) did not wash her hands prior to continuing R7's wound care, and completing R7's dressing change. V20 (RN) did not continuously wear gloves throughout the wound care observation and was observed touching the black sponge while it was inside the wound, touching the surrounding tissue, and touching the clean dressing without gloves on.

On 11/08/18 at 3:00 PM, V2 (DON) stated R7's wound treatment record has an order for treatment to R7's left posterior thigh that should be an order for treatment to R7's right buttock. V2 (DON) and this surveyor checked R7's left posterior thigh to ensure R7's left posterior thigh was wound/pressure area free. V2 confirmed during this observation that R7 did have an open area to the left posterior thigh. V2 (DON) confirmed she was not aware of the wound/pressure area on R7's left posterior thigh prior to the observation with the surveyor and there was no documentation in R7's record related to the wound/pressure area on R7's left posterior thigh.

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On 11/09/18 at 2:00 PM V2 (Director of Nurses -DON) stated she would expect the nursing staff to wear gloves when touching wounds, dressings, or surrounding tissue, and to wash their hands after wound care before leaving the room and/or touching other wound care supplies. V2 (DON) confirmed R7's wound vac is to be in place continuously. V2 stated sometimes R7 refuses to go to dialysis if the wound vac is left in place. V2 stated if R7 refused to wear the wound vac to dialysis it should be put back on as soon as she returns to the facility from dialysis.

R7's Braden Observation dated 11/06/17 documents a score of 13 which indicates R7 is at moderate risk of skin breakdown. On 11/09/18 at 2:00 PM, when asked where R7's quarterly Braden assessments were, V2 (DON) stated she was unable to locate any other Braden Observation assessments for R7.

R7's care plan with an initiation date of 8/7/18 documents a focus area of wound infections and chronic pressure ulcer. R7's care plan documents a Stage 3 pressure ulcer located on R7's coccyx, and on 10/26/18 an un-stageable pressure ulcer on R7's right buttock and a stage 3 pressure ulcer on R7's left buttock.

R7's care plan documents a stage 3 wound on R7's right buttock, left buttock, and coccyx on 10/26/18. R7's treatment record documents a treatment for R7's left buttock with no treatment orders documented for R7's right buttock or coccyx. R7's wound logs do not document consistent measurements/assessments for a wound on R7's coccyx and no measurements/assessments for a wound on R7's left buttock. Observation of R7's skin on 11/08/18

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showed a wound to R7's right buttock and a new area to R7's left posterior thigh. The facility documentation is unclear where R7's wounds are and what treatment R7 is receiving for what wound.

The facility pressure ulcers/wounds log documents R7 has a stage IV wound on her right buttock with the following measurements; 9/10/18 - 7.1 x 6.1, 10/02/18 - 5.8 x 3.1 x 0.6, 10/15/18 - 5.8 x 3.0 x 0.5, 10/29/18 - 7 x 9 x 5, and 11/5/18 - 6 x 8.5 x 4.5. R7's wound log did not document measurements on 9/17, 9/24, 10/08 and 10/22/18. R7's wound log does not document measurements, staging, or assessment of a pressure area on the left buttock. R7's wound log documents a stage 3 pressure area on R7's coccyx measuring 9 x12 on 8/27/18 and 8.5 x 11.75 on 9/4/18. There is no other documentation related to a pressure area on R7's coccyx after 9/4/18.

R7's treatment records document the following physician orders for treatments to R7's pressure areas.

R7's 9/1/18-9/30/18 Treatment Administration Record (TAR) documents an order for a foam dressing pad to be applied to R7's left posterior thigh once daily and for a solution to be applied to R7's coccyx topically twice daily with a wet to dry dressing.

R7's 10/01/2018-10/31/18 TAR documents a physician order for foam dressing pad to be applied to R7's left posterior thigh daily and for a solution to be applied to R7's coccyx with a wet to dry dressing twice daily.

R7's 11/01/18 -11/30/18 TAR documents a

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S9999	Continued From page 16 physician order for foam dressing pad to be applied to R7's left posterior thigh daily. R7's 11/2018 treatment administration record documents the foam dressing to R7's left posterior thigh was not in place on 11/07/2018. R7's regional wound clinic note dated 10/31/18 continues to document under assessment notes, "Pt (patient-R7) states the nursing home applied wound vac but "it kept beeping" so they "took it off." R7's weekly skin observations do not document measurements, descriptions of pressure areas, or staging on 9/7, 9/14, 9/21, 10/05, 10/12, 10/19, 10/26, 10/30 and 11/02. R7's weekly skin observations document on 11/02, "pressure ulcer right buttock, wound vac in place" and on 9/21/18 "deep wound ...coccyx ...wound clinic newly caring for R7's wound." R7's nurses notes reviewed from 8/6/18 through 10/30/18 do not consistently document stages, measurements, and/or assessments of R7's pressure areas. The facility pressure injury and skin condition assessment policy dated 1/17/18 documents, "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other ulcers and assuring interventions are implemented. Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and documented in the resident's clinical record	S9999		

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S9999	Continued From page 17 1. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and as necessary. 2. Residents identified will have a weekly skin assessment 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. 5. If the resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock area and groin. 6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. 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. 8. Prior to performing the skin assessment, the nurse is to have a sufficient supply of clean disposable gloves to perform assessments on multiple areas. Conduct hand washing in accordance with facility standard/universal precautions. 9. A disposable measuring device (one time use) will be used to measure dimensions, and if necessary, a clean cotton tipped applicator to measure wound depth/tunneling/undermining. 10. Pressure injuries and other ulcers (arterial, diabetic, venous) will be measured at least	S9999		

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weekly and recorded in centimeters in the resident's clinical record.
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
12. Measure length vertically in relation to head to toe position. Measure width horizontally in relation to hip to hip. Measure depth straight down into the deepest part of the wound. *If the wound is necrotic and the base of the wound bed is not
visible or tunneling, the stage cannot be measured and must be recorded as non-stageable with a undetermined depth.
13. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. Physician and responsible party notification will be documented in the clinical record. These
changes include, but are not limited to:
a. New onset of purulent drainage
b. New onset of odor
c. Cellulitis
d. Increased pain related to wound
e. Significant increase in wound measurements
f. Onset of new ulcers
14. Dressings which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall include the date of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness, and

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signs and symptoms
of infection.
15. Adherent or semi-permeable membranous dressing used for debriding or healing purposes will be removed at least weekly or more often in accordance to physician's orders. When used, the licensed nurse will document the observation in the treatment administration record and initial the dressing to verify the treatment was performed.
16. The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection.
17. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care.
18. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or
nurses noted (sic).
19. A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible party will be notified by charge nurse. Notification will be documented in the resident's clinical record.
20. The attending physician shall be notified within seven (7) to fourteen (14) days of the resident's lack of response to treatment.

(A)