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
	IL6009120	A. BUILDING: ______ B. WING ______	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S SENIOR COMMUNITY	1021 WEST E STREET BELLEVILLE, IL 62220

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)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. 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	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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:

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

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 regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess, implement progressive interventions including offloading of pressure to treat pressure ulcers for 2 of 5 residents (R31, R35) reviewed for treatment of pressure ulcers in the sample of 60. This failure resulted in R31 developing a facility acquired Stage III pressure ulcer to his right heel that

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deteriorated to an unstageable pressure ulcer requiring antibiotic treatment.

Findings include:

1. R31's Face Sheet showed R31 was admitted to the facility on 7/29/21.

R31's Admission Nurse Assessment, dated 7/30/21 at 12:51 PM, documented R31 was at moderate risk for skin breakdown and had no wounds or open areas at the time of admission.

R31's Admission Minimum Data Set (MDS), dated 8/5/21 documented R31 had no cognitive impairment. The MDS documented R31 required extensive assistance from two staff persons for bed mobility and transfers. The MDS documented R31 does not walk in room or in the corridor. The MDS documented R31 required one-person physical assist with dressing, toileting, personal hygiene and bathing. Mobility devices used include a walker and a wheelchair. The MDS documented R31 was at risk for developing pressure ulcers but currently had no pressure ulcers.

On 10/5/21 at 11:10 AM, R31 was self-propelling around his room sitting up in his wheelchair. R31 had yellow nonslip socks on and a hospital gown. R31 said R31 has a surgical wound on R31's back and another wound on R31's right heel and it "hurts like the dickens." There was a heel protector in R31's recliner chair in the room. R31 said R31 wears the boot on the right foot while in bed.

During medication administration on 10/6/21 at 9:10 AM V9, Licensed Practical Nurse (LPN) asked R31 if R31 was in pain and resident said

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S9999	Continued From page 3 R31's right heel hurt 9 out of 10 (10 being the worse pain) on a pain scale. On 10/6/21 at 2:00 PM, V4, Wound Care Nurse and V9, Licensed Practical Nurse (LPN) entered R31's room to provide pressure ulcer care to R31's right heel. V4 and V9 washed their hands and put on clean gloves. V4 removed the nonslip sock off the resident's right foot. The rolled gauze wad dated 10/5/21. The drainage on the dressing was betadine, there was no other drainage on the dressing. The entire wound bed was covered with eschar and measured 2.3 cm x 3.5 cm. V4 applied a 4x4 betadine-soaked gauze directly on the pressure ulcer then an ABD and rolled gauze then dated and initialed the dressing. On 10/8/21 12:15 PM, R31 was sitting up in a wheelchair in R31's room. R31 had on nonslip socks with both feet directly on the pedals of the wheelchair. R31 had no pressure relief to either heels. R31's foam boots were on the bed. R31 showed the surveyor the new air overlay on R31's bed and said R31 had the boots on prior to therapy today but that they did not put them back on after therapy. R31 said R31 is able to self-propel wheelchair using R31's arms for short distances, but cannot self-propel long distances using R31's feet because they hurt so bad. R31 showed the surveyor R31 cannot bend foot up and down, and puts heel directly on the floor and moves forward to propel himself forward. On 10/8/21 at 12:30 PM, V19, Physical Therapist, stated she worked with R31 today. V19 stated R31 had wheelchair pedals on and boots on both feet prior to therapy. V19 stated she did not put the boots back on R31's feet after the therapy session because she thought R31 only needed them on in bed. V19 was aware the resident has	S9999		

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S9999	Continued From page 4 a wound on his right heel, but no one told her R31 needs to have the boots on while up in the wheelchair. R31's Nurse's Note, dated 7/30/21 at 2:54 AM, staff documented R31's feet have red dry peeling skin with redness and tenderness noted to the right heel and going to inner right ankle with no open area noted. The Note documented "Red dry skin to left heel with no tenderness." R31's Braden scale, dated 7/30/21, documented R31 was at risk for skin breakdown. R31's Care Plan, dated 7/30/21, documented the following interventions related to skin integrity: avoid shearing while repositioning when in bed, encourage good nutrition and hydration in order to promote healthier skin, float heels while in bed, for dry and flaky skin use high quality moisturizers to rehydrate skin, assist resident to turn/reposition at least every two hours, more often as needed or requested. R31's Progress Note, dated 7/30/21 and 8/2/21, written by V13, Nurse Practitioner, documented no assessment of R31's right heel. R31's Skin Check Weekly & (and) PRN (as needed) form, dated 8/6/21, documented R31 had no new skin breakdown and no new areas of skin impairment. R31's Progress Note, dated 8/10/21, written by V13, documented no type of assessment of R31's right heel. There was no documentation of any skin impairment on R31's right heel. R31's Skin Check Weekly & PRN form, dated 8/13/21, documented R31 had no new skin	S9999		

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breakdown.

R31's Progress Note, dated 8/18/21 at 11:01 AM, documented "LATE ENTRY. This resident is experiencing a change in condition. See SBAR (Situation, Background, Assessment, Recommendation form) assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is new area to right heel."

R31's SBAR dated 8/18/21, documented R31 had a new area on the right heel. The SBAR documented things that make the condition worse was unknown. The SBAR documented things that make the condition better were float heels, supplements and change of positions. The SBAR documented under the Section Assessment "to have area new area to right heel pressure ulcer maybe started as blister area has dry darken brown skin layer with pink granulated present." There was no other skin assessment information documented including measurement of the pressure ulcer, description of wound bed, description of wound edges, drainage and/or presence of odor.

On 10/6/21 at 2:30 PM, V4, the facility wound nurse said she initially assessed the pressure ulcer on the R31's right heel on 8/18/21 and she documented an SBAR. When she initially assesses a new pressure ulcer, she documents the assessment on an SBAR because it is a change in condition. V4 stated, as the facility wound nurse, she assesses the pressure ulcers weekly and documents the weekly skin assessment in resident's medical record. She used to document the weekly skin assessments on a tablet, but she could not see all the options to document all the information on all the weekly

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skin assessments as far as draining and the appearance of the wound bed.

R31's Progress Note, dated 8/18/21 at 2:18 PM documented "therapy communicated that resident has open area on right heel. resident was assessed and area is a Stage 2, area cleaned and covered with a cushioned dressing. NP (Nurse Practitioner) is aware."

R31's Physician's Order Sheet (POS), dated 8/18/21, float heels and apply foam dressing.

There was no documentation in R31's medical record regarding the measurement or description of R31's right heel pressure ulcer from 8/18 through 8/24/21.

R31's Skin & Wound Evaluation, dated 8/24/21, documented R31 had a new facility acquired Stage III pressure ulcer on right heel that measured 1.8 centimeters (cm) x (by) 2.0 cm x 0.2 cm. The wound bed was covered with 10% epithelial and 90% granulation tissue. There was no assessment documented regarding exudate (drainage), the periwound area, pain, orders or treatment. The Evaluation documented the nurse practitioner was notified of the new pressure ulcer on the resident's right heel.

The National Pressure Injury Advisory Panel (NPIAP) Pressure Injury Stages documented a Stage III pressure ulcer as "Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present."

R31's Care Plan, updated 8/25/21, documented R31 had a right heel stage III pressure ulcer with new treatment orders in place until healed. The

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S9999	Continued From page 7 Care Plan Goal documented "right heel will continue to heal without complication until healed." The Care Plan Interventions documented a nutritional supplement to be given and heel protectors while in bed. The Care Plan did not address how R31 should offload pressure from his heels while up in his wheelchair. R31's Skin and Wound Evaluation, dated 9/1/21, documented R31 had a facility acquired Stage III pressure ulcer on his right heel that measured 1.8 cm x 1.8 cm x 0.1 cm. The Evaluation documented the wound bed was covered with 80% epithelial and 20% granulation tissue. The Evaluation documented "Treatment: cleanse with generic wound cleanser and foam dressing." The Evaluation documented R31's pressure ulcer progress was improving. There was no assessment documented regarding exudate (drainage), the periwound area, pain or orders. R31's Skin Check Weekly & PRN form, dated 9/2/21, staff documented there was a pressure ulcer on the resident's right heel. No other skin assessment was documented. R31's Skin & Wound Evaluation, dated 9/8/21, staff documented R31 had a facility acquired Stage III pressure ulcer on his right heel that measured 4.3 cm x 5.1 cm. The Evaluation documented the wound bed was covered with 70% epithelial and 30% granulation tissue. The Evaluation documented there was light amount of serosanguineous drainage (yellowish with small amounts of blood) and no odor present. The Evaluation documented the periwound area was dry/flaky and fragile (skin that is at risk for breakdown.) The Evaluation documented the progress of R31's pressure ulcer was improving.	S9999		

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S9999	Continued From page 8 R31's History and Physical, dated 9/8/21, written by V21, Physician, documented no assessment or documentation of R31's right heel pressure ulcer. R31's Skin Check Weekly & PRN form, dated 9/10/21, documented no new skin changes this week. No other skin assessment was documented. R31's Skin & Wound Evaluation, dated 9/14/21, documented R31 had a facility acquired Stage III pressure ulcer on his right heel that measured 2.1 cm x 2.0 cm. The Evaluation documented the wound bed was covered with 50% granulation tissue and 50% eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of wound." The Evaluation documented there was no drainage and no odor present, periwound area was dry/flaky. The Evaluation documented R31's pressure ulcer was improving although the pressure ulcer was now covered with 50% of eschar. There were no documented changes in R31's Physician's Orders at that time regarding his right heel pressure ulcer. R31's Physician's Progress note, dated 9/14/21, documented right heel dressing clean, dry and intact. There was no further assessment of the pressure ulcer on his right heel documented. R31's Skin Check Weekly & PRN form, dated 9/17/21, documented R31 had no new skin changes this week. No other skin assessment was documented.	S9999		

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R31's Physician Progress Note, dated 9/17/21, documented "no open areas, right heel black/dry scab. See wound/skin assessments for full details." There was no further assessment of the pressure ulcer on R31's right heel documented.

R31's Skin & Wound Evaluation, dated 9/21/21, staff documented the resident had a facility acquired Stage III pressure ulcer on right heel that measured 2.0 cm x 2.9 cm. The Evaluation documented the wound bed was covered with 100% eschar. The surrounding tissue was dry/flaky and calloused. Staff documented the progress of the pressure ulcer was stable although the R31's pressure ulcer was now covered with 100 % eschar.

R31's Physician's Progress note, dated 9/21/21 no open areas and right heel with black, dry scab, see wound/skin assessments for full details. Today the dressing was clean, dry and intact. There was no further assessment of the pressure ulcer on R31's right heel documented.

R31's Skin & Wound Evaluation, dated 9/28/21, documented R31 had a facility acquired Stage III pressure ulcer on his right heel that measured 1.9 cm x 2.5 cm. The Evaluation documented the wound bed was covered with 100% eschar. No drainage noted, periwound edges attached. The Evaluation documented the progress of the pressure ulcer was improving. Staff documented resident seen by physician; orders for dopplers. Education: keep heel protectors on while in bed and continue nutritional supplement. There was no documentation as to how R31 should offload heels while up in R31's wheelchair.

Review of the facility's wound report, dated

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S9999	Continued From page 10 9/28/21 at 7:02 PM, documented a Stage III on R31's right heel measuring 1.9 cm X 2.5 cm. The wound report documented R31's pressure ulcer status was improved. R31's POS, dated 9/28/21, documented a bilateral arterial doppler study was ordered due to chronic right heel wound, pain of the toes of both feet which are cool to palpation. R31's x-ray lower extremity arteries/arterial bypass graft, dated 9/29/21, documented impression as no evidence of hemodynamically significant stenosis. Staff documented reported to physician and dated the document 9/29/21. Reason for arterial doppler: swelling in bilateral lower extremities, pain in bilateral toes, bilateral weak pulses, chronic right heel stage II pressure ulcer, skin cool to touch. R31's Physician Progress note, dated 10/1/21, documented R31 complained of right heel pain worse overnight last night, "relieved with elevating right lower extremity." Right heel with black/dry scab. See wound/skin assessments for full details. Today dressing last changed 9/29/21 but no SOI (signs of infection)." Assessment and plan: new diagnosis: peripheral vascular disease (PVD) with right heel wound. Nutritional supplement, wound care, discussed with nursing imperativeness of dressing change, reminded resident to wear heel protectors and elevate heel on pillow, especially if hurting. R31's POS, dated 10/4/21, documented to consult (Wound consultant company) for R31's right heel. R31's POS, dated 10/5/21, new treatment order for right heel: cleanse right heel, pat dry, apply a	S9999		

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S9999	Continued From page 11 betadine soaked 4x4 and cover with an ABD dressing and rolled gauze. R31's skin and wound evaluation, dated 10/6/21, showed staff documented the resident had a facility acquired Stage III pressure ulcer on the right heel that measured 2.3 cm x 3.0 cm. The wound bed was covered with 100% eschar. No drainage noted. Staff documented the surrounding tissue was normal in color. The progress of the pressure ulcer was stable. Staff documented notes: refer to (Wound Care Company) wound care physician. On 10/6/21 at 10:40 AM, V9, LPN, said she did not assess skin breakdown on R31's right heel before it was assessed by the wound nurse. She recalled when R31 was initially admitted to the facility the resident's heels were red and R31 complained they hurt. When the wound nurse assessed R31's right heel the physician's treatment was 8/18/21 float heels and apply foam dressing and 8/25/21 change foam dressing until healed. R31's Progress Note, dated 10/7/21 at 8:21 AM, documented the physician assessed resident today regarding right heel. The Progress Notes documented a new order to discontinue betadine soaked 4x4 order and start new treatment order to: Cleanse right heel, pat dry, apply Santyl to 4x4 gauze apply to right heel cover with ABD pad and rolled gauze. The Note documented concerns of new redness to periwound right heel new orders to start antibiotic. The Note also documented: Add a mattress overlay to mattress. Some redness to buttocks and scrotum, the physician is aware and pending new treatment orders. The resident understands the new orders. The Progress Note did not address/document how	S9999		

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S9999	Continued From page 12 R31 should offload heels while up in wheelchair. R31's Progress Note, dated 10/7/21 at 12:12 PM, staff documented new order for a venous doppler to right lower extremity due to pain and non-healing wound on right heel. PRN pain medication administered as needed, will continue to monitor resident and update as results become available. R31's Nurse's Progress Note, dated 10/7/21 at 1:05 PM documented, spoke with resident's physician clarification as unstageable as of 9/14/21. On 10/7/21 at 1:18 PM, V21, R31's Physician, stated she started following R31 in September 2021. V21 stated she initially assessed R31 on 9/14/21 but did not take the dressing off the right heel. She stated she does not always take the dressing off to assess a wound. V21 stated the wound on R31's right heel was an unstageable pressure ulcer. She could not recall when she initially assessed the pressure ulcer on R31's right heel, she referred the surveyor to read the documented notes in R31's electronic medical record labeled physician's progress note. Review of R31's physician progress notes, dated 9/17/21 showed V21 documented an assessment of the pressure ulcer on the resident's right heel. V21 said R31 self-propelling in wheelchair would not cause the pressure ulcer on the right heel to be worse. R31's Physician's Progress Note, dated 10/7/21 at 6:14 PM, documented R31's right heel wound with black dry scab, appears about the same size but surrounding tissue is red and tender to touch. R31's POS, dated 10/7/21, documented new	S9999		

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antibiotic ordered Amoxicillin-Pot Clavulanate Tablet 875-125 mg (milligram) twice a day for diagnosis of R (right) heel cellulitis.

R31's POS, dated 10/7/21, consult with (Wound Company) skin specialists re (regarding) R (right) heel wound.

On 10/7/21 at 11:05 AM V13, Nurse Practitioner, said when R31 was initially admitted she was R31's nurse practitioner, but a new physician group started mid-September 2021, so she is no longer assigned to the resident. V13 stated when R31 was initially admitted she recalled R31 wore lace up work boots and R31 wanted to continue to wear them. She recommended to the resident and V4, the wound nurse that R31 should no longer wear them due to the pressure they cause. V13 assessed R31's heels at one point and said there was "a spot" on R31's right heel. V13 stated she never saw the wound as a Stage III pressure ulcer. V13 documents assessments in the resident's electronic record under progress notes. V13 stated if there were no documented assessments of the pressure ulcer on the R31's right heel then the assessment was not done.

R31's electronic medical record dated 8/18/21 through 9/15/21, showed no assessment of the pressure ulcer on R31's right heel documented by V13, the nurse practitioner.

R31's Progress Note, dated 10/8/21 at 12:54 AM, documented R31 had a doppler done on right lower extremity with result of no evidence of acute deep venous thrombosis. Start antibiotic, no complaint of pain or discomfort. Dressing dry and intact.

On 10/8/21 at 2:00 PM, V20 wound surgeon from

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(Wound consultant company), said the wound classification on R31's right heel is an unstageable pressure ulcer. He stated skin prep would not be an appropriate treatment for a Stage III pressure ulcer but that a foam dressing would be an appropriate treatment per standards of care. V20 stated the most important part of the treatment of a pressure ulcer is offloading to decrease pressure and promote healing.

2. R35's October 2021 Physician Order Sheet (POS) documents a diagnosis of Alzheimer disease, heart failure, diabetes mellitus, muscle weakness, and pain.

On 10/5/2021 at 8:39 AM, R35 was sitting in a geriatric wheelchair with right heel covered in a bandage and the heel was sitting directly on the bottom of the footrest. R35's heel was touching the footrest directly with both feet resting on the footrest.

R35's POS, dated 9/6/21, documents "To RT. (right) heel q (every) shift apply heel protectors to both feet Q HS (time of sleep/night) every shift to prevent skin breakdown."

R35's Wound Evaluation document on 9/15/2021, R35 developed a new pressure deep tissue injury with the surface area of 8 centimeters (cm) and 2 cm in length. This was acquired in house. (Facility Acquired Deep Tissue Injury).

The Skin & Wound Evaluation dated 9/15/2021 document the area was 8.0 cm x length 2.0 cm x width 4.0 cm. The Wound bed was 20% of wound covered epithelial and 80% of wound filled. Heel Suspension/Protection device, positioning wedge and Turning and Repositioning Program. Progress was documented as new."

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S9999	Continued From page 15 R35's Skin Check dated 9/23/2021 document, "new right lower extremity skin discoloration." The Check documented "New areas of skin impairment." R35's Wound Evaluation dated 9/29/2021, documents R35's deep tissue injury increased in size to 10.08 cm x 2.4 cm. R35's POS, dated 9/30/21 documents "Betadine solution (Providone-Iodine), Apply to right heel topically as needed for wound apply betadine to a 4 x 4 soak place to right heel cover with ABD pad with rolled gauze." R35's Care Plan with a Focus Area of Skin, undated, document, DTPI Deep Tissue Pressure Injury (DTPI) right heel treatment order in place. The Goal documented "Right heel shows signs of improvement by next review." R35's Care Plan also documents R35 receives assistance with activities of daily living and utilizes a wheelchair. On 10/5/2021 at 8:50 AM, V17, Licensed Practical Nurse (LPN) stated, "(R35) has boots that R35 wears at night. R35 does not have any boots in the day. I suppose R35's foot should not be touching the footrest." On 10/8/2021 at 2:11 PM, V20, Wound Surgeon stated, "I would expect all wounds to be off loaded to decrease pressure and promote healing." The Pressure Ulcer/Pressure Injury Prevention (PUP) with a revision date of 04/2018 documents "Prevention of Pressure Ulcers/Injuries A pressure ulcer/injury (PU/PI) can occur wherever pressure has impaired circulation to the tissue. A	S9999		

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S9999	Continued From page 16 facility must: Identify whether the resident is at risk for developing or has a PU/PI upon admission and thereafter: Evaluate resident specific risk factors and changes in the resident's condition that may impact the develop and/or healing of a PU/PI; Implement, monitor and modify interventions to attempt to stabilize, reduce or remove underlying risk factors; and If a PU/PI is present, provide treatment to heal it and prevent the development of additional PU/PIs.The first step in the prevention of PU/PIs, is the identification of the resident at risk of developing PU/PIs. This followed by implementation of appropriate individualized interventions and monitoring for the effectives of the interventions. 2. Planning: An individual plan of prevention will be developed to meet the needs of the resident. It will include the consideration of mechanical support surfaces, nutrition, hydration, positioning, mobility, continence, skin condition and overall clinical condition of the resident as well as the risk factors as they apply to each individual. The goal is for the resident to be free of preventable pressure ulcer/pressure injury. 3. Implementation Interventions for the prevention of pressure ulcer/pressure injury will be individualized to meet the specific needs of the resident. Interventions will consider the assessment of risk and skin condition of the resident. Minimize Pressure: Turning and Repositioning-every two to three hours when in bed, or more frequent depending on the need of the resident. Every hour when a chair. Teach the resident techniques for self-repositioning every 15 minutes. Utilize 30-degree lateral positioning, as opposed to direct side lying, using pillows or wedges for positioning. Avoid use of donuts and ring type devices. Avoid sheepskin for pressure reduction, useful for comfort only. Use support surfaces on beds and chair to redistribute or relieve pressure.	S9999		

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S9999	Continued From page 17 Relieve pressure to heels by using pillows or other devices. Do not depend on heel protectors, they do not provide pressure reduction/relief. Pressure reduction/relief devices should serve as adjuncts and are not replacements for repositioning protocols. 4. Evaluation and Reassessment - The facility's Care Management System committee will review program components to evaluate the effectiveness of the prevention program and facility systems. Findings and recommendations will be reviewed with the QA Clinical Committee. Based on evaluation, the need for reassessment and further changes to the individual resident's plan of care will be determined and acted upon." (B)	S9999		

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S 000	Initial Comments Annual Licensure Survey (Sheltered Care)	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a) 330.720b) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care. These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents on the sheltered care unit did not qualify or need skilled care for 4 of 14 residents (R301, R302, R303, and R304) reviewed for shelter care in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 sample of 5. Findings include: 1.R301's October 2021 Physician Order Sheet documents, "I hereby certify this resident continues to require 24-hour nursing care in a skilled facility." R301's OBRA (Omnibus Budget Reconciliation Act) screening form dated 9/24/2020 document " screening indicated nursing facility services are appropriate." On 10/5/2021 at 9:01 AM, R301 had an indwelling urinary catheter. The urine collection bag was attached on the left side of his wheelchair. On 10/5/2021 at 9:11 AM, R305, wife of R301 stated, "Staff empty catheter and do the tubing for the catheter. All of the catheter care is completed by staff." R301's Physician Order Sheet October 2021 documents "16 French catheter. Output every shift for indwelling catheter." On 10/5/2021 at 9:20 AM, V22, Care Plan Coordinator, Licensed Practical Nurse (LPN) stated, "Staff do catheter care, accu-checks and administer insulin for residents that need it on this unit." 2. R302's POS dated October 2021 documents a diagnosis of Type 2 diabetes. The POS documents an order for Accu checks am and after meals every morning and at bedtime for diabetes accuchecks AM and after meals. R302's Medication Administration Record (MAR)	S9999		

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S9999	Continued From page 2 documents R302 received 20 units of Lantus every morning and at bedtime. On 10/5/2021 at 9:12 AM, R302 stated staff take his accu-checks and give him his insulin daily. R302's OBRA screening form dated 3/30/2021 document " screening indicated nursing facility services are appropriate." 3. R303's POS dated October 2021 document a diagnosis of diabetes mellitus with hyperglycemia. R303's POS also documents accu-checks before meals and at bedtime. Lantus inject 20 units at bedtime. R303's MAR document R303 received 20 units of Lantus at bedtime from 10/2/2021 to 10/8/2021 and NovoLog 7 units at 8 PM, Noon, and evening before meals. R303's OBRA screening form dated 9/15/2021 document "screening indicated nursing facility services are appropriate." On 10/5/2021 at 9:15 AM, stated, "Staff do my accu-checks and insulin shots." 4- R304's POS dated October 2021 documents a diagnosis of Type 2 diabetes. The POS documents and order for accu-checks before meals and after meals and accu-checks at bedtime. Lantus 15 units at bed and lispro sliding scale. R304's MAR documents received his accu-checks for October at 8AM, 12PM, evening. Lantus was documented as being given, and lispro was documented as being given 10/1/2021 - 10/3/2021 and one dose at noon on 10/1/2021,	S9999		

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S9999	Continued From page 3 and 10/3/2021, 10/4/2021 and 10/5/2021. R304's OBRA screening form dated 3/30/2021 document "screening indicated nursing facility services are appropriate." On 10/8/2021 at 5:15 PM, V1, Administrator stated there was no policy on the shelter unit. (B)	S9999		