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CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

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S 000	Initial Comments Complaint Investigations: 2161457 / IL 131482 2161561 / IL 131602 2161734 / IL 131791 2161860 / IL 131929	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)2)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility 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: 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. 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status,	S9999		

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sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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. The plan shall be reviewed at least every three months.

These Requirements were not met evidencded by:

A.) Based on observation, interview, and record review, the facility failed to ensure a resident's safety while being transported in a facility van from a medical appointment. The resident (R2) slid from a wheelchair landing with buttocks on the footrests of the wheelchair which were on the floor of the van, with R2's legs extended and wheelchair "tipped forward." This failure affects one of three residents (R2) reviewed for falls in the sample of three. R2 sustained excruciating pain to bilateral lower extremities, immediately after and with movement after the fall on the van, prior to being diagnosed with bilateral femur fractures identified to be consistent with a traumatic incident or fall. This failure also has the potential to affect 26 additional residents (R5, R8, R16-R39) who utilize the facility transport vehicle.

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R2 reported R2 was having pain to V6, Registered Nurse (RN) upon V6 coming on the facility van to assess R2 after R2's fall on 2/27/21. R2 reported R2 screamed out in pain immediately following this fall. R2 reported R2 remained in bed until 3/1/21 due to having a Dialysis appointment. R2 tried not to move due to severe pain in R2's bilateral legs. R2 stated on 3/1/21, R2 had severe pain during transfer and movement which was reported to facility staff as well as V19, Dialysis Administrative Assistant upon arrival to R2's appointment on 3/1/21.

R2 was taken to the hospital emergency room and subsequently admitted for an elevated temperature.

On 3/4/21, after continued complaints of pain and V18, R2's family reporting R2's fall in the facility van, the hospital performed X-rays of R2's left and right femur and knees which showed R2 had bilateral femur fractures. On 3/16/21 at 10:55am, V14, Radiologist stated V14 reviewed/read R2's imaging studies which showed bilateral distal femur fractures. V14, stated it "is very uncommon/unlikely for acute bilateral femur fractures to occur spontaneously." V14 stated "given (R2's) clinical history including a fall" with the imaging studies, the fractures were most likely caused by trauma to bilateral lower extremities.

Findings include:

a.) R2's Physician Order Report dated February 2021 documents R2's diagnoses including End Stage Renal Disease (ESRD), Unstageable Pressure Ulcer of the Right Buttock, Gout, Edema, Renal Dialysis, Anemia, Diabetes with

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S9999	Continued From page 4 Diabetic Neuropathy, Obesity and Pressure Ulcer of the Sacral Region. R2's Minimum Data Set (MDS) dated 12/23/2020 documents R2 is cognitively intact. R2's functional limitation in range of motion is documented as R2 having "no impairment" of the lower extremity's. This MDS also documents R2 "occasionally" had pain but the pain did not have an effect on R2's sleep or day to day activities. R2's Minimum Data Set (MDS) dated 3/1/21 documents R2 is cognitively intact. This MDS documents for R2's functional limitation in range of motion as R2 having "impairment on both sides" of the lower extremity's. This MDS also documents R2 has experienced pain "Frequently" and the pain has made it hard for R2 to sleep as well as has limited day to day activities because of the pain. The facility's investigation file for R2's fall on 2/27/21 documents R2 slid out of R2's wheel on to the footboard/foot pedals of the wheelchair with the wheelchair tipping forward with the foot pedals/board to the ground of the van while being transported by a facility van driver (V7) in the facility van. R2's Progress Note dated 2/27/21 documents R2 had slid out of R2's wheelchair on the way back to the facility from Dialysis. This note documents when the van arrived to the facility, R2 was found in the transportation van, sitting on footboard that was laying across seat pedals. "(R2) c/o (complained of) discomfort d/t (due to) the position in which (R2) was laying." This note documents R2 is to "be securely placed in transport vehicle before leaving making sure seat belt and wheel locks are secured."	S9999		

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On 3/15/2021 at 2:05pm, V7, Facility Transport Driver stated V7 and R2 were talking and as the van was coming up to the light and V7 noticed R2 was "sliding slightly." R2 stated R2 was "okay." V7 stated V7 "kept driving" but V7 noticed R2 was sliding forward more as V7 continued to drive. V7 stated V7 called the facility (R2 was still in R2's chair) and let them know help would be needed with R2 in the van when they arrived. V7 stated the seat belt was still on R2. Once back to the facility, V7 "undid the seat belt" and R2's seat remained "tilted forward." V7 stated V6, Registered Nurse (RN) assessed R2. V7 stated R2 still had the "lap belt" over R2 while on the floor, but it "had come up a little over R2's upper stomach" not as "low" on R2 as when V7 first placed the lap belt. V7 stated V7 did not check to see if the straps were not tightened or loose or what may have caused R2's fall.

There is no documentation V7 has been trained by the facility on operating or safely transporting residents in the facility transport van. There is no documentation the facility transport van was evaluated for function of safety restraints after R2's fall on 2/27/21 until the six month inspection on 3/9/21. There is no documentation the van was evaluated during the fall investigation by the facility.

On 3/15/21 at 12:55pm, V6, RN stated, "(V6) got a call R2 fell out of the wheelchair. They (R2 and V7) were coming back from Dialysis." R2 had a foot board across foot pedals, she was sitting on that which was on the floor of the van due to wheelchair being tipped forward. "(R2) complained of discomfort then, but there was not much space" in relation to her position. "When (V6) got out to the van, there were no straps around (R2) (seat belt). V6 stated V6 does not

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know if the straps/seatbelt was removed by staff prior to V6 arriving to the van. V6 stated V6 asked R2 what happened and R2 reported the belt popped when van came to a stop and R2 slid out of the wheelchair. V6 stated according to V7, V7 "did not notice R2 had fallen out (of the wheelchair). R2 was saying help, help and then (V7) looked back to see R2's buttocks on the foot board to R2's wheelchair foot pedals." V6 stated V6 observed the straps to secure the bottom of the wheelchair were on the front wheels and the back wheels were in the air. R2's legs were extended out in front of R2, in the center of the van toward the front of the van. V6 stated R2 had complained of pain, but "once (R2) was laid in bed R2 had no complaints."

On 3/15/21 at 6:25pm, V1, Administrator stated the facility did not have documentation V7 had been trained in operating or safely transferring residents in the facility transport van. V1 stated V1 did not "look" at the van after R2's fall to check and see what may have caused R2's fall.

On 3/16/21 at 12:15pm, V19, Dialysis Administrative Assistant stated R2 arrived at dialysis on 3/1/21 and "had a temperature" so the ambulance was called to take R2 to the hospital. V19 stated R2 was complaining R2's legs hurt with movement. V19 stated R2 had not fallen at the dialysis center nor did R2 receive Dialysis on 3/1/21.

On 3/16/21 at 12:20pm, V20, Dialysis Clinic Manager stated R2 had a history of chronic pain, but the chronic pain was more of a generalized pain and not severe. V20 stated when R2 arrived at the clinic on 3/1/21 from the facility via the facility transport van, R2 complained R2 could not straighten R2's legs.

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S9999	Continued From page 7 R2's Ambulance transport report dated 3/1/21 does not document R2 had any falls while being transported from the dialysis center to the hospital on 3/1/21. R2's Hospital Acute Care Surgery Progress Notes dated 3/4/21 at 8:32am document R2 "is complaining of some bilateral knee pain" and that R2 fell during transportation "a few days ago." This note documents the hospital would follow up with x-rays of bilateral lower extremities. R2's x-rays of bilateral lower extremities were completed on 3/4/21 and document R2 was found to have "Acute Comminuted Displaced Distal Femoral Metadiaphyseal Fracture with approximately 75% displacement of the dominant distal fracture segment" of the right femur. There is apex posterolateral angulation with varus angulation of the lower leg. "Impaction and angulation results in foreshortening of the femur." "Osseous excrescence directed posterolaterally from the superior acetabulum may relate to prior trauma." Thickened appearance of the quadriceps tendon may relate to redundancy associated with the femoral fracture angulation." These reports document R2 had an "Acute Comminuted Angulated Fracture of the Distal Femoral Metaphysis with apex dorsal angulation" of the left femur. Angulation and mild impaction results in foreshortening of the femur." R2's Physician's Post-op (operation) Note dated 3/5/21 by V15, R2's Orthopedic Surgeon documents R2 had a fall "during accident." This note documents after R2's admission to the hospital for "other conditions" R2 was found to have bilateral supracondylar femur fractures. This note documents V15's evaluation of R2's x-rays	S9999		

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and CT scan demonstrated comminuted displaced extra-articular fractures of the bilateral supracondylar femurs. V15 documented V15 spoke with V18, R2's family to explain the injuries and expectations of outcome from them. This note documents "primarily this is a palliative surgery to provide pain control." V15 also ensured V18 understood "there is a very high risk of complications associated with this including infection fixation failure." This note documents, "(V15) have been frank with (R2) and (V18) again that this is primarily palliative surgery. No guarantees were given. Again prognosis is extremely guarded at this point."

On 3/15/2021 at 10:35am, V17, Registered Nurse (RN) stated V17 has been R2's nurse while at the hospital. V17 stated R2's bilateral femur fractures were concerning, especially since R2 had fallen on 2/27/21 with no follow up imaging completed until after R2 came to the hospital and "screamed" in pain any time R2 had any movement. V17 stated due to the continued complaints of pain to the bilateral lower extremities and V18, R2's Family report of the fall in the facility transport van, the hospital completed x-rays and computed tomography (CT) imaging studies where R2's bilateral femur fractures were identified.

On 3/9/21, V18, R2's Family stated V18 saw R2 on 3/2/21. V18 stated R2 reported to V18 about R2's fall out of the wheelchair while R2 was a resident at the facility (on 2/27/21). V18 stated R2 was in excruciating pain to the point when staff attempted to lift the head of R2's bed, R2 was "screaming in pain." V18 stated R2 has a history of chronic generalized pain, but the pain R2 was reporting was not R2's normal chronic pain. V18 stated the request was made to take x-rays of

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R2's bilateral lower extremities do to this extreme pain in addition to V18 reporting the fall to the facility and they found "both (R2's) femurs, right above the knee were fractured." V18 reported it was "found (R2) was not strapped in" when the fall occurred.

On 3/15/21 at 10:45am, R2 was laying in the hospital bed. R2 stated R2 was being transported back from dialysis " around a couple weeks ago" to the hospital (facility) when R2 fell out of the wheelchair in the facility transport van and "hit both legs on something and started screaming in pain." R2 stated R2 calls the facility R2 resides in a "hospital." R2 stated as soon as R2's legs hit something and immediately R2 had "horrible, severe pain" to both legs. R2 stated V7, Facility Transport Driver continued driving after R2 had began to slide and eventually fallen out of R2's wheelchair to the floor of the van until arriving at the facility. R2 stated R2's "supposed to be strapped in" but that R2's wheelchair did not feel like it had been secured because the chair was moving which had not happened during any prior transports. R2 repeated R2 had "oh, a lot of pain" with R2's eyebrows raised. R2 stated R2 reported the pain to V6, Registered Nurse (RN) immediately once V6 came on the van to assist R2 off the floor of the van. R2 stated the facility got R2 in bed and R2 just "did not move" until R2 had to because any movement caused pain in R2's bilateral knees/ legs right above R2's knees. R2 stated R2 was unable to "bend (R2's) legs at the knees right."

On 3/16/21 at 10:55am, V14, Radiologist stated V14 reviewed/read R2's imaging studies which showed bilateral distal femur fractures. V14, Radiologist stated it "is very uncommon/unlikely for acute bilateral femur fractures to occur

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spontaneously." V14 stated "given (R2's) clinical history including a fall" with the imaging studies, the fractures were most likely caused by trauma to bilateral lower extremities.

The facility's undated Van Transfer Policy and Procedure documents the facility will provide safe wheelchair transportation with properly securing the wheelchair shoulder and lap belts. This policy documents the facility will provide a safe resident environment as free of accident hazards as possible, with residents receiving adequate supervision and appropriate assistive devices to prevent accidents. "All drivers will have a hands on return demonstration of the proper use of Safe-lock retractable combination belt with height adjustment and four point floor retractors... In the event of any type of emergency, the driver will be responsible to first ensure the safety of the residents. The administrator must be called as soon as possible and prior to leaving the incident... Any faulty equipment or problems during a transfer must be reported upon return to the facility."

The facility's undated Vehicle Safety Policy and Procedure Manual documents the purpose of the procedure is to help ensure that people driving for facility do so in a safe manner. Seat belts, shoulder harnesses and wheelchair restraints (occupant restraint systems) shall be worn or used whenever the vehicle is in operation. "Incident response and reporting I. In case of injury, call or have someone else call 911 immediately for emergency assistance. If you are involved in an incident and are not injured, do the following: 1. Protect the incident scene... Training I. Authorized Drivers shall be provided basic driver safety training including a review of the Vehicle Safety Policies and Procedures II.

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Additional training may be required for select employees based on incident involvement... Loading/Unloading - Balance the load; Plan ahead; Secure load from shifting, properly securing residents in wheelchairs."

The facility's undated list labeled "Residents needing transport" provided by the facility on 3/18/21 documents 26 residents (R5, R8, R16-R39) utilize the facility transport vehicle.

B. Based on observation, interview, and record review the facility failed to complete post fall investigations to identify the root cause, complete post fall assessments, and develop and implement post fall interventions for three of four residents (R3, R5, R14) reviewed for accidents in the sample list of 40.

Findings include:

b.)1). R14's Face Sheet dated 3/23/21 documents R14 admitted to the facility on 1/29/21 and has diagnoses of Hypertension and has a Cardiac Pacemaker.

R14's Admission Minimum Data Set (MDS) dated 2/5/21 documents R5 is cognitively intact, uses limited assistance of one staff person for transfers and ambulation, and extensive assistance of one staff person for toileting. This MDS documents R14 had a fall with a fracture within the last six months. R14's Fall Risk Assessment dated 1/30/21 documents R14 is at risk for falls and R14 overestimates or forgets R14's limitations.

R14's Care Plan revised on 3/19/21 documents "(R14) can potentially have a fall incident and

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may have an injury for being in a new environment, medications taken and current medical condition." This care plan documents R14 had multiple falls prior to admitting to the facility and documents interventions dated 1/29/21 to assist with transfers and Activities of Daily Living (ADL's) care needs.

On 3/23/21 at 9:20 AM V28 (R14's Family Member) stated: R14 fell twice, two hours apart, on 3/18/21. V28 stated a nurse told V28 that R14 was found on the floor by staff after staff had assisted R14 into the bathroom and left R14 unattended. On 3/17/21 R14 had complained of feeling unsteady and feeling like R14 was going to fall when R14 would transfer. V28 reported R14's complaints to an unidentified nurse on 3/17/21.

R14's Progress Notes document: On 3/17/21 at 2:44 PM V28 reported that R14 complained of vertigo (dizziness) and V29 Nurse Practitioner was notified. On 03/18/2021 at 12:15 PM staff found R14 lying on R14's left side in the bathroom with a bump to R14's forehead and a scrape to the left arm. R14 did not use R14's call light and urine was on the bathroom floor.

V29's Progress Note dated 3/18/21 at 12:51 PM documents: R14 was evaluated for complaints of vertigo and a fall. R14 had transferred R14's self into the bathroom and did not ask for help. R14 has "increased weakness" and "is suppose to have assistance with transfers." R14 has been receiving Physical and Occupational Therapy. V29 recommended to obtain orthostatic blood pressures every shift for 3 days, Complete Blood Count and Basic Metabolic Panel on 3/19/21, Meclizine 25 milligrams three times daily as needed, and a urinalysis. This note documents

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R14's fall was possibly related to weakness and noncompliance with asking for help.

R14's Progress Note dated 03/18/2021 at 2:35 PM documents R14 was found on the floor in the bathroom and R14's call light was not used. R14 stated R14 was trying to walk back to the bed after using the toilet. The Witness Statement dated 3/18/21 at 2:40 PM signed by V32 Certified Nursing Assistant (CNA) documents: V32 assisted R14 to the bathroom and instructed R14 to use the call light when R14 was finished. V32 left R14 in the bathroom to obtain R15's vitals (R14's room mate), and when V32 returned R14 was sitting on the bathroom floor.

On 3/23/21 at 9:03 AM R14 was lying in bed. R14 had bruising to both eyes and a hematoma to R14's left forehead.

On 3/23/21 at 11:13 AM R15 stated R14 would frequently forget to use the call light and R14 would get up unassisted and without using R14's walker. R15's Progress Note dated 3/14/21 documents R14 is alert and oriented to person, place, and time.

On 3/23/21 at 11:16 AM V33 Registered Nurse (RN) stated: On 3/23/21 around 2:00 PM V32 CNA told V33 that R14 was found on the bathroom floor and R14's call light was not on. R14 told V33 that R14 was trying to self transfer from the toilet to the bed. V32 told V33 that V32 had assisted R14 into the bathroom, instructed R14 to use the call light, and left R14 unattended to obtain R15's vitals. When V32 returned to the bathroom, R14 was sitting on the floor.

On 3/23/21 at 11:45 AM V32 CNA stated: V32 worked 2nd shift on 3/18/21. During shift report at

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the beginning of V32's shift, V34 CNA reported to V32 that R14 had fallen during day shift. Around 2:00 PM on 3/18/21 V32 assisted R14 into the bathroom. R14 requested privacy, so V32 instructed R14 to use R14's call light, V32 left R14 unattended in the bathroom leaving the door open "a crack." V32 stated V32 left the bathroom to enter R14/R15's room to obtain R15's vitals. When V32 returned to the bathroom "a couple minutes later", R14 was sitting on the floor, and R14's bathroom call light was not on. V32 stated V32 did not witness R14 fall, or hear R14 fall.

On 3/23/21 at 11:55 AM V41 Physical Therapist stated R14 should not be left unattended in the bathroom, since R14 may try to attempt to self transfer. R14 needs staff assistance with use of a gait belt and wheeled walker for toileting, transfers, and ambulation.

On 3/23/21 at 1:01 PM V29, Nurse Practitioner confirmed with R14's history of vertigo and fall on 3/18/21 at 12:15 PM, staff should not have left R14 unattended in the bathroom. V14 stated R14 being left unattended in the bathroom could have contributed to R14's fall.

b.)2.) R5's MDS dated 12/15/20 documents R5 is cognitively intact, uses supervision of one staff person for ambulation, and limited assistance of one staff person for transfers.

R5's Care Plan revised on 3/15/21 documents R5 has history of falls, is at risk for injury, and tells staff that R5 will sit on the floor as a behavior. This care plan documents interventions including on: 3/4/21 Physical Therapy and Occupational Therapy to screen R5, 3/10/21 a low bed was implemented, 3/15/21 encourage R5 to ask for assistance with repositioning while in the

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wheelchair, and 3/22/21. R5's Care Plan dated 3/22/21 documents R5 self reports that R5 has fallen with interventions dated 3/22/21 including a psychiatry referral, obtain information to determine how the fall occurred and when the fall occurred at the time of the fall.

R5's Physician Order Report dated 2/22/21-3/22/21 documents a physician order dated 3/5/2021 for Physical Therapy and Occupational Therapy to evaluate and treat.

R5's Event Report dated 3/3/21 documents R5 had an unwitnessed fall on 03/03/21 at 6:20 PM. R5 was found kneeling on the floor mat beside R5's bed. R5 attempted to get on the floor to clean up food and the post fall intervention was for Physical Therapy and Occupational Therapy to screen R5. R5's Rehabilitation Screen dated 3/4/21 documents R5 has had recent falls/history of falls and per an unidentified CNA R5 has had a decline in transfers and balance. This screen also documents R5 has not had a decline in Activities of Daily Living (ADL's) per the CNA and an evaluation of Physical Therapy is indicated. There is no documentation in R5's medical record that an Occupational Therapy Evaluation was completed as ordered.

R5's Event Report dated 3/10/21 documents R5 self reported at 4:15 PM that R5 attempted to self transfer from the bed to the wheelchair, fell, and self transferred back into the bed. This report documents R5 did not remember details of the fall, R5 complained of back pain at the time of reporting R5's fall, and an x-ray was ordered. This report documents the Interdisciplinary Team reviewed R5's fall and determined R5 was not capable of transferring R5's self from the floor to the bed. R5 has had multiple falls in the past six

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months with several related to behavioral issues. This root cause of R5's fall on 3/10/21 was R5 displayed a behavior of self reporting a fall and it is not likely that R5 could transfer R5's self from the floor if R5 had fallen. This report documents R5's care plan was updated to include a psychiatric referral. The post fall investigation for R5's fall documents interviews were conducted with R5, V22 Registered Nurse (RN), and V23 Licensed Clinical Social Worker (LCSW). V3 Assistant Director of Nursing (ADON) provided a list of employees who worked on 1st and 2nd shifts on 3/10/21. The list documents V24-V27 Certified Nursing Assistants were assigned to care for R5 on 3/10/21 and there is no documentation that V24-V27 were interviewed about R5's self reported fall on 3/10/21.

R5's Event Report dated 3/12/21 documents on 3/12/21 at 2:50 PM R5 staff witnessed R5 slide out of R5's wheelchair onto the floor.

R5's Progress Notes document: Post fall nursing assessments were not completed after R5's fall on 3/3/21 for 3rd shift on 3/3/21, 2nd and 3rd shifts on 3/4/21, all shifts on 3/5/21 and 1st and 2nd shifts on 3/6/21. Post fall nursing assessments were not completed after R5's fall on 3/10/21 for 3rd shift on 3/11/21 and first shift on 3/12/21. Post fall nursing assessments were not completed after R5's fall on 3/12/21 for 3rd shift on 3/12/21, 1st and 2nd shifts on 3/13/21, 1st shift on 3/14/21, and 3rd shift on 3/14/21.

On 3/22/21 at 9:30 AM V5 Director of Rehabilitation stated therapy staff do not always complete an evaluation if a resident has orders for Occupational or Physical Therapy to evaluate and treat. V5 stated sometimes a screen is completed instead of an evaluation to determine if

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S9999	Continued From page 17 there has been a decline in ADL's. V5 stated R5 did not have an Occupational Therapy evaluation completed in March 2021, and a rehabilitation screen was completed due to R5 having a fall. On 3/18/21 at 2:04 PM V3 ADON stated V3 completes the post fall investigations and R5's fall investigations were not completed yet for R5's falls on 3/10/21 and 3/12/21. V3 stated R5's post fall intervention for the fall on 3/3/21 was to have Occupational Therapy and Physical Therapy to evaluate and treat. On 3/22/21 at 11:07 AM V3 stated post fall nursing assessments should be documented in the nursing notes and completed immediately following the fall, and then every shift for 72 hours after the fall. V3 stated sometimes the nurses do not document post fall assessments and V3 has to remind them. On 3/22/21 at 12:35 PM V3 stated the floor nurses are instructed to obtain interviews with staff who were working at the time the fall occurred and then turn the interviews into V3. V3 stated V3 often does not receive the staff interviews and V3 has to complete the interviews the following day. V3 stated V3 was not able to identify the time and date that R5's self reported fall on 3/10/21 actually occurred. V3 stated V3 interviewed R5, V22 RN, and V23 LCSW and confirmed V3 did not interview any other staff that were assigned to care for R5 on 1st and 2nd shifts on 3/10/21. V3 stated R5 has behaviors of putting R5's self on the floor, and R5 would not have been able to self transfer from the floor to the bed if R5 had fallen. V3 stated V3 didn't think R5 had actually fallen. On 3/24/21 at 9:28 AM V3 stated R5's post fall investigation for the fall on 3/10/21 was completed on 3/22/21. The facility referred R5 for psychiatric services on 3/22/21 (12 days after R5's reported fall on 3/10/21) for R5's behaviors of putting R5's self on the floor.	S9999		

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S9999	Continued From page 18 b.)3.) R3's MDS dated 1/18/21 documents R3 has short and long term memory impairment, uses limited assistance of one staff person for transfers, and extensive assistance of one staff person for ambulation and toileting. This MDS documents R3 is occasionally incontinent of bowel and bladder. R3's Care Plan revised on 1/7/21 documents R3 needs assistance with toileting and transfers. R3's Care Plan revised on 2/18/21 documents R3 has had multiple falls and is at risk for injury due to medications, poor safety awareness, and impulsivity. This Care Plan documents an intervention dated 2/17/21 to transfer R3 to the Emergency Room for evaluation and treatment. R3's Fall Event Report dated 2/17/21 documents: R3 was found sitting on the floor on 02/17/21 at 6:00 PM. R3 was bleeding from R3's nose and mouth. R3 was unable to give details of the fall, and was alert and oriented to self. This report documents R3's care plan was updated with an intervention to send R3 to the Emergency Room for treatment and the root cause of R3's fall was R3 ambulated independently and lost R3's balance. The Witness Statement dated 2/23/21 at 1:15 PM signed by V42 CNA documents on 2/17/21 V42 heard R3 yell out for help and found R3 sitting on the floor with R3's back against the bed. V42's statement documents V42 last saw R3 sitting on the side of the bed about an hour prior to the fall on 2/17/21. There is no follow up documentation if V42 responded to R3 sitting on the edge of the bed. There is no documentation that the facility determined the last time R3 was toileted or if R3 was incontinent at the time of R3's fall.	S9999		

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R3's Progress Notes do not document post fall nursing assessments were completed for 2nd and 3rd shifts on 2/18/21, 2nd and 3rd shifts on 2/19/21 and day shift on 2/20/21.

On 3/22/21 at 2:50 PM V3 stated: V3 completed R3's 2/17/21 fall investigation. The root cause of R3's fall was determined to be that R3 ambulated independently, lost R3's balance, and fell. V3 was unsure of the reason why R3 got up on R3's own. V3 confirmed there is no documentation of when R3 was last toileted prior to the fall, or if R3 was incontinent at the time of the fall. V3 stated V3 could not say if V42 assisted R3 when V42 saw R3 sitting on the edge of the bed an hour prior to R3's fall. V3 stated staff assist R3 with toileting after meals and it would be ok to leave R3 sitting on the side of the bed even with R3's history of falls. V3 confirmed the post fall intervention was to transfer R3 to the Emergency Room. V3 confirmed there were no other post fall interventions implemented following R3's fall.

The facility's undated Documentation policy documents "Clinical rehabilitation documentation will conform to all federal requirements. Documentation will include, but not limited to the following: Information necessary to communicate patient/resident need, Evidence of medical necessity of services provided, Rehabilitative services provided, Progress made and discharge status." This policy documents "COMPONENTS: Evaluation/Plan of Care 1. The initial evaluation should sufficiently detail a baseline that reflects the patient's/resident's specific need for the indicated skilled rehabilitation services, in response to a physician's order for evaluation. 2. Time spent in the evaluation of the patient/resident must be sufficient to assess the patient's/resident's condition and develop a

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S9999	Continued From page 20 treatment plan. 3. The evaluation must clearly reflect the medical necessity for the services delivered." The facility's Falls Prevention Program revised November 2017 documents: Identifythe root cause of the fall and evaluate and document falls including where and when the fall occurred and observations. Complete assessments including vital signs, injuries, change in level of consciousness/cognition, pain, frequency of falls, details on how the fall occurred, medications and diagnosis. This program This program documents "Collect and evaluate any information until either the cause of the falling is identified, or can be speculated as to what the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk." This program documents staff will identify pertinent interventions to try and prevent subsequent falls, and if the underlying cause is not readily identified staff will implement various interventions until the falling reduces or stops or until a reason for continuation is identified. " A " (2 of 2) 300.610a) 300.1210b) 300.1210d)3)5 300.1220b)2)3)	S9999		

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S9999	Continued From page 21 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 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: 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.	S9999		

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S9999	Continued From page 22 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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. The plan shall be reviewed at least every three months.	S9999		

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S9999	Continued From page 23 These Requirements were not met evidencded by: Based on observation, interview, and record review, the facility failed to identify pressure ulcers, failed to document pressure ulcer monitoring/measurements and failed to implement pressure ulcer relieving/prevention interventions, and treatments for three of three residents (R1, R2, R3) reviewed for pressure ulcers in the sample of 40. These failures contributed to R2 developing a Necrotizing Soft Tissue Infection of a pressure ulcer requiring hospitalization with three surgical debridements due to infection and necrosis of the pressure ulcer wound. Findings include: 1. R2's Progress Notes dated 2/19/21 document R2 readmitted to the facility on 2/19/21 with a "stage 3 on coccyx" with no documentation of wound measurements on admission. R2's Progress Notes dated 2/24/21 at 6:41pm document R2 was seen today (2/24/21) by V49, R2's Wound Physician for wounds including a "wound to right buttock. New treatment orders" per V49. R2's Minimum Data Set (MDS) dated 3/1/21 document R2 is cognitively intact. This MDS documents R2 has one unstageable pressure ulcer.	S9999		

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R2's Physician's Orders dated March 2021 document R2's diagnoses including End Stage Renal Disease, Unstageable Pressure Ulcer of the Right buttock, Edema, Dependence on Renal Dialysis, Covid-19, Anemia in Chronic Kidney Disease, Diabetes Mellitus with Diabetic Neuropathy, Mild Protein Calorie Malnutrition, Obesity and Stage III Pressure Ulcer of the Sacral Region.

These orders document R2's orders including the following:
Hemodialysis three times weekly on Tuesday, Thursday and Saturdays at 6:00pm.

Order start date 2/19/21 - Cleanse buttocks with soap and water, pat dry and apply house barrier cream every shift and as needed.

Order start date 2/26/21 - Right Buttock: Cleanse with normal saline or wound cleanser and pat dry. Apply honey alginate wafer and cover with silicone border foam and change daily and as needed.

R2's facility "Wound Management" notes document R2 has a pressure ulcer to the left buttock that was identified on 12/2/2020 at 3:50pm. These notes document this wound's measurements on 2/24/21 of 0.5cm (centimeters) length by 0.3cm width by 0.2cm in depth. There is no documentation of an assessment or measurements for R2 in the these notes regarding R2's Right Buttock pressure ulcer or a coccyx pressure ulcer.

R2's Medication Administration Record (MAR) dated February 2021 document on 2/19/21 through 2/28/21 that R2 did not have behaviors.

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S9999	Continued From page 25 This MAR documents R2 is to have a weekly skin assessment on Monday mornings with a frequency to complete once a day on Monday and Thursdays. R2's skin assessment documents R2 had the following skin impairments: 2/22/21 - open areas to the coccyx and bilateral feet, redness to the coccyx 2/25/21 - open areas to the coccyx and left heel, redness to the buttock and that a current treatment was in place. R2's Treatment Administration Record (TAR) dated February 2021 documents R2's treatment to cleanse the buttocks with soap and water, pat dry and apply house barrier cream every shift including evening shift which is scheduled for administration between 2:30pm and 10:00pm and as needed documents this was not administered on: 2/20/21 at 9:12pm "Not Administered: Resident (R2) unavailable," 2/23/21 at 6:42pm, "Not Administered: Resident (R2) unavailable, Comment: resident (R2) is out for dialysis," and 2/25/21 at 9:21pm "Not Administered: Resident (R2) unavailable, Comment: Dialysis." There is no documentation of an attempt to administer this treatment prior to R2's Dialysis treatment and/or within the scheduled time frame on these days. R2's Wound Evaluation and Management Summary documented by V49, R2's Wound Physician dated 2/24/21 documents R2 "has multiple wounds." This summary documents R2 has an Unstageable (due to necrosis) pressure ulcer of the right buttock with measurements of length 7cm by width of 5cm and depth of 0.1cm with moderate serous exudate with 25% of thick	S9999		

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S9999	Continued From page 26 adherent devitalized necrotic tissue. This summary documents R2 received surgical debridement of the right buttock pressure ulcer at the facility on 2/24/21. The dressing treatment plan is to apply honey alginate wafer and cover with a foam silicone border once daily for 30 days. This summary also documents R2 has a Stage III left buttock pressure ulcer with measurements of length 0.5cm by width of 0.3cm by depth of 0.1cm with light sero-sanguineous exudate. This summary documents R2's left buttock pressure ulcer has "abnormal granulation present within the wound margins" and a dressing treatment plan to apply honey alginate wafer and cover with a foam silicone border once daily for 30 days. Chemical cauterization of abnormal granulation tissue was performed to facilitate healing. There is no documentation in R2's Electronic Medical Record/Physician's Orders that V49's order for the left buttock dressing change was transcribed once received or implemented as ordered. R2's TAR dated February 2021 documents R2's treatment to cleanse the right buttock with normal saline, or wound cleanser and pat dry. Apply honey alginate wafer and cover with a silicone border foam dressing daily and as needed with a diagnosis of Unstageable Pressure Ulcer of the right buttock with a start date of 2/26/21 (instead of starting 2/24/21 as ordered.). This TAR documents R2's right buttock pressure ulcer treatments were not completed due to "refused" on 2/26/21, 2/27/21, and 2/28/21 with no documentation as to reason for refusal or attempts to complete the treatment by other nurses or at another time. There is no documentation V49, R2's Wound Physician was	S9999		

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S9999	Continued From page 27 notified of the refusals or delay in starting the treatment as ordered. This TAR also does not document the facility was completing the left buttock pressure ulcer dressing change as ordered on 2/24/21 by V49. There is no documentation in R2's medical records documenting V40, Registered Dietician was notified of R2's pressure ulcers after R2 readmitted to the facility on 2/19/21 with multiple pressure ulcers. There is no documentation the facility attempted to contact V18, R2's Family related to R2's pressure ulcer wounds after readmission on 2/19/21. On 3/10/21 at 1:34pm, V4, Wound Nurse stated R2 had an open wound to R2's coccyx/buttock area. V4 stated V49 Wound Physician was "following that wound." V4 stated the staff should be measuring and documenting wounds upon admission and when treatments are completed but many times the measuring and documenting of the wounds/measurements does not get completed. V4 stated refusal of treatments should be documented in the residents medical record as well as a reason for refusal and notification of the resident's physician and family of the refusals. V4 stated V4 thought there were measurements for R2's right buttock pressure ulcer but V4 was unable to find facility wound management notes for R2's right buttock pressure ulcer. On 3/23/21 at 2:30pm, V8, Nurse Manager stated V4 rounds with V49, Wound Physician. If the wound nurse rounds with the wound physician V4 is responsible for entering orders and measurements. V8 stated wound treatment orders should be "immediately" entered in the	S9999		

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resident's medical record and started/implemented upon receiving the order. V8 stated R2's treatment orders should have been started on 2/24/21 instead of waiting two days before entering the orders and implementing the dressing change orders on 2/26/21. V8 stated V50, RD should be consulted to evaluate when a resident has pressure ulcers. V8 stated the staff should make multiple attempts to complete wound dressing changes and notify the physician of refusals and "chart all of that." V8 stated ,"I (V8) tell them (staff) to reattempt/document/continue to encourage resident (to allow wound dressings to be changed)"

R2's Progress Notes on 3/1/21 at 10:33pm document R2 was sent to the hospital from the Dialysis center for a temperature and was "noted to have an infection in buttock."

R2's Hospital notes dated 3/1/21 document R1 reported feeling "ill" since R2 woke up on 3/1/21. These notes document R2 was sent to the hospital emergency room for a temperature obtained at the Dialysis center of 101.4 degrees Fahrenheit (F) with the emergency medical technician's obtaining a temperature of 99.0 degrees F. These notes document R2 had pressure wounds to the right medial buttocks and sacrum. Additional hospital notes document R2 has a "draining wound" on the right buttock which is greater than the left buttock wound.

R2's Hospital History and Physical (H&P) dated 3/1/21 documents R2 presented to the hospital with "likely necrotizing soft tissue infection of the right gluteal region" which may extend in to the left gluteus as well. This H&P documents this is "likely a complication of a long standing pressure

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injury that has been secondarily infected." R2 would benefit from "urgent operative exploration and debridement of any devitalized tissue." This H&P documents R2's diagnoses including Necrotizing Soft Tissue Infection (NSTI) with sepsis.

R2's Post Op (operative) note dated 3/1/21 documents R2 had a procedure of "sharp excisional debridement of the right gluteus to the level of the periosteum, gluteus muscle and fascia." This note documents "Findings: Approximately 20cc (cubic centimeters) of purulent material drained with surrounding tissue necrosis. Final wound was approximately 10 by 15 by 5cm (centimeters) to the level of the sacral periosteum."

R2's hospital Acute Care Progress Note dated 3/2/21 documents R2 "would benefit from additional debridement in the operating room"

R2's Procedure Note dated 3/2/21 documents R2 had a "sharp excisional debridement of right gluteus to level of periosteum, gluteus muscle and fascia (total dimensions 24 x 15 x 5cm)."

R2's Hospital Progress Notes dated 3/6/21 at 12:16pm document R2's right gluteal wound "looks worse" with "multiple necrotic regions" and that R2 would benefit from a third surgical debridement. R2's Surgical Note dated 3/6/21 documents R2's wound had sharp excisional debridement of right gluteal wound with excision of necrotic muscle, fascia, and subcutaneous fat.

On 3/15/21 at 10:30am, V17, R2's Registered Nurse stated R2's pressure ulcer wounds "are a big problem." V17 stated the wounds "were obviously not taken care of" prior to

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S9999	Continued From page 30 hospitalization and infected upon admission. On 3/15/21 at 10:30am, R2 was observed in the hospital Dialysis unit receiving Dialysis. R2 stated the facility had a dressing on R2's wounds. R2 stated R2 has had severe pain in R2's pressure ulcers to the buttock, sometimes more severe than others while a resident at the facility. R2 stated sometimes the facility staff would come in and "ask if (R2) want" my dressing to the pressure ulcers changed and sometimes R2 hurts too bad to have them change the dressings. R2 stated R2 does try to make sure they get changed as much as possible. R2 stated staff do not ask R2 why if R2 refuses to have staff complete a dressing change, offer pain medications prior to dressing changes or to perform the dressing changes at a different time. 2. R1's Face Sheet dated 2/25/21 documents R1's diagnoses including Sepsis, Parkinson's Disease, Dementia with Lewy Bodies, Pneumonia, Unstageable Pressure Ulcer of Sacral Region, Adult Failure to Thrive and Dehydration. R1's Census List documents R1 went to the hospital from the facility on 1/20/21 and re-admitted to the facility on 2/3/21. R1 went to the hospital on 2/22/21 and returned to the facility on 2/25/21. R1 went back to the hospital on 3/3/21 and did not return to the facility. R1's undated handwritten notes from report from the hospital scanned in with "from" date of 2/3/21 for R1's readmission to the facility documents R1 has a Stage I (pressure ulcer) to the left heel. There is no documentation of this pressure ulcer was measured/evaluated on R1's readmission to the facility on 2/3/21. R1's Progress Notes dated 2/3/21 at 6:13pm document "no skin issues."	S9999		

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S9999	Continued From page 31 R1's Nutritional Assessment completed by V50, Registered Dietician on 2/6/21 documents R1's skin as intact. There is no documentation V50 was notified of R1's pressure ulcer to the left heel. R1's Progress Notes dated 2/8/21 at 12:00pm document "wounds noted on examination. See wound care notes for specifics" There are no wound care notes documented on 2/8/21. R1's Progress Notes dated 2/9/21 at 1:12pm document "no skin issues at this time." Progress notes dated 2/10/21 at 12:12pm and 2/13/21 at 12:08pm, 2/15/21 at 12:16pm, 2/17/21 at 11:34am, and 2/22/21 at 10:20am document "wounds noted on examination. See wound care notes for specifics" with no wound care notes associated with this progress note documented for R1 on 2/10/21, 2/13/21, 2/15/21, 2/17/21 and 2/22/21. R1's Progress Notes dated 2/22/21 at 11:40am document "a close wound/pin point in the middle with black color in the middle and reddish edges, warm to touch, measuring 6.5 X 13" was noted on R1. New orders were received for a Hydrocolloid dressing to be applied and changed every 3 days on the buttock. R1's Medication Administration History dated February 2021 documents R1's weekly skin checks to be completed on Mondays. This medication record documents R1 did not have any skin impairments on 2/8/21 and 2/15/21. This record documents R1 had an order dated 2/22/21 for Hydrocolloid dressing to right buttock to be changed once every three days and as needed. This record also documents R1's treatment orders dated 2/22/21 to apply "Skin prep to bilateral heels and outer left foot" once daily .	S9999		

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S9999	Continued From page 32 R1's treatment order dated 2/26/21 documents "coccyx: Cleanse with normal saline (NS), apply calcium alginate and cover with bordered foam dressing" to change once daily. R1's Skin Integrity Event dated 2/22/21 at 11:20am documents R1 had "open wound on right buttock." This event documents this wound as a "pressure ulcer" measuring 6.5 x 13 (no unit of measurement documented) and contained necrotic tissue. There is no documentation V51, R1's Family was notified of R1's pressure ulcer at this time. R1's Admission Observation dated 2/25/21 documents R1 had a coccyx ulcer and that it was present at the facility prior to being sent to the hospital (on 2/22/21). This document does not contain measurements for R1's coccyx ulcer. R1's Progress Note dated 2/25/21 at 6:39pm documents R1's Stage I coccyx pressure ulcer but does not document an assessment or measurements of this pressure ulcer. There is no documentation in this document that V51 was notified of R1's coccyx ulcer. R1's Skin Integrity Event dated 2/26/21 at 11:28am documents R1 has "an open area on coccyx" with type of skin condition documented as "Other- Deep Tissue Injury" with measurements of "10 x 6" with no units of measurement documented. This event documents the pressure ulcer contains "necrotic tissue" with a scant amount of exudate. R1's Medication Administration History dated March 2021 documents R1's weekly skin assessments once daily on Tuesdays. This record documents R1 did not have skin alterations on 3/2/21 but documents R1 was	S9999		

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receiving the following treatments for R1's pressure ulcers per physician's orders:
Hydrocolloid dressing to R1's right buttock change once every three days
Skin prep to bilateral heels and outer left foot once daily
Cleanse R1's coccyx with normal saline, apply calcium alginate and cover with bordered foam dressing once daily.

On 3/9/21 at 10:37am, V51 stated the facility did not notify V51 of R1's skin condition with the multiple areas of pressure ulcers and breakdown. V51 stated on 3/3/21, V4, Wound Nurse called V51 to notify V51 of R1's coccyx pressure ulcer worsening. V51 stated V51 questioned if the facility were monitoring R1's skin for pressure ulcers or providing treatments for R1's pressure ulcers.

On 3/10/21 at 1:34pm, V4 stated V4 had not been following R1's pressure ulcers. V4 stated V4 happened to be assisting with cares for R1 when V4 observed R1's deep tissue injury to the coccyx. V4 stated the staff are to measure the wounds and document them. V4 stated V4 tries to educate the staff about assessing wounds, documenting the assessments and notifying V4 as soon as a wound is observed. In event notes and/or progress notes is where the measurements should be documented for each resident. V4 stated V4 documents resident wound notes in the facility wound management program but was unsure if R1 had measurements in that program.
V4 attempted to find pressure ulcer notes for R1's coccyx pressure ulcer in the facility wound management program but was unable to find any. V4 stated the facility should have notified V50, Registered Dietician of R1's pressure ulcers and

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skin impairments, but V50 was not notified. V4 stated there is minimal documentation to monitoring, assessing and/or measuring R1's pressure ulcers and that there should have been more detailed monitoring and documentation.

3. R3's Care Plans dated 2/19/21 document R3 has a Stage II Pressure Ulcer with infection to the right second toe due to "Shoes not fitting correctly." These care plans document interventions including to administer antibiotics as ordered and to evaluate, record, report effectiveness and signs of cellulitis. These care plans also include an intervention to "leave shoes off and use nonskid socks."

R3's Initial Wound Evaluation & Management Summary notes dated 2/18/21 document R3 has an Unstageable (Due to Necrosis) Pressure Ulcer to the right second toe. These notes document the periwound to have erythema and light serous exudate with 100% thick adherent necrotic tissue. These notes also document "No shoes until wound heals" and to use non skid socks. These notes document orders to administer Doxycycline (Antibiotic) 100mg (milligrams) twice daily and Amoxicillin (Antibiotic) 500mg twice daily by mouth for 10 days until 2/27/21 (or 10 days total.) There is no documentation a wound culture was obtained for R3's right 2nd toe pressure ulcer infection prior to beginning R3's antibiotics.

R3's Wound Evaluation & Management Summary dated 2/24/21 documents R3 has a Stage 4 Pressure Wound of the right second toe with moderate serous exudate. These notes document R3's pressure ulcer to the right second toe has "persistent cellulitis" and to change R3's antibiotics to Bactrim 400-80mg by mouth twice daily for 10 days. There is no documentation a

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S9999	Continued From page 35 wound culture was performed to ensure proper antibiotic use. On 3/10/21 at 1:34pm V4 stated reported R3 had an open wound on the second right toe "before." V4 stated when V4 assessed the wound it was "pressure due to shoe - too small." V4 stated R3's shoe had "hardened blood and drainage inside" of R3's shoe and that the pressure ulcer had been going on for some time prior to V4 being notified. V4 stated the pressure ulcer "hurt (R3)" V4 stated R3's foot "kept rubbing" on the shoe and when V4 observed the wound, "it looked infected." V4 stated R3's right second toe pressure ulcer was causing R3 pain and "had infection- visible characteristics of infection, warm, swollen, puffy" V4 stated the facility did not do a wound culture but V49, R3's Wound Physician had ordered antibiotics for R3. V4 stated V4 questioned obtaining a wound culture and stated V49 typically puts residents on oral antibiotics without culturing the wound. V4 stated after a week of the Amoxicillin and Doxycycline antibiotics, V4 and V49 assessed R3's wound and noted the infection was not getting better, so V49 changed antibiotics at that time. V4 stated the change in antibiotics helped R3's toe to finally heal and had a culture been done sooner, it would have identified the appropriate antibiotic the wound needed. On 3/18/21 4:34-5:04 AM V46 Certified Nursing Assistant (CNA) entered R3's room. V46 removed R3's socks and R3 had a dressing to the right foot dated 3/17/21. V46 transferred R3 back to bed after toileting, changed R3's clothes and transferred back into R3's wheelchair. V46 applied R3's black tennis shoes on R3's bilateral feet.	S9999		

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S9999	Continued From page 36 3/18/21 6:19 AM V4 Wound Nurse stated R3 has had wound to right 2nd toe since 2nd week of February. V4 stated V4 believed it was from R3's shoes because R3's toes curl up and rub against R3's shoes. V4 stated V49, R3's Wound Physician had cut a hole in R3's white pair of shoes that were believed to be the cause of R3's pressure ulcer to the right 2nd toe to relieve the pressure to the wound. V4 stated family were going to get R3 some new house slippers or shoes. V4 stated V4 was not sure if R3's black shoes were the new pair. V4 stated the facility tries to have R3 wear the nonskid socks at times. R3 was sitting up in R3's wheelchair wearing black tennis shoes at this time. V4 confirmed these black tennis shoes were not the tennis shoes V49 had cut out for pressure relief. V4 removed R3's shoe and completed R3's dressing change to the pressure ulcer to the 2nd toe on the right foot. After administering R3's treatment V4 reapplied R3's black shoe to the right foot instead of only a non skid sock. The facility's Prevention of Pressure Ulcer policy dated November 2015 documents general preventative measures including to routinely assess and document the condition of the resident's skin for any signs and symptoms of irritation/breakdown. Immediately report signs of a developing pressure ulcer to the nurse. Risk Factor - Friction and Shear, shoes need to be monitored for proper fit to avoid the development of blisters, corns and calloused areas, Risk Factor - Poor Nutrition a. Dietician will assess nutrition and hydration and make recommendations based on the individual resident's assessment" This policy documents additional clinical conditions and treatments that	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

(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
S9999	Continued From page 37 indicate a resident is at risk for pressure ulcers including impaired/decreased mobility, co-morbid conditions "such as end stage renal disease, Diabetes Mellitus," resident refusal of some aspects of care and treatment, cognitive impairment and a history of a healed ulcer. The facility's Assessment of Skin Alteration policy dated November 2017 documents residents with skin alterations will be assessed and treatment will be provided as ordered by the physician. The assessment of any skin alteration should be started immediately upon identification of a pressure ulcer or other skin ulcer with findings to be documented in the medical record. Wound Assessment should be completed and documented in the medical record to reflect progress. The facility is to review and update appropriate interventions/changes as necessary and notify appropriate interdisciplinary team members as appropriate, physician, resident and family member as appropriate. Once the wound is healed, update the physician order and treatment administration record. This policy documents the resident's plan of care should be reviewed and updated as needed. The facility's Pressure Ulcer Risk Assessment policy dated November 2015 documents the skin assessment helps identify the resident who is refusing care and treatment. If the resident is refusing care, an evaluation of the basis of the refusal and the identification and evaluation of potential alternatives is indicated. This policy documents diagnoses and conditions that increase the risk for pressure ulcers including Urinary incontinence, sepsis, chronic or end stage renal disease, Diabetes, Alzheimer's disease or other Dementia and Edema.	S9999		

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S9999	Continued From page 38 The facility's Wound Treatment policy dated November 2015 documents, "As ordered by the physician, wound treatment will be provided to the resident's needing one." This policy documents to verify the order for the wound treatment and see if the resident requires analgesia prior to assessment or dressing change. The facility will address the resident's concerns and offer relevant alternatives if the resident has refused treatments/interventions. The facility's Change in Condition Clinical Practice Guidelines dated 3/20/2020 document the Charge Nurse or Designee will notify the resident's attending physician, physician assistant, nurse practitioner, Clinical Nurse Specialist or on-call physician when there has been a significant change in the resident's physical condition, there is a need to alter the resident's medical treatment significantly or "refusal of treatment or medications (for example two or more consecutive times.)" These guidelines document the Charge Nurse or Designee will notify the resident's family or representative when there is a change in the resident's physical status. Information relative to the changes in the residents condition or status will be recorded in the resident's medical record. The facility's Wound Culture policy dated November 2015 documents "culturing and reculturing of wound will only be completed to wounds showing signs and symptoms of infection and or as ordered by the physician. To be considered infected, your resident has to exhibit 3 or more signs and symptoms of infection. Infection is evidenced by induration, fever, edema, erythema, increased pain in wound area and exudates (purulent or serous exudates, increase in exudates)"	S9999		

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S9999	Continued From page 39	S9999		

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