STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009765	A. BUILDING: _____ B. WING _____	C 06/22/2021

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S 000	Initial Comments Complaint 2164174/IL134972	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.1220b)2) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 injury or change in condition at the time of notification. 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: 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: modified in keeping with the care needed as indicated by the resident's condition. The plan shall 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical	S9999		

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S9999	Continued From page 2 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. 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 Requirements are not met as evidenced by: Based on observation, interview, and record review ,the facility failed to administer physician's ordered treatments and wound interventions, monitor and assess wounds, perform hand hygiene during a wound treatment, and assess for and implement nutritional recommendations for four of four residents (R1, R2, R3, R4) reviewed for skin conditions in the sample list of six residents. This failure resulted in R1's right diabetic heel wound deteriorating and requiring mechanical debridement. Findings include: The facility's Skin Condition Monitoring policy revised January 2018 documents: "Upon identification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurse's notes and complete the QA (Quality Assurance) form for Newly Acquired Skin Condition. The Nurse will then implement the following procedure: a. Notify the physician and obtain a treatment order." "Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until	S9999		

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S9999	Continued From page 3 the area is healed. Documentation of the area must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Odor 5. Color 6. Presence of granulation tissue or necrotic tissue. b. Treatment and response to treatment. Observe and measure pressure ulcers at regular intervals. c. Prevention techniques that are in use for the resident. The facility's Nutritional Assessment policy revised March 2019 documents residents will have a comprehensive nutritional assessment upon admission, annually, and with significant changes in condition. This policy documents the Dietitian will complete a resident's nutritional assessment that includes food allergies or intolerances, ability to chew and swallow, mental, emotional, psychological issues, physical appearance, noting any signs of malnutrition and dehydration, and height and weight including any changes, vitamin and mineral supplements, food and fluid intake, history of drug/alcohol abuse, ability to eat, level of mobility, hearing and vision, cultural or religious food preferences, medications, significant lab values, skin condition, use of catheters, colostomies, feeding tubes or intravenous fluids, calculation of energy, protein and fluid needs, assessment of diet adequacy, nutritional needs, goals, and approaches, and educational needs. 1.) R1's Admission Minimum Data Set (MDS) dated 4/1/21 documents: R1 is cognitively intact, uses extensive assistance of two staff for bed mobility, transfers, and extensive assistance of one staff for dressing. R1 did not admit to the facility with pressure ulcers or diabetic foot ulcers. R1's Care Plan dated 3/30/21 documents R1 admitted with skin breakdown with interventions to refer to R1's Physician's Orders for treatments,	S9999		

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assess and measure wounds weekly and as needed, wound consult as needed, evaluate nutritional needs and refer to the Registered Dietitian as needed, and notify the physician if the condition worsens or if no improvement noted with current treatment.

R1's March 2021 Physician's Orders document R1's diagnoses include Diabetes Mellitus, Coronary Artery Disease, Peripheral Vascular Disease, and Rhabdomyolysis. R1's March orders do not document any orders for wound treatments. R1's April 2021 Physician's Orders documents the following orders: On 4/3/21 apply a skin protectant to bilateral heels twice daily for 14 days and protective heel boots at all times. On 4/7/21 cleanse R1's right heel wound, right knee wound, and right lateral side wound with Betadine twice daily for 14 days, cleanse R1's perineal area with (topical foam solution) and apply antifungal powder twice daily and as needed for 14 days. On 4/14/21, cleanse right lateral side wound with wound cleanser, apply hydrogel and collagen, covered by a dry dressing daily and as needed, and cleanse breasts with (topical foam solution) and apply zinc oxide cream twice daily and as needed for 14 days. On 4/16/21 cover heel with Santyl, calcium alginate, foam pad, and gauze wrap daily, and apply zinc oxide, antifungal ointment, and Triamcinolone to buttocks twice daily.

R1's Nursing Admission Assessment dated 3/25/21 documents to refer to the attached shower sheet for wound and skin assessments and measurements. The shower sheet dated 3/25/21 documents the following skin issues: R1's right lateral rib was bruised with avulsed (torn) skin that measured 19.5 cm (centimeters) by 9.5 cm. R1's right lateral knee scab measured 5 cm

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by 2 cm. R1's left breast was excoriated and red, and the area measured 6 cm by 2 cm.

R1's Shower Sheets document: On 3/28/21 R1 had open areas to R1's right flank and right knee. On 4/9/21 the areas to bilateral breasts, abdomen, and groin are circled with a description "all red". R1's Nursing Note dated 4/3/21 at 5:30 PM R1's bilateral heels were red and soft and orders were received to apply a skin protectant twice daily for 14 days and heel protectors in place at all times.

R1's Initial Wound Evaluation & Management Summary by V7 Wound Physician dated 4/7/21 documents: R1 had scabbed wounds to the right lateral knee that measured 3 by 4 cm and right flank that measured 2.5 by 1.5 cm, orders to apply Betadine daily for 30 days, and recommendations to off-load wound, reposition side to side and front to back in bed every 1 to 2 hours. This summary also includes recommendations to elevate R1's legs and float R1's heels. R1's Wound Evaluation & Management Summaries document: On 4/14/21 R1's right lateral knee wound measured 2.5 by 3.4 cm, and R1's right flank wound measured 2.5 cm by 1.5 cm by 0.1 cm. R1 had a diabetic right heel wound was a fluid filled blister that measured 2.8 cm by 3.4 cm by no measurable depth. R1's right heel wound treatment order was Betadine daily and V7 recommended R1 wear pressure relieving boots to bilateral lower extremities when in bed. On 4/21/21 R1's right lateral knee wound measured 2.3 by 3.3 cm. R1's right flank wound measured 2.4 by 1.3 by 0.3 cm, apply collagen covered by a bordered gauze dressing daily. R1's diabetic wound to the right heel deteriorated and measured 7 cm by 8.5 cm by 0.2 cm with 50 % black necrotic (dead) tissue and required

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mechanical debridement (removal of dead tissue.) R1's medical record does not contain measurements of R1's right heel wound between 4/14/21 and 4/16/21 when the treatment order changed from a skin protectant to Santyl.

R1's March 2021 Treatment Administration Record (TAR) does not document any treatments were administered to R1's breasts, right flank wound, or right knee wound. R1's April 2021 TAR does not document the following treatments were administered: R1's skin protectant to R1's bilateral heels on day shift on 4/5 and 4/6/21, and evening shift on 4/3 and 4/4/21. R1's heel boots on day shift 4/1, 4/2, 4/8-4/11, 4/13, 4/15, 4/16, 4/20, 4/22, 4/24-4/25/21, and evening shift on 4/2, 4/4, and 4/8-4/25/21. Betadine to R1's right heel on day shift 4/8-4/11, and 4/13/21, and evening shift on 4/7/21-4/13/21. Betadine to R1's right knee wound on day shift on 4/1, 4/3, 4/4, 4/6, 4/8-4/11, 4/13, 4/15, 4/16, 4/20, 4/22, 4/24-4/25/21, and on the evening shift on 4/1-4/25/21. Betadine to R1's lateral side on day shift on 4/1, 4/3, 4/4, 4/6, 4/8-4/11 and 4/13/21, and evening shift on 4/1-4/13/21. Antifungal powder to perineal area on day shift on 4/1, 4/3, 4/4, 4/6, 4/8-4/11, 4/13, 4/15, 4/16, 4/20-4/22, 4/24-4/25/21, and evening shift on 4/1-4/6, 4/8-4/25/21. Hydrogel, collagen, and dry dressing to R1's right lateral side on 4/15, 4/16, 4/20, 4/22, 4/24-4/25/21. Zinc oxide cream to breasts on day shift on 4/15, 4/16, 4/20, 4/22, 4/24-4/26/21, and evening shift on 4/14-4/25/21. Santyl, silver alginate, and gauze wrap to the right heel on 4/20, 4/22, 4/24, 4/25, and 4/26/21. Zinc oxide, antifungal and Triamcinolone cream on day shift on 4/20, 4/22, and 4/25/2, and on the evening shift on 4/17-4/25/21.

R1's Nutritional Assessment dated 3/26/21 and

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S9999	Continued From page 7 signed by V14 Registered Dietitian (RD), includes a check list of risk factors which includes skin breakdown. This assessment does not document R1 has skin breakdown and does not assess R1's caloric/nutritional/fluid needs. This assessment documents "wt (weight) pending for full assessment." There are no other documented nutritional assessments in R1's medical record after 3/26/21. On 6/21/21 at 9:58 AM V13 (R1's Family Member) stated R1 admitted to the facility at the end of the March 2021 following a hospital stay. R1 developed a bed sore to the right heel that was down to the bone and infected. R1 did not admit to the facility with the wound. R1 admitted to the facility with a yeast infection under R1's breasts, abdomen, and groin that looked worse when R1 discharged from the facility at the end of April 2021. V13 stated R1 was supposed to have antifungal cream applied to the areas and V13 was not sure that the cream was being applied. R1 also had friction sores all over R1's body upon discharge. On 6/22/21 at 11:00 AM V14, RD stated V14 is in the facility two to three times per month to complete resident nutritional assessments. V14 stated the facility sends V14 an electronic mail with a list of resident referrals including new admissions, or residents with new weight loss or wounds for V14 to evaluate. V14 was uncertain if V14 was made aware that R1 had skin issues or if V14 was notified after 3/26/21 to evaluate R1. V14 stated V14 provides a copy of V14's nutritional recommendations to V1 Administrator and V2 Director of Nursing after each visit. V14 expects the facility to implement V14's recommendations within one week.	S9999		

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S9999	Continued From page 8 On 6/22/21 at 1:35 PM V7,Wound Physician stated R1's right heel wound was a diabetic wound and pressure was a contributing factor since R1 was bed bound. V7 recommended to keep R1's heels elevated in bed at first, and then changed to pressure relieving boots. R1's wound declined and required debridement. V7 stated once a blister forms, the underlying tissue becomes compromised and contributes to a decline along with small vessel disease, pressure, and decreased appetite. V7 stated V7 would expect V7's orders to be implemented as written, unless the facility notified V7 of a resident's noncompliance or if the facility did not have the ordered wound care supplies. V7 stated is not acceptable for treatments not to be administered and that absolutely can contribute to a decline or worsening of the wound, or a delay in improvement. On 6/22/21 at 2:35 PM V2, Director of Nursing (DON) stated referrals are made to V14 if the resident is newly admitted, has a feeding tube or fluid restriction, or if a resident admits with or develops new wounds. V2 confirmed R1's Nutritional Assessment does not document that V14 was aware of R1's impaired skin, and R1's medical record does not document that V14 completed an assessment for R1 after 3/26/21. V2 confirmed R1's medical record does not document wound treatments to R1's right flank and right knee were not implemented until 4/7/21 after V7 assessed R1. V2 stated V2 thought that R1 had returned from the local emergency room with the right heel wound, but was V2 was unable to locate documentation. V2 stated R1's right heel wound started as a blister that V2 attributed to V2's overall decline and refusal to get out of bed. 2.) On 6/21/21 at 8:47 AM R2 stated R2 admitted	S9999		

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to the facility with wounds to R2's feet. R2 stated R2's wound treatments are daily and the nurses only administer R2's wound treatments on Thursdays and Fridays.

R2's MDS dated 4/19/21 documents R2 is cognitively intact.

June 2021 Physician's Orders document R2's diagnoses include Multiple Sclerosis and Diabetes Mellitus Type 2. R2's orders do not include orders for a protein supplement for wound healing or treatment orders for R2's right and left heel wounds. R2's May 2021 Physician's Orders documents an order dated 5/12/21 cleanse right medial foot wound with Betadine and leave open to air.

R2's Telephone Order dated 3/26/21 document an order for Prostat (protein supplement) 30 ml (milliliters) by mouth twice daily. There is no documentation that this order was transcribed to R2's Physician's Orders Sheets and Medication Administration Records (MARs) after 3/26/21. R2's April-June 2021 MARs do not document that R2 received Prostat 30 ml twice daily as ordered.

R2's Dietary Notes signed by V14, RD, documents the following: On 3/26/21 V14 recommended the addition of Prostat Advanced Wound Care 30 ml twice daily to aid in wound healing. On 4/27/21 V14 documents R2 receives Prostat Advanced Wound Care 30 ml twice daily.

R2's Wound Evaluation & Management Summaries by V7, Wound Physician, document the following: On 4/14/21 R2's wound to the distal medial right foot was scabbed and measured 2 cm long by 1.5 cm wide, R2's diabetic wound to the right heel measured 1.2 cm long by 1.1 cm

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wide by 0.1 cm deep, and R2's diabetic wound to the left heel measured 2.2 cm by 2.2 cm by no depth. On 5/5/21 R2's left diabetic heel ulcer was healed, R2's right distal medial foot wound measured 1.2 cm by 0.8 cm by 0.1 cm, and R2's right heel diabetic wound is scabbed and measured 5.5 cm by 7.5 cm by 0 depth. R2's right medial foot wound treatment was cleanse with Betadine, apply collagen and hydrocolloid dressing daily and as needed. V7's treatment orders for R2's diabetic right heel wound was to apply Betadine daily. On 5/12/21 R2's right medial foot wound measured 1 by 0.7 cm and V7 ordered Betadine daily. On 5/19/21 R2's right heel diabetic wound healed, and R2's right medial foot wound measured 0.8 cm by 0.6 cm by 0.2 cm. On 5/26/21 R2's right medial foot wound measured 0.7 cm by 0.5 cm by no depth and V7 ordered Betadine daily. On 6/16/21 R2's distal medial right foot scabbed wound measures 0.4 cm long by 0.3 cm wide. This summary documents a treatment order to apply Betadine daily and recommendations to elevate R2's legs, float heels, off load wound, and reposition side to side and front to back every 1 to 2 hours if able. There are no documented measurements or assessments of R2's right and left diabetic heel wounds in R2's medical record after 5/19/21.

R2's April 2021 TAR does not document the following: Betadine was administered to R2's left heel wound on day shift on 4/5 and 4/8/21, and evening shift on 4/2-4/4, and 4/8-4/11/21. Betadine was administered to R2's medial foot wound on day shift on 4/5, 4/8, 4/11, 4/27, 4/30/21 and evening shift on 4/2-4/4, 4/8-4/11, 4/21, 4/22, 4/24, 4/25, and 4/27-4/30/21. Betadine was administered to R2's bilateral foot wounds on day shift on 4/15/, 4/16, 4/19, 4/20, 4/27, and 4/30/21, and the evening shift on 4/15-4/18,

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4/20-4/25, and 4/27-4/30/21. R2's May 2021 TAR does not document the following: Betadine was applied to R2's bilateral heels on day shift 5/6, 5/7, 5/10, 5/11, 5/20, 5/27, 5/28, and evening shift on 5/1, 5/2, 5/5-5/8, 5/11-5/17, 5/19-5/23, 5/26-5/31/21. Betadine, collagen, and hydrocolloid was administered to R2's right medial foot wound on day shift on 5/6-5/9/21, and Betadine was not administered on the evening shift from 5/12-5/17, 5/19-5/23, and 5/26-5/31/21.R2's June 2021 TAR does not document Betadine was applied to R2's bilateral heel wounds on day shift on 6/3 and 6/5/21, and evening shift on 6/3-6/5, 6/7, 6/9-6/12, and 6/16-6/19/21. This TAR does not document an entry to record the administration of R2's right distal medial foot wound.

On 6/21/21 at 11:34 AM V5, Registered Nurse (RN), entered R2's room to administer R2's wound treatments. V5 applied Betadine to a small scabbed area to R2's left heel, right inner heel, and right inner foot near R2's great toe.

On 6/22/21 at 2:35 PM V2, DON, stated R2 admitted to the facility with bilateral heel wounds, believed to be diabetic wounds. V2 stated V2 was the nurse who transcribed the telephone order for V14's recommendation for Prostat 30 ml twice daily, and the order was not transcribed onto R2's Physician's Orders Sheets and MARs.

3.) R3's Care Plan dated 5/19/21 documents R3 has arterial ulcers to R3's left leg, left foot, and right foot with interventions that include measure and monitor wound weekly, administer treatments as ordered, and dietary consult for nutrition and hydration recommendations. R3's Nursing Note dated 4/19/21 documents R3 is alert and oriented to person, place, and time.

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S9999	Continued From page 12 R3's Physician's Orders dated 6/1/21-6/30/21 documents an order dated 6/11/21 for multivitamin once daily and a nutritional supplement 60 ml by mouth twice daily. R3's Physician's Orders dated 5/1/21-5/31/21 documents the following: An order dated 5/5/21 to cleanse R3's left calf wound with Betadine, apply collagen, cover with a hydrocolloid dressing every 3 days and as needed, cleanse left medial foot wound with Betadine, apply collagen, cover with hydrocolloid dressing and change every 3 days and as needed, cleanse right medial foot wound with Betadine, apply Collagen, cover with hydrocolloid dressing and change every 3 days and as needed, and heel protector boots on at all times. An order dated 5/12/21 documents to cleanse R3's left calf wound with Betadine twice daily and leave open to air. R3's Telephone Order dated 3/17/21 documents to cleanse R3's groin with (foam solution), apply zinc ointment and antifungal powder twice daily and as needed. R3's Telephone Order dated 5/26/21 document orders to cleanse R3's left lateral ankle wound and right medial foot wound, apply hydrogel and collagen, and cover with a dry dressing daily. R3's Dietary Services Communication form dated 5/14/21 documents V14 gave recommendations for a multivitamin daily and a nutritional supplement 60 ml twice daily. There is no documentation in R3's medical record that V14's recommendation was implemented prior to 6/11/21 (28 days later.) R3's March 2021 TAR and April 2021 TARs do not document R3's antifungal powder was administered on day shift on 3/20, 3/21, 3/23,	S9999		

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S9999	Continued From page 13 3/25, 3/26, 3/29, 3/30, 4/1, 4/3, 4/6, 4/8-4/11, 4/13, 4/15, 4/16, 4/20, 4/22, 4/24-4/26, 4/29, and 4/30/20, and on the evening shift on 3/17-3/30/21, and 4/2-4/4, 4/6-4/26/21, and 4/28-4/30/21. R3's May 2021 TAR does not document R3's left calf wound treatment was administered on day shift on 5/14, 5/17-5/25, 5/30, and 5/31/21, and on evening shift on 5/12-5/16, 5/18-5/21, 5/24, 5/25, and 5/27-5/31/21. This TAR does not document R3's right medial foot treatment and left medial foot treatments were administered on 5/8-5/11, 5/14, and 5/17-5/24/21. R3's June 2021 TAR does not document the following: R3's heel boots were implemented on day shift 6/1, 6/3-6/8, 6/10, 6/13-6/15, 6/17, 6/19, 6/20/21, and evening shift on 6/3-6/8, 6/10-6/15, 6/17-6/21/21. R3's left calf wound treatment was administered on day shift on 6/1, 6/3-6/8, 6/10, 6/13-6/15/21, and the evening shift on 6/2-6/7, 7/9-6/15/21. R3's left ankle and medial foot wound treatments were administered on 6/1, 6/3-6/8, 6/10, 6/13-6/15, 6/19, and 6/20/21. R3's Wound Evaluation & Management Summaries by V7 document the following: On 5/5/21 R3's left calf arterial wound measured 1.4 cm long by 1.4 cm wide by 0.1 cm deep, R3's left lateral ankle arterial wound measured 0.5 cm long by 0.6 cm wide by 0.2 cm deep, and R3's right foot arterial wound measured 0.5 cm long by 0.7 cm wide by no depth. R3's left ankle wound resolved on 5/12/21. On 6/16/21 R3's left distal, posterior, medial calf arterial wound measured 0.8 cm long by 0.8 cm wide by 0.1 cm deep. R3's right foot arterial wound measured 0.6 cm long by 0.4 cm wide by 0.2 cm deep. R3's treatment orders for R3's calf wound and right foot wound are documented to apply collagen, and a bordered gauze dressing daily. There are no documented measurements or assessments of	S9999		

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S9999	Continued From page 14 R3's left lateral foot wound after 5/12/21 in R3's medical record. On 6/21/21 at 12:01 PM V4, Licensed Practical Nurse, entered R3's room, washed V4's hands, and applied gloves. R3 was lying in bed with R3's heels floated on a pillow and R3 was not wearing pressure relieving boots. R3 had dressings to R3's outer left foot near the ankle and inner right foot that were dated 6/18/21. V4 confirmed the dressings were dated 6/18/21. V4 removed R3's left foot wound dressing which had a small amount of tan drainage. R3's wound was a small circular shape and pink. V3 cleansed R3's wound, changed gloves, applied hydrogel and collagen covered with a bordered foam dressing. V4 changed V4's gloves and removed the dressing to R3's right foot. There was a small amount of tan drainage and R3's wound was pink, and a small circular shape. V4 cleansed R3's wound, changed gloves, applied hydrogel and collagen covered with a bordered foam dressing. V4 did not perform hand hygiene when V4 changed gloves or between administering each wound treatment. V4 applied R3's nonskid socks, floated R3's heels on a pillow, covered R3 with blankets, and left R3's room. V4 did not apply R3's pressure relieving boots. On 6/21/21 at 12:18 PM V4 stated hand hygiene should be performed before and after treatments, and Alcohol Based Hand Rub should be used between glove changes. V4 confirmed hand hygiene was only completed before and after R3's wound treatments. On 6/21/21 at 1:55 PM, V4 stated R3 wears heel protectors when in bed and confirmed R3 was not wearing heel protectors before or after R3's wound treatment administration. On 6/21/21 at 1:30 PM V9, V11, and V12 Certified	S9999		

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S9999	Continued From page 15 Nursing Assistants (CNAs) entered R3's room. R3 was not wearing pressure relieving boots. V9, V11, and V12 provided incontinence care for R3 and transferred R3 with a full mechanical lift from the bed to the wheelchair. V9, V11, and V12 did not apply R3's pressure relieving boots. V9 pushed R3 in the wheelchair into the hallway. On 6/21/21 at 3:50 PM, R3 was sitting in a wheelchair in the hallway and R3 was not wearing pressure relieving boots. R3 stated R3's pressure relieving boots went missing about two weeks ago. On 6/21/21 at 4:57 PM and 6/22/21 at 9:03 AM, R3 was not wearing pressure relieving boots while R3 was sitting in R3's wheelchair. On 6/21/21 at 4:57 PM V12 ,CNA stated R3 has heel protectors that are lying on R3's bed. R3 only wears heel protectors when R3 is in bed. On 6/21/21 at 2:35 PM V2 confirmed V14's recommendation on 5/14/21 for R3 to have a multivitamin daily and nutritional supplement 60 ml twice daily was not implemented until 6/11/21. V2 confirmed R3 has an order for pressure relieving boots to be worn at all times. V2 stated: R3 frequently refuses to wear them, and refusal of care would be documented in nursing notes or behavior logs. Hand hygiene should be completed before and after wound treatments, and when changing gloves and moving from soiled to clean areas during a wound treatment. 4.) R4's Physician's Orders Sheet (POS) dated 5/1/21-5/31/21 documents an order dated 5/26/21 to cleanse R4's abdominal folds and buttocks, and apply a skin protectant cream twice daily and after perineal care. R3's April, May and June 2021 POS do not document an order to apply antifungal powder twice daily and as needed for 14 days to R4's perineal area.	S9999		

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S9999	Continued From page 16	S9999		

R4's April 2021 TAR documents an entry dated 4/7/21 to apply antifungal powder twice daily and as needed to R4's perineal area for 14 days. This TAR does not document antifungal powder was administered on 4/8, 4/12, 4/13, 4/15, 4/16, 4/19, and 4/20/21 on day shift, and on 4/8-4/11, 4/15-4/18, and 4/20/21 on the evening shift. R4's May 2021 TAR does not document R4's abdominal fold treatment was administered on the day shift on 5/27, 5/28, and 5/31/21, and on the the evening shift on 5/25-5/31/21. R4's June 2021 TAR does not document R4's abdominal fold treatment was administered on the evening shift on 6/3, 6/4, 6/5, 6/7, 6/9-6/12, and 6/16-6/19/21.

On 6/21/21 at 8:36 AM V5, RN, stated R4 has fungal areas to R4's abdominal folds. On 6/22/21 at 9:53 AM, R4 was lying in bed. R4 stated R4 has redness to R4's abdominal folds. On 6/22/21 at 11:10 AM V8 and V9, CNAs, entered R4's room and provided incontinence care for R4. V9 cleansed R4's abdominal folds and applied a skin protectant cream to R4's abdominal folds and perineal area. R4's skin was intact and without redness. V9 stated R4's skin used to be red and raw, but the skin protectant has helped. R4 stated the night shift staff have not been applying R4's skin protectant cream.

On 6/22/21 at 2:35 PM V2 was unable to locate R4's original order from 4/7/21 for antifungal powder. V2 stated the order is not on R4's April 2021 Physicians Orders Sheet, and V2 could not locate a telephone order or written order. V2 stated the nurses are to sign out the TAR when treatments are administered and V2 expects the nurses to follow physician's orders. V2 stated the floor nurses are responsible for completing wound assessments and measurements upon

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S9999	Continued From page 17 admission, readmission and when a new wound is identified. V2 stated wounds are measured and assessed weekly by V7 and documented in V7's progress notes. V2 confirmed V2 provided all of R1's, R2's, and R3's wound measurements between 2/25/21 and 6/21/21. On 6/22/21 at 3:57 PM V2 and V3 Social Services confirmed there is no documentation that R2 or R3 refuse wound treatments or interventions. (B)	S9999		