STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007082	A. BUILDING: _____ B. WING _____	C 08/04/2022

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PRAIRIE ROSE HEALTH CARE CTR	900 SOUTH CHESTNUT PANA, IL 62557

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S 000	Initial Comments Complaint 2244915/IL148294	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)3)4)5) 300.1210c)2)3) 300.1210d)5) 300.1220b)1)2) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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, 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. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition	S9999		

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S9999	Continued From page 2 demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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	S9999		

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S9999	Continued From page 3 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: 1) Assigning and directing the activities of nursing service personnel. 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. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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)	S9999		

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S9999	Continued From page 4 These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide treatments as ordered, and implement interventions including pressure relief and timely turning and repositioning to prevent pressure ulcers for 7 of 8 residents (R1, R2, R3, R6, R7, R8, and R12) reviewed for pressure ulcers. This failure resulted in the deterioration of R1's left heel and buttock resulting in the need for multiple debridement. 2) The facility failed to provide nursing care/services and implement care in accordance with residents' plan of care to attain residents' highest practicable physical and psychosocial well-being for 7 of 13 residents (R1, R2, R3, R6, R7, R8, R12) reviewed for quality of care. These failures resulted in numerous situations observed as follows: the nursing staff failed to assess and monitor R8's peripherally inserted central catheter (PICC) line and provide care to prevent ongoing urinary tract infections, failed to provide incontinent care/service to prevent R3's non-pressure ulcer skin injury in accordance with R3's Plan of Care. R1, R2, R3, R6, R7, R8 and R12 did not receive supervision and timely care to prevent urinary tract infections, non-pressure related skin injuries and psychosocial harm. The facility failed to provide timely incontinent care/services for R1, R2, R6, R7 and R12 in accordance with their Plan of Care to prevent potential Urinary tract infections, incontinent related skin injury and psychosocial harm. Due to R1, R2, R3, R6's, R7, R8's and R12's vulnerabilities and comorbidities related to their	S9999		

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diagnoses, this failure increased their likelihood for risk of decline to overall health and psychosocial harm. Using the reasonable person approach for R1, R6, R7, and R12 because these residents were unable to articulate/verbalize the impact of sitting in soiled incontinent briefs for extended periods of time, a reasonable person would have feelings of shame, embarrassment, humiliation, anxiety, hopelessness, and dehumanization.

Findings include:

1. R1's Current Face Sheet documents R1 was admitted on 7/10/21 with a diagnosis of Severe Alzheimer's, Atrial fibrillation, Hypertension, anemia, dementia with psychosis, acute toxic metabolic, electrolyte abnormalities, urine retention, and history of Urinary Tract Infection (UTI).

R1's Care Plan, dated 7/20/21, documents: (R1) unstageable pressure ulcer to left heel (2/20/22), stage 1 to bilateral buttocks (3/11/22), stage two right gluteal fold (3/28/22). Risk factors include Alzheimer's need for assist with bed mobility and transfer. Interventions: apply house stock incontinent barrier cream to peri area with after every incontinent episode. Turn and reposition every two hours and PRN (as needed). Dressing to left heel as ordered. (2/20/22, float heels while in bed. Dressings to bilateral buttocks per MD order. (3/11/22). Dressing as ordered to right gluteal fold (3/28/22). R1's Care Plan further documents R1 is morbidly obese and interventions to attempt to anticipate needs-toileting, hydration, hunger and provide cares before R1 attempts to fulfill on own. Assist of 2 staff members for mechanical lift bearing

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assist and or mechanical device to place resident on toilet upon rising and hs (hour of sleep) and after all meals as tolerated. Place brief on when up, pad on bed, change every 2 hours and as needed when repositioning. Assist resident with cleansing peri area after each incontinent episode. Barrier cream as needed upon cleansing (7/20/21). Assist to transfer resident using mechanical device and 2 staff members. Total assist of transfer with transfer on and off toilet (10/1/21). Unable to position self without assist of 2 staff. Scheduled repositioning program. Scheduled to be repositioned every 2 hours and as needed to maintain comfort, pressure reducing mattress on bed and pressure reducing cushion in chair when up.

R1's Minimum Data Set (MDS) dated, 04/13/2022, documents R1 has severe cognition impairments and does not resist care. The MDS documents R1 requires extensive assistance of 2 staff members for activities of daily living (ADL). The MDS documents R1 is frequently incontinent of urine and occasionally incontinent of bowel. The MDS further documents R1 is at risk of developing pressure ulcers and has one or more unhealed pressure ulcers with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications.

R1's Bowel and Bladder Assessment dated 4/19/22 documents R1 is incontinent day and night and has history of urinary tract infections and is totally dependent to transfer to toilet.

R1's Braden Score for Predicting Pressure Ulcer dated 4/19/22 documents R1 does not have any unresolved pressure ulcers, and pressure ulcers in last 90 days is left blank. The Braden Score

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documents R1 requires pressure reducing mattress for bed and turning and positioning program. The Braden Assessment had no documentation that the following were needed: barrier cream/ointment, occasional moist, chair fast and pressure reducing cushion for chair is left blank. R1's Shower Sheets, dated 2/28/22 documented R1 had a sore on his heel that was not new. Interventions of briefs, float heels and turning and repositioning.

On 6/27/22 with intermittent observations of approximately 15-20 minutes from 8:30AM through 2:18PM, R1 was up in his tilt back geriatric chair parked in front of the television without being provided incontinent care, checks, or repositioning. At approximately 11:45 AM, R1 was wheeled to the dining room for lunch and then back out to the television area at approximately 12:15PM where he remained until 2:18 PM. R1 appeared anxious and was scooting back and forth in his chair without staff intervention. V11, Certified Nurse Assistant, CNA, stated at 2:10 PM that R1 always tries to scoot in his chair and is fidgety. V11 stated R1 has not been laid down or provided incontinent care since breakfast.

On 6/28/22 at 9:27 AM V8 and V9, CNAs, transferred R1 by mechanical lift to R1's bed to provide incontinence care. R1 did not have any pressure reducing device in his tilt back wheelchair. R1's incontinent brief was saturated with urine and had heavy creases in his groin and buttock. V8 and V9 did not have Peri Wash, soap/cleanser or washcloths and provided peri-care with water only. R1's bilateral buttock area was pinkish red and R1 had an opened pressure area to his right buttock. R1 did not have a dressing in place. V8 and V9 did not dry

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S9999	Continued From page 8 R1 off upon completion of incontinence care or apply barrier cream. V8 and V9 did not float R1's heels, apply heel protectors or offer hydration/fluids when care was completed. R1's heels were lying directly on the mattress. V8 stated at this time that the nurses put a "patch" on R1's open area. V8 stated she "forgot to bring the barrier cream in the room with her, and doesn't have any in her pocket, where I usually keep it". V8 stated sometimes they don't have enough washcloths, or towels to do complete peri care and she didn't dry R1 off because she forgot the towels. V8 further stated they don't have enough staff here to do the care that needs done. V8 stated "We have so many mechanical lifts (residents that require two assist with lift machine), like 8 lifts, that takes two people, and sometimes we've had to use only one staff to transfer a resident with a mechanical lift." On 6/29/22 at 11:00 AM, V6, Licensed Practical Nurse (LPN) provided wound treatment to (R1), with assistance of V11, CNA. R1's left heel pressure ulcer was open with red beefy tissue. V6 stated the pressure ulcer size was approximately 3 centimeters (cm) x (by) 2.5 cm and open and red. V6 further stated R1's left heel pressure ulcers has a brownish/black area within the left heel wound that is approximately 1.5 cm x 1 cm in size. V6 did not measure R1's left heel pressure ulcer but gave approximate size. R1's left ankle had a red area on the underside of the lateral malleolus (ankle). V6 stated R1's ankle is "always pretty angry looking". V6 then cleansed R1's left heel with wound cleanser, applied collagen and an island dressing, wrapping with gauze. V6 then provided pressure ulcer treatment to R1's right buttock and cleansed with wound cleanser, applied calcium alginate with silver and Duoderm (provides a	S9999		

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S9999	Continued From page 9 bacterial and viral barrier when the dressing remains intact and without leakage, adhesive dressing). V6 stated R1's right buttock was approximately 1.2 cm x 1 cm. R1's right buttock pressure ulcer was open with yellow slough and buttocks were reddened. At the completion of care, V6 and V11 did not apply heel protectors to R1. V11 stated at this time, that it's hard to find heel protectors because we don't have enough. R1's heels were laying directly on the mattress. R1's March 2022 Shower Sheets were reviewed. R1's Shower Sheet, dated 3/14/22 documents R1 had an old area on left heel. R1's Shower Sheet dated 3/16/22 documented R1 had opened sores on left heel and bottom of both butt cheeks which were not new. R1's Shower Sheet, dated 3/21/22, documented R1 had an opened sore on left heel not new, skin tear on right elbow not new, new blister on top of right foot not new, raw on top/side of right foot, with interventions of briefs, float heels, seat cushion and turning and repositioning. R1's Shower Sheet dated 3/23/22 documents area on heel. R1's Shower Sheet, dated 3/28/22, documents circled areas on coccyx, right buttock and right heel. R1's Shower Sheet, dated 3/31/22, documents raw spot on back of testicles. R1's Telephone Orders dated 3/11/22 document an order to apply Duoderm to areas to left and right buttocks and change every 72 hours and as needed. R1's March 2022 Treatment Administration Record (TAR) documents Duoderm to left and right buttocks and changed every 72 hours and as needed. The TAR was not signed off that R1 received treatment on 3/17 and 3/20/22.	S9999		

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S9999	Continued From page 10 R1's Telephone Orders dated 3/17/22 document an order to apply collagen then calcium alginate with silver, cover with ABD (Abdominal dressing/Army Battle Dressing, sterile and absorbent dressing) and roll gauze but doesn't indicate what area to receive treatment. Heel protectors while in bed. R1's March 2022 TAR documents apply collagen then calcium alginate with silver cover with ABD (absorbent dressing) and roll gauze daily but doesn't indicate what area to receive treatment. Reviewed with V3 on 7/7/22 at 11:00AM and confirmed the order doesn't document where the treatment is indicated and V3 does not know what area was being treated with this order. R1's March 2022 TAR documents skin prep three times daily and as needed to right heel, float right heel and apply heel protectors while in bed and is not signed off as received on 3/30, 3/31. R1's March 2022 TAR documents daily skin checks that were done only on 5 days 3/1, 3/8, 3/15, 3/22, 3/29/22. R1's Nurse's Note, dated 03/28/22, documents, at 11:00AM "Resident has new pressure area to right gluteal fold. Called (V12) Wound Physician, ordered apply calcium alginate and cover with island dressing daily (dressing applied to a wound to promote healing and also to prevent any further harm to the wound. The wound dressing is sterile, breathable and is considered most conducive for a moist healing) and PRN (as needed). Area 3 cm x 2 cm with slough (dead tissue separating from living tissue) noted to wound bed. Surrounding skin slightly red. (V12) Wound Physician will assess at next visit, family aware".	S9999		

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S9999	Continued From page 11 R1's Telephone Orders dated, and Physician Order sheet dated 3/28/22 document an order for new pressure area to right gluteal fold, apply calcium alginate and cover with an island dressing daily and as needed. Reviewed order with V3 on 7/7/22 at 11:00AM and confirmed that the order did not get transcribed on to the April 2022 TAR. V3 Stated the April TAR would have been printed when the 3/28/22 order was written, and the nurses should have transcribed it on the TAR. V3 stated there is no documentation that R1 received this treatment. V3 confirmed there were no orders transcribed for R1's 3/28/22 order for April, May and June for right gluteal fold. V3 stated there is no documentation that R1 ever received this treatment. R1's April 2022 Shower Sheets were reviewed. R1's Shower Sheet, dated 4/4/22 document circled old area, coccyx, left heel, old area. R1's Shower Sheet, dated 4/7/22 documents left skin tear back of left elbow, open areas on bottom area and heel, bruising to arm. R1's Shower Sheet dated 4/11/22 documents area on heel (circled right heel), left arm sore on forearm and skin tear back elbow and 2 open areas on bottom. R1's Shower Sheet, dated 4/14/22 document no findings. R1's Shower Sheet, dated 4/18/22, documents area of right buttock circled and left heel old area. R1's Shower Sheet, dated 4/20/22, documents an open area on bottom, area on heel and red in abdominal fold, cream applied. R1's Shower Sheet, dated 4/25/22, documents circled areas on coccyx and left heel. R1's Shower Sheet, dated 4/28/22, documents no new findings. R1's Wound Physician (V12) notes dated 4/7/22 document: "At the request of the referring provider, (V13, R1's Physician), a thorough	S9999		

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S9999	Continued From page 12 wound care assessment and evaluation was performed today. (R1) has a stage 4 pressure wound to the left heel for at least 31 days duration with moderate serous exudate (drainage). Support surface: chair: pressure reduction cushion, feet: pillow. Appearance: Obese. Site #1: Stage 4 pressure wound of the heel full thickness: 4x5x0.4 with moderate serous exudate, 30% eschar, (A slough or piece of dead tissue that sheds off from the surface of the skin after an injury). 20% devitalized necrotic tissue, 20% slough, 30% granulation tissue: Wound progress: deteriorated. Dressing Treatment plan: primary dressing: alginate calcium with silver apply once daily for 23 days; collagen sheet with silver applies once daily for 9 days. Secondary dressing: gauze roll 4.5' apply once daily for 23 days, tape (retention) apply once daily for 23 days; abd (abdominal) pad apply once daily for 9 days. Recommendations: elevate legs; float heels in bed; offload wound; reposition per facility protocol; turn side to side and front to back in bed every 1-2 hours if able; sponge boot. Site 1 surgical excisional debridement (procedure to remove debris or infected/dead tissue from a wound) procedure: indications for procedure-remove necrotic tissue and establish the margins of viable tissue. The indicated debridement was discussed with V13 on 3/6/22 and its necessity was mutually agreed upon. Procedure Note: Surgical excise 14 cm of devitalized tissue and necrotic tendinous and aponeurotic fibers (sheet of pearly-white fibrous tissue) the slough and biofilm were removed at a depth of 0.6 cm. The Wound Physicians Note further documents: Site #2: Stage 3 pressure wound of the right, inferior buttock full thickness: 4.2x3.9x0.2cm. with moderate serious exudate, 20% devitalized necrotic tissue, 20% slough, 60% granulation tissue. Dressing treatment plan:	S9999		

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primary dressing: alginate calcium with silver apply once daily for 30 days. Secondary dressing: gauze island with bdr (border) apply once daily for 30 days. Recommendations: elevate legs; float heels in bed; offload wound; reposition per facility protocol; turn side to side and front to back every 1-2 hours if able. Site 2 surgical excisional debridement procedure: indications for procedure- remove necrotic tissue and establish the margins of viable tissue. The indicated debridement was discussed with V13 on 4/7/22 and its necessity was mutually agreed upon. Procedure Note: Surgical excise 6.55cm of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissue with slough and biofilm at a depth of 0.3cm. Summarized Wound Care assessment and Individualized Treatment Plan: Site 1 Stage 4 pressure wound of the left heel-deteriorated. Procedure: surgical excisional debridement was performed today on this wound. Site 2 stage 3 pressure wound of the right inferior buttock- initial evaluation full thickness. Procedure: surgical excisional debridement performed today on this wound.

R1's Wound Physician notes dated 4/21/22 document: R1 has a stage 4 pressure wound to the left heel for at least 44 days duration with moderate serous exudate. Support surface: chair: pressure reduction cushion, feet: pillow. Appearance: obese. Site #1: Stage 4 pressure wound of the heel full thickness: 4x5x0.3 with moderate serous exudate, 20% slough, 70% granulation tissue: Wound progress: improved. Dressing Treatment plan: primary dressing: alginate calcium with silver apply once daily for 9 days; collagen sheet with silver apply once daily for 30 days. Secondary dressing: gauze roll 4.5' apply once daily for 9 days, tape (retention) apply once daily for 9 days; abd pad apply once daily

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S9999	Continued From page 14 for 30 days. Recommendations: elevate legs; float heels in bed; offload wound; reposition per facility protocol; turn side to side and front to back in bed every 1-2 hours if able; sponge boot. Site 1 surgical excisional debridement procedure: indications for procedure- remove necrotic tissue and establish the margins of viable tissue. Procedure Note: Surgical excise 6 cm of devitalized tissue including slough and biofilm and non-viable tendinous and aponeurotic fibers were removed at a depth of 0.4 cm. The Wound Physicians Note further documents: Site #2: Stage 3 pressure wound of the right, inferior buttock full thickness: 2.6x3.2x0.2 with moderate serious exudate, 20% slough, 80% granulation tissue. Dressing treatment plan: primary dressing: alginate calcium with silver apply once daily for 16 days. Secondary dressing: gauze island with bdr apply once daily for 16 days. Recommendations: elevate legs; float heels in bed; offload wound; reposition per facility protocol; turn side to side and front to back every 1-2 hours if able. Site 2 surgical excisional debridement procedure: indications for procedure- remove necrotic tissue and establish the margins of viable tissue. Procedure Note: Surgical excise 1.66 cm of devitalized tissue including slough, biofilm and non-viable subcutaneous fat and surrounding connective tissues were removed at a depth of 0.2. Summarized Wound Care assessment and Individualized Treatment Plan: Site 1 Stage 4 pressure wound of the left heel/ Procedure: surgical excisional debridement was performed today on this wound. Site 2 stage 3 pressure wound of the right inferior buttock; Procedure: surgical excisional debridement performed today on this wound. R1's Nurse's notes dated 4/23/22 at 10:20AM,	S9999		

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S9999	Continued From page 15 documents R1 has new pressure area to right outer distal foot from where (R1) crosses his feet. Calcium alginate with silver and cover with island dressing daily per (V12) Wound Physician, family and appropriate staff aware. R1's Telephone Orders date 4/23/22 document apply calcium alginate with silver to right outer distal foot cover with border gauze daily. R1's April 2022 TAR documents apply collagen, thin calcium alginate with silver, abd, roll gauze and a brand name (self-adherent elastic wrap that functions like tape, but sticks only to itself), change daily to right heel with start date of 4/14/22. The treatment was not documented as completed on 4/22, 4/25, 4/26, 4/27, 4/28. 4/29, and 4/30/22. R1's April 2022 TAR continues to document a treatment of calcium alginate with silver to right outer distal foot and cover with bordered gauze daily starting 4/23/22. The TAR did not document R1 did receive this treatment on 4/25, 4/27, 4/28, 4/29 and 4/31/21. R1's TAR further documents apply collagen, then calcium alginate with silver ABD, roll gauze and self-adherent elastic wrap and change every day to right heel with a start date of 4/14/22. The TAR did not document R1 received the treatment on 4/22, 4/25, 4/26, 4/27, 4/28, and 4/29/22. R1's TAR documents collagen then calcium alginate silver cover with ABD and roll gauze daily to left heel. There are 8 days R1 did not receive treatment. The TAR further documents daily skin checks were not completed on 4/2, 4/3, 4/16, 4/22, 4/25, 4/27, 4/28, and 4/29/22 for both skin checks and left heel treatment. R1's April 2022 TAR documents float heels and apply heel protectors while in bed: on day shift there are 10 days not completed, on	S9999		

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S9999	Continued From page 16 evenings shift: 11 days not completed, and on night shift: 26 times not completed. R1's May 2022 Shower Sheets were reviewed. R1's Shower Sheet, dated 5/2/22 documents old areas to coccyx and left heel. R1's Shower Sheet, Dated 5/5/22, documents area on buttocks and circled coccyx and area on right heel. R1's Shower Sheet, dated 5/9/22, documents areas on bottom, areas on heel. R1's Shower Sheet, dated 5/11/22, documents no new findings. R1's Shower Sheet, dated 5/16/22, documents left heel wound, right foot next to pinky toe wound, and 3 open spots on buttock, none are new. R1's Shower Sheet, dated 5/19/22, documents old area on coccyx, old area right heel. R1's Shower Sheet, dated 5/22/21, documents sores on heel and buttocks not new. R1's Shower Sheet, dated 5/25/22, documents no new findings. R1's Shower Sheet, dated 5/30/22, documents new skin tear on right knee, old open wound left heel and top of left foot. R1's Hospice Admission Orders date 5/2/22 document wound care to left heel bilateral buttocks and right little toe, of calcium alginate, cover with foam and change every 24 hours and as needed. R1's May 2022 TAR documents calcium alginate with silver to right outer distal foot, cover with bordered gauze daily. There are 6 days R1 did not receive treatment to right foot. R1's TAR further documents daily skin checks were not completed for 6 days. The TAR documents the ordered treatment of collagen then calcium alginate with silver cover with ABD, roll gauze daily to left heel were not done for 5 days. R1's Shower Sheets, dated 6/6/22 documents	S9999		

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S9999	Continued From page 17 nothing new, 6/9/22 documents none, 6/13/22 documents no new findings, 6/17/22 is blank, 6/27/22 is blank. R1's June 2022 Physician Order Sheet (POS) documents, a treatment to left heel apply dry dressing daily until healed, then handwritten collagen then calcium alginate with silver cover with ABD and roll gauze. The POS further documents an order for right outer distal foot, apply calcium alginate with silver and cover with border gauze daily. R1's June 2022 TAR documents a treatment to the left heel, apply dry dressing daily until healed from 2/25/22. This order had previously been crossed out and had a handwritten order of collagen then calcium alginate with silver, cover with ABD and roll gauze daily written in. R1's Tar documents R1 did not receive treatment to left heel except for two days (6/1 and 6/4) in the month of June. R1's TAR further documents R1 did not receive a treatment to R1's right outer distal foot of calcium alginate silver and cover with border gauze daily for two days (6/1 and 6/4). The TAR also documents R1's daily skin checks were not done for the month of June with the exception of 2 days (6/1 and 6/4). On, 06/28/2022 at 1:41 PM V4, Licensed Practical Nurse, (LPN), MDS Coordinator, stated "I don't see where the Treatment Assessment Record (TAR), has been documented for treatments, and a lot of holes." V4 stated, "Looks like the ball got dropped on transferring orders to (TAR) for R1". V4 stated, R1 is now on Hospice Care, and Wound Physicians no longer see R1 for wounds because R1 was admitted to Hospice. V4 stated she thought hospice was going to see R1. V4 stated the last time R1 was seen was in	S9999		

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S9999	Continued From page 18 April 2022. V4 stated it looks like an order changed in March but, I don't know to what, there is nothing on TAR. V4 said, if area heals or resolves, there should be an order to discontinue it and put on TAR. On 6/29/22 at 9:15AM, V13, R1's Medical Doctor/Medical Director, stated residents with wounds see the wound physician, that is their specialty. V13 stated he thinks he was aware that the wound physicians have not been coming to see residents since May, but unsure and the nurse can call him if needed. V13 stated he could not comment on individual residents without reviewing their individual records. On 06/30/2022 at 10:28 AM V12, Wound Physician stated via phone interview " I haven't seen any residents at the facility for at least 5 weeks. V12 stated he retired and doesn't think anyone is doing wounds at the moment. V12 stated like anywhere else there is staff shortages in wound physician group and also the facility. V12 stated he would expect the facility to coordinate with the Primary physician of any resident with wounds to be contacted for orders or changes if they are not seeing wound physicians. R1's July 2022 shower sheet, dated 7/4/22 documents no new findings. On 7/5/2022 at 9:56AM V4, Licensed Practical Nurse/MDS Coordinator stated The TARs should not have new written orders without the old order being discontinued, then new order written in a new box on the TAR. On 7/5/22 at 10:30 AM V5, LPN stated, "I made round's with (V12) when he was here." V5 stated	S9999		

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V12 did the measuring when he was here. V5 stated V3 (LPN) is supposed to do the wound measurement when V12 isn't here to do measurements. V5 stated the last time V12 made rounds was probably a month ago or longer, not really sure when measurements were done, I can't say really."

On 7/7/22 at 11:00 AM, V3 (Resident Care Coordinator/Licensed Practical Nurse, LPN), confirmed that the treatment for the left heel was not carried over onto June as it was handwritten in April and May and the nurses aren't good about faxing orders to pharmacy unless it's medication. V3 stated the dry dressing order from 2/25/22 is an old one that was never discontinued and replaced with the current order. V3 further stated it was just handwritten month to month and the nurses do that and they do not have any documentation that R1 received the right treatment or any treatment. V3 stated the wound physician had retired and R1 is now in hospice care, and think orders are from them. When asked how the nurses would know the correct treatment for discrepancies/changes, V3 replied, "she knows this isn't a good answer, but they just go off of memory". V3 confirmed there were no orders transcribed for R1's 3/28/22 buttock treatment order for April, May and June 2022.

R1's March 2022 Weekly Wound tracking documents as follows:
Area 1: blank, Date onset: blank, Admit/Acquired: blank, date: 3/22, type: pressure, stage: blank, L (length) x (by) W (Width): 2 cm x 2 cm, drainage: minimal
Area 2: blank, date: 3/28/22, type: Pressure, stage: blank, LxW: 3cmx2, drainage: none
Area 3: blank, date: 3/11/22, type: pressure right buttock, LxW: 0.5x illegible, drainage: minimal

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S9999	Continued From page 20 Date: 3/11/22: type: pressure: left buttock, LxW 0.5 x illegible, drainage: minimal The March 2022 Weekly Wound tracking does not document where the pressure ulcers are located for area 1 or area 2. The March 2022 Weekly Wound tracking does not document when the pressure ulcer developed for area 1. R1's April 2022 Weekly Wound tracking documents as follows: Area 1: blank, date 4/7, type D left heel wound stage 4, LxW: 4x5x0.4, drainage: minimal, odor: yes Date: 4/21, typed left heel, stage 4, LxW: 4x5x0.3, drainage: minimal, odor: yes Area 2: blank, date: 4/21, type pressure right butt, stage 3, LxW 2.6x3.2x0.2 with tunnel time: 8.32, drainage: minimal, odor: yes Area 3: bank, dated 4/23, pressure right foot, stage: blank, LXW 2.0x illegible, drainage: minimal. The Weekly Wound tracking does not document what "D" stands for. R1's May 2022 Weekly Wound tracking document as follows: Area 1: left heel, date 5/12/22, type: pressure, stage 4, LxW: 3.9x4.8 x 0.3, drainage: minimal, odor: yes Date: 5/26/22, type: pressure, stage 4, LxW: 3.9x4.9x0.3, draining: minimal, odor: yes Area 2: R butt, date: blank, type: pressure, stage bank, LxW blank, drainage: bank, odor: blank. healed Area 3: R foot, date: blank, type: pressure, stage: blank, LXW blank, drainage: blank, odor: blank healed R1's June Weekly Wound tracking document as follows:	S9999		

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S9999	Continued From page 21 Area 1: left heel, date 6/2/22, type: D, stage 4, LxW: 3.8x4 x 0.3, drainage: moderate, odor: yes Date: 6/09/22, type: D, stage 4, LxW: 3.8x4x3, drainage: moderate, odor: yes Date: 6/16/22, type: D, stage 4, LxW: 3.7x3.9, drainage: moderate, odor: yes Date: 6/23/22, type: D, stage 4, LxW: 3.8x3.9, drainage: moderate, odor: yes Date: 6/30/22, type: D, stage 4, LxW: 3.8x3.8, drainage: moderate, odor: yes Area 2: R outer distal foot, date: 6/2/22, type: pressure, stage 2, LxW: 0.5x1x0.1, drainage: moderate, odor: yes Date: 6/9/22, type: pressure, stage 2, LxW: 0.4x0.9x0.1, drainage: moderate, odor: yes Date: 6/16/22, type: pressure, stage 2, LxW: 0.4x0.9x0.1, drainage: moderate, odor: yes Date: 6/23/22, type: pressure, stage 2, LxW: 0.4x0.9x0.1, drainage: moderate, odor: yes Date: 6/30/22, type: pressure, stage 2, LxW: 0.4x0.9x0.1, drainage: moderate, odor: yes On 7/7/22 at 11:00 AM, V3 stated there is no documentation of any other assessments, measurements, or areas the facility was monitoring, and this is all they have. On 7/7/22 at 1:10 PM, V3 stated she did not know where R1's location of pressure ulcers are from the March 2022 Weekly wound log. V3 stated she did not know what the D stood for because she was not doing wounds and wasn't for sure if R1 was diabetic or not. V3 stated V20, LPN/Unit Coordinator was doing the wound logs in March. On 7/7/22 at 1:15 PM, V20, Licensed Practical Nurse, LPN, stated the "D" meant deteriorating on the April 2022. V20 stated she didn't think R1 was diabetic and marked D for deteriorating in the	S9999		

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S9999	Continued From page 22 second legend at the bottom of the page. 2.R3's Face sheet documents R3 was admitted on 9/29/21 with a diagnosis of Major Depression Disorder, Anxiety, hypertension, Type II Diabetes, Cellulitis, Left Hemiplegia, Cerebral Vascular Accident, Benign prostate hyperplasia, dysphagia, and weakness. R3's MDS, dated 4/13/22, documents R3 is cognitively intact and is mildly depressed and does not reject care. The MDS documents R3 requires total dependance of two staff members for bed mobility, transfer, toiletings, and extensive assistance/physical help of 2 staff members for bathing. The MDS further documents R3 has impairments on upper and lower extremities, uses a wheelchair for mobility, is unable to ambulate and is frequently incontinent of bowel and bladder, at risk of developing pressure ulcer/injuries with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications. R3's Braden Scare for Predicting Pressure Ulcer Risk dated 4/13/22 documents R3 is a high risk for pressure ulcers. The Assessment documents R3's skin as: very moist with linens must be changed at least once a shift and chairfast. R3's Bowel and Bladder Assessment, dated 4/14/22, documents R3 is incontinent both day and night, has dribbling with history of UTI in the last 6 months. The Assessment document R3's restorative need is scheduled toileting. R3's June 2022 Physician Order Sheet (POS) documents R3 required furosemide (Lasix-a diuretic, increases passing of urine) 80 milligrams	S9999		

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S9999	Continued From page 23 (mg) twice daily. The POS documents treatments to coccyx apply barrier cream twice daily, and abdominal/groin folds apply dry moisture-wicking fabric as needed. R3's Care Plan dated 9/29/21 documents R3 requires assist of 2 staff for mechanical device transfers and a focus area of: alteration in bladder elimination as related to incontinence with approaches/interventions pad appropriately for dignity and comfort, toilet and or change padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening after napping and PRN (as needed) for incontinence, apply house stock barrier cream with every incontinent care, report to nurse in charge for any skin conditions. R3's Care Plan further documents a focus area of: R3 may display alterations in psychosocial wellbeing, observe and report changes in behavior, psychosocial status or condition to nurse. Altered Mood state (anger/easily upset) potential for altered social reaction with approach/intervention of assess residents strength and positive coping skills and encourage resident to utilize them in present situation, encourage, invite and praise involvement in activities assist as necessary, encourage resident to vent feelings through active listening, validate feelings, restate comments to allow resident to hear and understand self-expressions, assess for changes in sleep patterns, appetite, mood interest in self-care and leisure activities- if resident is expressing anger with self or others, attempt to determine source of anger and encourage appropriate outlets for expression. Attempt to anticipate needs-toileting hydration, hunger and provide cares before Resident attempts to fulfill on his own, keep call light within reach at all times, answer promptly and notify resident help is	S9999		

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S9999	Continued From page 24 on the way. R3's Care plan does not document actual skin impairments. R3's 6/24/22 Shower Sheet document a red open area on buttocks. On 6/27/22 at 10:15 AM, R3 stated he is up in his wheelchair all day and would like to be laid down during the day. R3 stated at his previous facility he laid down twice a day and he liked that, but he doesn't lay down here. R3 stated he has an incontinent in his brief and doesn't get up to the toilet. R3 states staff have to clean him up. R3 stated he had to wait 2-3 hours last week to get changed after he "s*** my pants!" R3 stated staff "scrubbed him so hard and it hurt". R3 stated his skin is rubbed raw and he told staff to leave him some skin, but they said they had to get the poop off because it had been on so long. R3 stated it doesn't make him feel good when he "s**** all over" and it stings his skin because his skin is so raw, and he sits in the wheelchair all day on the mechanical lift sling. On 6/27/22 based on intermittent observations of approximately 15-20 minutes from 8:30AM-2:18PM, R3 was up in his wheelchair without being provided incontinent care or checks. At approximately 11:35AM, R3 self-propelled his wheelchair to the dining room for lunch and then back to his room where he remained until staff laid him down. On 6/27/22 at 1:47 PM, R3 was sitting in his wheelchair in his room waiting to be laid down. V11 Certified Nurse Assistant, (CNA) stated she had to wait on another staff member to get here so she could lay R3 down. On 6/27/22 at 2:18 PM, V11 and V18, CNA used	S9999		

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S9999	Continued From page 25 a mechanical transfer to transfer R3 in bed and provided incontinent are to R3. R3 did not have any pressure reducing device on his wheelchair or bed. V11 stated the facility had no clean washcloths so she grabbed a hand towel. R3 was heavily soaked thru his pants. R3 states "I'm wet! My butt is sore! Careful!" R3's incontinent brief was heavily saturated with urine and smelled of strong odor. R3's scrotum, peri area and inner thighs and buttock had deep creases of heavy lines from where the mechanical lift sling had been in place all day. R3's peri area, scrotum, inner thighs and buttock were deep red, maroon in places that had a mushy, boggy appearance with maceration (softening and breaking down of skin resulting from prolonged exposure to moisture). R3 had an open area to his buttock. R3 grimaced when V11 and V18 wiped R3's scrotum and groin. There was dark yellow residual on R3's hand towel that was used for incontinent care after cleaning R3's groin and scrotum. V11 and V18 did not continue to clean R3 after noting the yellow residual on R3's hand towel being used to clean R3. No barrier cream was applied to R3. At the completion of care, V11 and V18 did not float R3's heels, apply heel protectors or offer hydration/fluids. On 6/27/22 at 2:25 PM, V11 confirmed that R3 had not been provided incontinent care all day and had urine soaked through his pants. V11 stated there are 2 staff members (V11 and V7) taking care of approximately 27 residents with 7 mechanical lifts (residents who require two assist with a mechanical lift). V11 stated it takes both of them to transfer residents and they do not have time during the day. V11 stated R3 gets changed in the morning and then again after lunch when they can get to R3. V11 states R3's skin is red and very sore and gets skin breakdown.	S9999		

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S9999	Continued From page 26 On 6/27/22 at 8:25 PM, V14, LPN, stated she doesn't feel like there is enough staff. V14 visibly upset describing trying to provide care to residents without enough staff. V14 stated residents are sitting 3-4-5 hours soiled from being incontinent and not being repositioned and are left in bed at times because there isn't enough staff to get them up. On 6/27/22 at 9:20AM, V6 LPN, stated the CNAs work really hard to try and make sure residents don't sit for over 3 hours. V6 stated residents don't get toileted or checked or changed (incontinent residents) until after lunch unless a resident asks. V6 stated residents have to stay in bed sometimes because they don't have enough staff to get them up, and mechanical lift transfers are most often left in bed. V6 stated CNAs don't have time to turn and reposition residents, but they sure do try. On 6/29/22 at 9:15 AM, V3, Resident Care Coordinator/LPN stated R3 does get gaulded (red, raw-looking rash) and has a barrier cream and that usually resolves it. V3 stated she would expect staff to keep R3 clean and dry to prevent skin breakdown and barrier cream to be applied. V3 stated R3 has a known history of explosive diarrhea. V3 stated she was not aware of any open areas to R3's buttock or the 6/24/22 shower sheet that document R3's red/opened area on buttock. 3. R2's Face sheet documents R2 was admitted on 4/6/2018 with a diagnosis of Alzheimer's with Dementia, Type II Diabetes, history of DVT, and morbid obesity. R2's MDS dated 3/28/22 document R2 is mildly	S9999		

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cognitively impaired and is mildly depressed and does not reject care. The MDS further documents R2 requires total dependance of two staff members for bed mobility, transfer, toiletings, and bathing; extensive assistance/physical help of 1 staff member for personal hygiene, uses a wheelchair for mobility, unable to ambulate, and supervision of one staff member for eating. The MDS documents R2 is always incontinent of bowel and bladder. Active diagnoses include need for assistance with personal care. The MDS documents R2 is at risk of developing pressure ulcer/injuries with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications.

R2's Current Braden Scare for Predicting Pressure Ulcer Risk dated 4/14/22 documents R2's linens must be changed at least once a shift, and chairfast.

R2's Current Bowel and Bladder Assessment dated 4/14/22 documents R2 is frequently incontinent both day and night, has dribbling and current medication of Lasix which could affect the resident's continence status. The assessment documents R2 would not benefit from incontinent training program with no explanation of why not and restorative need not marked.

R2's Care Plan dated 7/20/21 documents R2 is morbidly obese and attempt to anticipate needs, Assist of 2 staff members for mechanical lift bearing assist and or mechanical device Place brief on when up, pad on bed, change every 2 hours and as needed when repositioning. Unable to position self without assist of 2 staff. Scheduled repositioning program. Scheduled to be repositioned every 2 hours and as needed to

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S9999	Continued From page 28 maintain comfort, pressure reducing mattress on bed and pressure reducing cushion in chair when up. On 6/27/22 at 10:05 AM R2, states she has to sit in her wheelchair all day and would like to lay down sometime through the day. On 6/27/22 based on intermittent observations of approximately 15-20 minutes from 8:30AM-1:00PM, R2 was up in her wheelchair without being provided incontinent care or checks. At approximately 11:40 AM, R2 was taken to the dining room for lunch and then back out to the television area at approximately 12:15PM where she remained until 1:00 PM when staff laid R2 down. On 6/27/22 at 1:00 PM V7, CNA and V11, CNA transferred R2 to bed using a mechanical lift and provided incontinent care to R2. R2 did not have any pressure reducing device in R2's wheelchair. R2's incontinent brief was heavily saturated with yellow urine. V7 stated R2 is a heavy wetter. R2's buttock, peri area and groin were reddened and heavily creased in multiple areas from mechanical lift sling that R2 was sitting on all day. V11 confirmed R2 was last changed around 8:00 AM. At the completion of care, V7 and V11 did not float R1's heels, apply heel protectors or offer hydration/fluids to R2. 4. R7's Face sheet documents R7 was admitted on 12/8/21 with a diagnosis of dementia with behavior disturbances, impaired mobility, dehydration, Congestive heart failure, history of cellulitis, and Depression Disorder. R7's MDS dated 5/18/22 document R7's cognition is cognitively intact and does not reject care. The	S9999		

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S9999	Continued From page 29 MDS further documents it is "very important" to bedtime. R7's MDS documents R7 requires total dependance of two staff members for bed mobility, transfer, toileting and extensive assistance, impairments on upper and lower extremities, uses a wheelchair for mobility, unable to ambulate. R7's MDS documents R7 is frequently incontinent of bladder. At risk of developing pressure ulcer/injuries with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications. R7's Braden Scale for Predicting Pressure Ulcer Risk dated 4/19/22 documents R7's moistures: very moist with linens must be changed at least once a shift and is chairfast. R7's Bowel and Bladder Assessment dated 4/19/22 documents R7 is incontinent both day and night. R7 would not benefit from incontinent training but does not explain why. R7's Care Plan dated 1/13/2022 documents R7 requires assist of 2 staff for mechanical device: place brief on when up. Pad on bed, change every 2 hours and as needed when repositioning. On 6/27/22 based on intermittent observations of approximately 15-20 minutes from 9:30AM-1:55PM, R7 was up in his wheelchair without being provided incontinent care or checks. At approximately 11:30 AM, R7 was wheeled to the dining room for lunch and then back to hallway at approximately 12:15 PM where she remained until 1:55 PM when staff laid R7 down. On 6/27/22 at 1:55 PM V7 and V11, transferred R7 to bed using a mechanical lift and provided incontinent care to R7. There was no pressure	S9999		

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reducing device in R7's wheelchair or bed. R7's upper thighs had dry skin, and deep creases on buttocks and upper thighs where mechanical lift sling (a sheet used to transport resident in mechanical transfer) had been all day. R7's incontinent brief was wet and a small light discolored area on R7's bilateral buttock of old pressure area was noted. V11 confirmed R7 got up around 9:30 AM and had not been provided incontinence care since before R7 had gotten up. At the completion of care V7 and V11 did not float R7's heels, apply heel protectors or offer hydration/fluids to R7.

5. R6's Face sheet documents R6 was admitted on 7/7/2017 with a diagnosis of weakness, paresthesia, dementia with agitation, benign prostate hyperplasia, dementia, unspecified psychosis, dysphagia, major depression disorder, and Alzheimer's late onset.

R6's MDS dated 4/22/22 document R6 is moderately cognitively impaired and does not reject care. The MDS further documents R6 requires total dependence of two staff members for bed mobility, transfer, toiletings, personal hygiene, and bathing; uses a wheelchair for mobility, unable to ambulate, and total dependence of one staff member for eating. R6's MDS documents R6 has upper and lower extremality impairments and is always incontinent of bowel and bladder. R6's MDS documents R6 has an active diagnosis that includes contractures of right and left elbow and right hip and is at risk for developing pressure ulcer/injuries with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications.

R6's Braden Scare for Predicting Pressure Ulcer

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S9999	Continued From page 31 Risk dated 4/11/22 documents R6's skin is very moist and linens must be changed at least once a shift and chairfast. R6's Bowel and Bladder Assessment dated 4/11/22 documents R6 is incontinent both day and night. The assessment documents R6 would not benefit from incontinent training program with no explanation of why not and restorative need not marked. R6's Care plan dated 7/21/2017 documents R6 has impaired cognition with approach to give resident adequate time to express self and make needs known and anticipate as needed. Dependent for ADL's (Activities of Daily Living)-unable to assist/assist only minimally with approaches to perform ADL's according to resident needs, maintain schedule as able for consistency, anticipate needs to maintain comfort/minimize distress (Pads on bed, change every two hours and as needed when repositioning, attempt to anticipate needs). On 6/27/22 based on intermittent observations of approximately 15-20 minutes from 9:30AM-1:20 PM, R6 was up in his wheelchair without being provided incontinent care or checks. At approximately 11:43 AM, R6 was wheeled to the dining room for lunch and then back to hallway at approximately 12:15PM where he remained until 1:20 PM when staff laid R6 down. On 6/27/22 at 1:20 PM V11, CNA, and V7, CNA, transferred R6 to bed using a mechanical lift and provided incontinent care to R6. There was no pressure reducing device in R6's wheelchair or on R6's bed. R6's incontinent brief was heavily soaked with dark urine with a strong, pungent, foul-smelling odor. V7 stated R6 has dark urine	S9999		

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and stinks. R6 had deep leg creases and were red from where the mechanical lift sling was all day. V7 stated R6 has been up in his tilt back wheelchair since 8AM. At the completion of care V7 and V11 did not float R6's heels, apply heel protectors or offer hydration/fluids when care to R6.

6. R8's Factsheet documents R8 was admitted on 12/23/21 with a diagnosis of depression, diabetes type II, altered mental status, congestive heart failure, cerebral vascular accident (stroke), chronic urinary tract infection and cystitis.

R8's MDS dated 3/16/22 documents R8 is cognitively intact and does not refuse care. The MDS documents R8 requires extensive assistance of one staff member for transferring, toileting, and personal hygiene. The MDS further documents R8 is occasionally incontinent of urine and has a current toileting program in place which has decreased wetness and is at risk for pressure ulcers.

R8's Current Braden Scare for Predicting Pressure Ulcer Risk dated 6/16/22 documents R8's skin as occasionally moist, requiring an extra linen change at least once a day.

R8's Current Bowel and Bladder Assessment dated 6/16/22 documents R8 is incontinent, has dribbling and history of urinary tract infection. The assessment documents R8 would benefit from incontinent training program with no further instruction and restorative need and recommended interventions are left blank.

R8's Infectious Disease Progress note dated 4/14/22 written by V19, R8's Infectious Disease

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S9999	Continued From page 33 Physician, documents: "To reduce the risk of recurring urinary tract infections, both hydration and vaginal health are critical. The ability to flush the urinary tract depends upon adequate hydration and bladder emptying. The ability of the vagina to establish its own flora, with acidification, and resist contamination with bowel flora, protects periurethral areas. To accomplish this, (R8) needs to implement the following plan of care: Implement a voiding schedule to begin in the morning upon awakening, before lunch, before dinner and before bedtime (and otherwise as needed) to encourage flushing of the urinary tract as a defense mechanism to prevent urinary tract infections. Upon completion of voiding, wait 30 seconds and void again for optimize bladder emptying. Hydration as feasible given her medical history. Drink 6-8 glasses of water per day to encourage and flushing of the urinary tract. (R8) reports difficulty with frequent urination, leakage of urine and dysuria." R8's Care Plan, dated 1/5/22 documents "Problem of alteration in bladder elimination as related to incontinent; approach/intervention of pad appropriately for dignity and comfort, toilet and/or change padding and give proper hygiene before/after meals, upon arising, upon request, before retiring for the evening, after napping and as needed. R8's Care Plan was not revised to address the voiding schedule that includes V19's orders/recommendation for waiting 30 seconds and void again to optimize bladder emptying. R8's Care Plan dated 1/5/22 documents: Place brief on when up-check every 2 hours and as needed, change as needed. Pads on bed, change every two hours and as needed when repositioning, attempt to anticipate needs.	S9999		

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S9999	Continued From page 34 The Facility's April 2022 Infection Control and Antimicrobial log documents R8 had a Urinary Tract Infection (UTI) with organism of E. Coli and was treated with Macrobid twice daily from 4/18/22-4/29/22. Nursing Notes dated 6/6/22 documents R8 was found on floor of R8's bathroom holding right shoulder and stated, "I fell trying to go potty." R8's Doctor here and ordered Xray of right shoulder/humorous. New order received for ertapenem (antibiotic) 1gram daily x 10 days for UTI. R8 has been in bed all evening with low grade fever. The Facility's June 2022 Infection Control and Antimicrobial log documents R8 had a UTI with organism of E. Coli and was treated with Ertapenem (antibiotic) IV (intravenously) once daily for 10 days for 10 days from 6/6/22 - date resolved is blank. R8's June 2022 Physician Order Sheet documents and order on 6/6/2022 for Ertapenem 1 gram IV x 10 days, hold doxycycline and clindamycin (both antibiotics) due to restarting on IV antibiotics for UTI. R8's Nurse's Notes dated 6/9/22 documents: ambulance service able to obtain IV access to left hand for antibiotic. R8's Nurse's Note, dated 6/10/22 documents ambulance service placed IV access on 6/9 after multiple failed attempts by nurses, current IV site infiltrated and attempted to restart IV and R8 stating she was in pain. The Nurse's Note documented staff contacted V19, Infectious Disease Physician, and scheduled midline	S9999		

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S9999	Continued From page 35 placement. Contacted three area hospitals and were unable to place, instructed to call vascular surgery for appointment for 6/11/22 for placement. R8's Physician Order Sheet documents an order on 6/11/22 of doxycycline 100 milligrams (mg) twice daily and clindamycin 300 mg by mouth (po) three times a day, continue until midline placed. R8's Nurse's Note, 6/12/22 documents continue to complain of pain to IV sites. R8 complains of burning in peri (external) vaginal area. R8's Nurse's Note dated 6/13/22 documented placing Midline today at 1 PM. R8's June 2022 Medication Administration Record (MAR) documents R8 did not get ordered antibiotic started until 6/9/22 and then missed her scheduled doses on 6/11, 6/12, 6/13, and 6/21/22. The MAR further documents R8 only received one day of the ordered doxycycline 100mg and clindamycin until midline placed on 6/13/22. R8's Final Report of Midline Catheter insertion dated 6/13/22 documents: "Your midline will need some care to keep it clean and working. This care includes changing the dressing, flushing the catheter with fluids and changing the cap on the end of the catheter. Homecare: change the dressing over the site as directed. This is usually once a week. Change it sooner if the dressing gets wet or soiled. Check the dressing daily. Sterile technique must be used for Midline dressing change." R8's June 2022 Treatment Administration Record (TAR) documents: 6/13/22 keep dressing on	S9999		

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	IL6007082	A. BUILDING: _____ B. WING _____	C 08/04/2022

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midline right upper arm dry and intact, check daily for signs and symptoms of infection. Change midline dressing once weekly on Mondays and as needed. Flush midline with 10cc (cubic centimeters) of saline every 12 hours that is crossed out and handwritten "cannot do". The June 2022 TAR is blank and there is no documentation on the June TAR that R8 received any dressing changes or monitoring of her right upper arm midline site.

R8's Current Bowel and Bladder Assessment dated 6/16/22 documents R8 is continent, has dribbling and history of urinary tract infection. The assessment documents R8 would benefit from incontinent training program with no further instruction and restorative need and recommended interventions are left blank.

R8's Nurse's Note, dated 6/22/22 document V19 will not be rechecking u/a (urinalysis) post antibiotic. Midline may be removed.

On 6/28/22 at 9:29 AM, V6, Licensed Practical Nurse (LPN), stated R8 had an IV (intravenous catheter) that kept blowing and then she had to get a PICC (peripherally inserted central catheter). R8 stated "We don't have an RN (Registered Nurse) here to do that, so they had someone coming from another facility, I guess."

R8's Physician Order Sheet documents an order for 6/28/22: may remove midline.

On 6/28/22 at 11:00 AM, V3, LPN, stated she wasn't sure when R8's midline catheter would be discontinued or who would take it out since the facility did not have any RNs on staff. V3 stated she would work on it.

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S9999	Continued From page 37 On 6/29/22 at 9:15 AM, V3 stated R8 has chronic history of urinary tract infections and had Midline catheter inserted for antibiotic treatment for UTI (Urinary Tract Infection). V3 stated R8 sees infectious disease physician for her chronic UTIs. V3 stated R8 toilets frequently and facility tried a toileting program every 2 hours, but it didn't work because R8 toilets too frequently with her urgency and frequent requests to toilet. V3 stated R8 requires 1 assist to toilet and the expectation is to toilet R8 when she requests it. V3 stated R8 is at risk and prone to infection given her history of chronic UTIs. V3 stated R3 has suffered a fall self-transferring to the toilet because of her frequency and urgency. On 6/29/22 at 10:37AM, V2, Assistant Administrator, stated there is no RN coverage for 8 hours a day and there has not been a DON (Director of Nursing) for about the last 2 months. V2 stated to her knowledge they have enough staff, but she doesn't determine staffing needs, the Resident Care Coordinator handles the schedule. V2 stated they are not using agency and haven't requested agency. V2 stated she can't recall the last time a PICC/Midline catheter was in the facility-- not sure when one was in the building and couldn't give a time frame of when the last one was without looking. On 7/5/22 at 9:06 AM, V13, Medical Director, stated he expects residents who are incontinent or need toileting assistance to be done every 1-2 hours and as needed. V13 stated geriatric residents are at an increase for urinary tract infections when incontinent and are not provided care timely. V13 stated if any resident was sent out to the hospital or checked for urinary tract infection, they would most likely have it, but not	S9999		

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everyone is treated and is based upon clinical presentation. V13 stated he could not comment on individual residents' clinical status without looking at their chart. V13 stated he wouldn't know if the facility was short staffed and stated they know to call him if needed.

On 6/27/22 from 9:30 AM-1:30 PM, based on 15-20 minutes observation intervals, R8 was up in her wheelchair without being provided toileting, checks or incontinent care. At approximately 11:30 AM, R8 self-propelled and then staff assisted her to the dining room for lunch and then back to her room at approximately 12:15 PM where she remained until 1:20 PM.

On 6/28/22 at 10:45 AM, R8 stated she needs assistance with toileting and has incontinent episodes at times because she goes frequently and has to wait for staff to change her. When asked about how waiting makes R8 feel, R8 stated " I really don't like it." R8 states she has urinary tract infections frequently and has recently received antibiotics through a midline catheter, which was still intact in R8's upper left arm with a date of 6/13/22 on the dressing. R8 continued and stated she wanted her midline site removed but they don't have anyone who knows how to do it and pointing to her right upper arm midline access. R8 stated its itchy and she has been asking to get it removed and they say they don't have anyone to do it.

On 7/6/22 at 1:30 PM, V11, Certified Nursing Assistant (CNA), stated "We try to take (R8) potty and try our best to keep her dry, but our staffing is just bad-we only have 1 CNA for 2-10PM today." V11 stated she was unaware if there was a toileting program for R8.

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8. R12's Face Sheet dated 11/13/2018 document a diagnoses of heart failure, hypotension, Benign prostatic hyperplasia, renal insufficiency, arthritis, and Alzheimer's Disease.

R12's MDS dated 4/21/22 document R12 is moderately cognitively impaired and requires extensive assistance of 2 staff persons for transfers and toileting. The MDS further documents R12 is frequently incontinent of bowel and bladder, at risk of developing pressure ulcer/injuries with interventions of pressure reducing device for chair and bed, turning and repositioning program, application of ointments/medications.

On 7/7/22 at approximately 6:45 PM, V23, CNA, went to R12's room after V25, Unit Aide, informed V23 that R12 needed to use the bathroom. V12 was in his wheelchair with food particles on his shirt and was visibly soiled. R12's pants were saturated in the peri/groin area. V23 assisted R12 up with no gait belt and put R12 on the toilet. R12's incontinent brief was heavily soiled with urine. V23 stated she has been here since 2:00 PM and R12 had not been out of his wheelchair and provided with care until now.

On 6/27/22 at 9:00AM V5, LPN, states R1, R2, R3, R6, R7, and R8 are incontinent and dependent upon staff and need turned and repositioned at least every 2 hours. V5 stated there are times when residents don't get care sometimes due to not enough staff.

On 6/27/22 at 2:00 PM V11, there isn't enough staff to care for everyone and care gets missed. V11 stated night shift gets residents up before

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S9999	Continued From page 40 breakfast and then we lay them down again after lunch. V11 states there is only 2 of us out on the main hallway for 27 residents and do what we can. V11 states residents are left in soiled incontinent briefs so the residents get red on their bottoms and have skin breakdown/pressure areas and aren't turned and repositioned. On 6/27/22 at 8:30 PM V17 CNA stated residents are getting urinary tract infection symptoms and skin breakdown because of staffing issues. V17 states it's very difficult and we don't have time for everyone needs. On 6/29/22 at 10:37 AM, V2, Administrator in Training stated she was not aware of any residents not being turned and repositioned timely. V2 stated there is not a Director of Nursing in the facility since mid-May. On 6/29/22 at 12:15 PM, V1, Administrator stated he was not aware of any residents not receiving care. V1 stated there is not a Director of Nursing in the facility. On 6/29/22 at 9:15 AM, V3 (Resident care coordinator/LPN) stated she expect interventions to be put in place according to each resident's Care plan. V3 states she was unsure what reposition per program in the Care Plan means but expects residents to be turned and repositioned every 2 hours. On 7/5/22 at 9:06 AM, V13, Medical Doctor/Medical Director stated he would expect residents who need turned and repositioned every 1-2 hours and as needed. The Facility's Policy Decubitus care/Pressure areas dated 5/2007 with revised date of 1/2018	S9999		

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documents "It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. 2.The pressure area will be assessed and documented on the TAR. 3. Complete all areas of the TAR i) document size, stage, site, depth, drainage, color, and treatment 4. Notify physician for treatment orders. 5. Documentation of pressure area, must occur upon identification and at least once weekly on the TAR. 6. Reevaluate the treatment for response at least every 2 -4 weeks. 8. When a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or reoccurring pressure ulcers.

The Facility's Pressure Sore Prevention Guidelines dated 1/2018 documents "It is the facility's policy to provide adequate interventions for prevention of pressure ulcers for residents who are identified as high or moderate risk for skin breakdown as determined by the Braden scale."

The Facility's Policy Turning and Repositioning dated 1/2018 documents "To ensure residents at risk for pressure ulcers are turned and repositioned per the plan of care. Procedure: turning and repositioning will occur as indicated by the resident's plan of care."

The Facility's Policy Preventative Skin Care dated 1/2018 documents "It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying and observation of the resident's skin conditions to keep them clean, comfortable, well-groomed and free from pressure ulcers."

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S9999	Continued From page 42 The Facility's Policy Transcription dated 10/2006 documents "Licensed nurse receiving the physician order should completely transcribe the order before returning the chart to the rack." (A)	S9999		