Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001457	A. BUILDING: ______ B. WING ______	R-C 08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Compliant Investigation: 2263314/IL146316 First Certification Revisit to Complaint Investigation survey of 05/03/2022.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)3) 300.2040b)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	S9999	Attachment A Statement of Licensure Violations	

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

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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, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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S9999	Continued From page 2 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's	S9999		

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comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

2) The diet shall be served as ordered.

Section 300.3240 Abuse and Neglect

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

These Regulations are not met as evidenced by:

Based on record review, observation and interview the facility failed to provide treatment and services to prevent pressure ulcer development, complete skin assessments, and failed to assess for new pressure ulcers, for three (R48, R71, R72) residents. The facility failed to prevent cross contamination during wound care and failed to follow Registered Dietician (RD) recommendations for nutritional support for R48.

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S9999	Continued From page 4 The facility failed to transcribe and complete physician orders for pressure wound treatments for one (R71) resident. These failures resulted in R48 developing a stage 4 sacral ulcer, R71 developing a Stage 3 pressure ulcer on Right Buttock, Stage 3 pressure ulcer on Left Buttock and R72 developing a Suspected Deep Tissue Injury (SDTI) that worsened to a Stage 3 pressure ulcer on Left Lateral Heel. These failures affect three residents (R48, R71, R72) out of seven residents reviewed for Pressure Ulcers in the sample of 27. Findings include: 1.) R48's Skin Only Evaluation dated 4/29/22 documents R48's skin as warm, dry with good turgor and is within normal limits. R48's Nurse Progress Notes dated 4/29/22-7/29/22 did not document any abnormal skin observations. R48's Nurse Progress Notes document the following: On 7/30/22 at 6:21 PM documents "Skin warm and dry, skin color within normal limits (WNL), mucous membranes moist, turgor normal. (R48) has current skin issues. Skin Issue: Discoloration. Skin Issue Location: right bottom heel Length: 2 centimeters (cm), Tissue: Warm." On 7/30/22 at 11:39 PM documents "(R48) noted with Suspected Deep Tissue Injury (SDTI) of right heel noted area discolored. Noted (R48) has Stage Four area to sacrum noted sacrum with discoloration to peri wound with open area with slough at 100% of wound bed noted to left side of sacrum open area with pink wound bed. No odor	S9999		

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S9999	Continued From page 5 noted. Noted moderate serosanguinous drainage from area." R48's undated Face Sheet documents an admission date of 4/29/22. This same Face Sheet documents medical diagnoses of Stage Four Pressure Ulcer of Sacrum, Pressure Induced Deep Tissue Damage of Right Heel, and History of Stage Alzheimer's Disease, Repeated Falls, Bipolar Disease, Muscle Weakness, and Difficulty in Walking. R48's Pressure Ulcer Risk Assessment dated 5/27/22 documents R48 is at risk for Pressure Ulcers. R48's Shower Sheets dated 7/1/22, 7/5/22, 7/7/22, 7/12/22, 7/15/22, 7/29/22 and 7/31/22 do not document any abnormalities of R48's skin. R48's Shower Sheet dated 8/1/22 documents a circle shape over Sacrum area on body picture and notes intervention "treatment in place." R48's Care Plan dated 6/17/22 documents a focus area of "(R48) has potential impairment to skin integrity due to fragile skin." This same Care Plan instructs staff to "monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, and etcetera to Physician." R48's Electronic Medical Record (EMR) documents R48's weight on 4/29/22 as 118.2 pounds (lbs), 7/11/22 as 109.6 lbs and 8/18/22 as 92.8 lbs. R48's EMR documents as of 8/1/22 R48 had 15.3% weight loss from 7/11/22 and 21.5% weight loss from 4/29/22.	S9999		

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S9999	Continued From page 6 R48's Medication Administration Record (MAR) dated August 1-31, 2022, documents skin assessments were completed via staff entering nurse initials with a check mark on 7/21/22, 7/28/22, 8/4/22 and 8/11/22. R48's EMR does not document wound evaluation assessments were completed on 7/21/22 and 7/28/22. R48's EMR does not document any skin only evaluations from 4/30/22 through 7/29/22. V20 Registered Dietician (RD) progress note dated 7/28/22 documents "Reviewed for weight loss since admit and low Basal Metabolic Index (BMI) at 20.5. Goal is 23. Diet is regular and appetite is fair. At risk for weight loss due to progressing Alzheimer's Disease. Will request addition of 2.0 Calorie Nutritional Supplement 90 milliliters (ml) three times per day to provide additional 540 kilo calories (kcal), 25 grams (gms) protein. Skin intact, no wounds noted." R48's Pressure Ulcer Risk Assessment dated 7/30/22 documents R48 is at moderate risk for Pressure Ulcers. R48's Physician Order Sheet (POS) dated July 1-31, 2022, documents a Physician order of skin assessments are to be completed weekly. This same POS documents a Physician order starting on 7/31/22 to cleanse (R48) Stage Four Sacrum Pressure Ulcer with wound cleanser, pat dry, pack cavity and tunnel with one quarter strength bleach solution moistened gauze to the wound bed. Cover with absorbent pad and secure with tape. Change dressing three times per day and as needed for 30 days.	S9999		

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S9999	Continued From page 7 R48's Minimum Data Set (MDS) dated 8/1/22 documents R48 as moderately impaired and requires extensive assistance of two people for bed mobility and extensive assistance of one person for transfers, eating, toileting and personal hygiene. R48's Skin Audit Flow Sheet dated 8/4/22 documents R48's facility acquired Sacrum Stage Four Pressure Ulcer, Left Buttock Stage Two Pressure Ulcer and Right Heel Suspected Deep Tissue Injury (SDTI). R48's Skin Audit Flow Sheet dated 8/11/22 documented R48's Left Buttock Stage Two Pressure Ulcer and Right Heel Suspected Deep Tissue Injury (SDTI) as resolved. On 8/17/22 at 2:30 PM V30 Licensed Practical Nurse (LPN) completed R48's dressing change to Stage Four Pressure Ulcer on Sacrum. V30 LPN did not wash hands prior to dressing change. V30 LPN removed prior moderately soiled dressing, then threw it on the floor next to R48's bed. V30 LPN did not cleanse R48's Stage Four Sacral Pressure Ulcer after removing soiled dressing and prior to applying new dressing. V30 LPN used contaminated gloves to apply new dressing to R48's Stage Four Pressure Ulcer. V30 LPN did not change gloves or perform hand hygiene during entire dressing change. On 8/18/22 at 9:25 AM V2 Director of Nurses (DON) stated R48 has a new facility acquired Stage Four Pressure Ulcer on R48 Sacrum. V2 stated "the facility nurses sign out the weekly skin checks but are not really going to assess the residents. The nurses sit at the desk and click buttons on the computer but do not really do the	S9999		

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S9999	Continued From page 8 skin assessments. There is no reason this wound should just be found at a Stage Four." V2 DON stated the staff are supposed to assess any new reddened areas and if they are not blanchable, then the Physician, Power of Attorney (POA), wound nurse and DON all need notified. V2 stated the nurses are supposed to be filling out a skin only evaluation form with any new pressure area. On 8/18/22 at 9:30 AM V3 Wound Nurse/Licensed Practical Nurse (LPN) stated facility has already completed education with individual nurses and held in services for all nurses regarding the responsibility of the nurse in wound care. V3 stated any new redness should be reported so that the assessments can be completed, treatments put in place, nutritional supplements can be added, and all notifications can be made timely. V3 stated a Weekly Skin Assessment should be completed on every resident. V3 stated "nurses should document the assessment every week whether there is a new skin condition or not. That obviously has not been happening." V3 stated "there is more to it than just putting your initials in a box." V3 stated "In the case of (R48) we (facility) may have avoided (R48)'s Pressure Ulcer becoming a Stage Four if the wound had been reported earlier." On 8/18/22 at 3:15 PM V23 Medical Director stated "This facility caused harm to the patient (R48) by causing the Stage Four Pressure Ulcer to (R48)'s Sacrum. They (staff) should have noticed a wound forming before it gets to be such a detriment to (R48). (R48) Stage Four Pressure Ulcer can get infected by cross contamination during wound care. The nurse (V30) should know to change the gloves	S9999		

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and wash hands. That is basic nursing care and should not happen. If this wound becomes infected, then I will know why.

V23 stated "This weight loss is concerning because I should have been notified and was not. Losing excessive amounts of weight in such a short time frame could be very harmful to most residents, especially (R48) since that would have been almost 20% of (R48)'s weight. The nutritional supplement should have been put in place. I was not notified of Registered Dietician (V20) recommendations for the nutritional supplement for (R48). I would have definitely approved of that recommendation."

On 8/19/22 at 9:45 AM V20 Registered Dietician (RD) stated reviewed R48 for weight loss on 7/28/22 and made recommendation for 2.0 Calorie (Cal) Nutritional Supplement. V20 stated "2.0 Cal has been out of stock, so this facility replaced it with a House Supplement. There are less grams (gm) of protein in the house supplements than the 2.0 Cal but would still help support weight gain." V20 confirmed R48's 15.3 % weight loss from 7/26/22-8/1/22 and 16.4% weight loss from 7/26/22-8/18/22. V20 stated the facility did not notify V20 of (R48)'s weight loss in early August. V20 stated "I would expect to be notified of such a weight loss."

On 8/24/22 at 10:06 AM V4 Wound Physician confirmed a wound care plan is a guide for staff to use to provide cares for each resident and should include information on skin prevention to aide in preventing pressure ulcers. V4 Physician stated R48's Sacral wound should have been noted before deteriorating to a level of Stage 4. V4 stated "(R48)'s Stage 4 Pressure Ulcer did not happen overnight. It is not a Kennedy Ulcer. That

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S9999	Continued From page 10 wound has been growing for a while before staff noticed it. They (staff) should have noticed it when it was a Stage 2 or maybe even a Stage 3." 2.) R71's undated Face Sheet documents an admission date of 5/4/22 and medical diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Diabetes Mellitus Type II, Peripheral Vascular Disease, Iron Deficiency Anemia and Hemiplegia/Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side. R71's Minimum Data Set (MDS) dated 5/13/22 documents R71 is severely cognitively impaired. This same MDS documents extensive assistance of one person for bed mobility, toileting, personal hygiene and dressing. R71's Care Plan does not include a focus area, goal nor interventions for R71 being at risk for pressure ulcers or having acquired pressure ulcers. R71's Skin Only Evaluation dated 5/4/22 documents R71' skin was warm, dry and good turgor. R71's Pressure Ulcer Risk Assessment dated 5/4/22 documents R71 is at risk for developing a pressure ulcer. R71's EMR documents an 8.3% and 13.7% weight loss from 5/4/22-8/5/22 and 5/4/22-8/19/22 and 8/22/22 respectively. R71's Pressure Ulcer Risk Assessment dated 8/4/22 documents R71 is at high risk for developing a pressure ulcer. R71's Skin Only Evaluation dated 8/4/22 documents a new facility acquired Right Buttock Stage Three Pressure Ulcer with serous drainage. R71's Nurse Progress Note dated 8/8/22 at 2:11	S9999		

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S9999	Continued From page 11 PM documents "Stage 2 pressure ulcer on (R71) Sacrum. Cleansed the wound with wound cleanser, patted dry and applied Calcium Alginate and Foam." R71's EMR does not document a skin assessment for R71's facility acquired Stage 2 pressure ulcer on Sacrum. R71's Wound Evaluation and Management Summary Report dated 8/11/22 documents a Stage Three Pressure Ulcer to Right Buttock as resolved. R71's Wound Evaluation and Management Summary Report dated 8/18/22 documents an initial evaluation of R71's Stage Three Pressure Ulcer to Left Buttock and initial evaluation of Stage Two Pressure Ulcer to Right Buttock. R71's EMR does not document a developing pressure ulcer to R71's Left Buttock prior to 8/18/22. R71's Physician Order Sheet (POS) dated August 1-31, 2022, documents a physician order to cleanse Stage 2 Pressure Ulcer on Sacrum, apply Calcium Alginate and foam every shift beginning 8/8/22 and discontinued 8/8/22. This same POS documents a physician order to cleanse R71's Stage 3 Pressure Ulcer on Sacrum, pat dry, apply Calcium Alginate, cover with bordered foam daily starting 8/8/22 and discontinued 8/10/22. This same POS does not document a physician order to treat R71's Right Buttock pressure ulcer. R71's Medication Administration Record (MAR) dated August 1-31, 2022, does not document a physician order nor dressing changes for R71's Right Buttock Stage Three Pressure Ulcer. This same MAR documents a physician order to cleanse R71's Sacrum with wound cleanser, pat dry, apply Calcium Alginate with bordered foam	S9999		

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daily which was only signed out 8/9/22. This same MAR documents a physician order to turn and reposition R71 every one to two hours from side to side or front to back. This same MAR documents R71 was not turned and repositioned every one to two hours on 8/10/22-8/14/22, 8/16/22-8/18/22 and 8/21/22-8/23/22.

On 8/24/22 at 11:08 AM R71 laying on back in bed in room with head of bed at 60-degree angle and foot of bed angled up at 45 degrees. R71's buttocks positioned in lowest middle section of bed. R71 stated "my bottom is so sore."

On 8/24/22 at 12:44 PM V4 Wound Physician and V3 Licensed Practical Nurse (LPN)/Wound Nurse completed dressing change for R71. R71's Left Buttock was open in several small areas in close proximity to one another with moderate serosanguinous drainage noted. Left Buttock peri wound was dark red. R71's Right Buttock had several small and medium dime sized open areas with dark red peri wound and moderate serous drainage. No open areas noted to R71's Sacrum.

On 8/24/22 at 2:00 PM V3 Licensed Practical Nurse (LPN)/Wound Nurse stated R71 should have had a skin care plan in place from admission. V3 stated without a care plan the staff do not know the specifics of a resident's care. V3 confirmed the staff use the care plan to ensure the care provided is resident specific. V3 stated when a resident acquires or admits with a wound, the wound is assessed, notifications should be made to the Physician and Power of Attorney (POA), treatments should be entered into the EMR, and care plan should be updated to reflect resident being at risk for having pressure wounds and for an actual pressure wound. V3 stated "(R71)'s physician orders were never entered into

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	IL6001457	A. BUILDING: ___ B. WING ___	R-C 08/26/2022

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

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the Electronic Medical Record (EMR) and should have been. We (facility) do not have any documentation that the treatments were completed as the physician ordered. That is my fault."

On 8/24/22 at 1:00 PM V4 Wound Physician stated (R71) did have a Stage 3 Sacral Pressure Ulcer two weeks ago that since resolved. V4 stated "(R71) currently has a Stage 3 Right Buttock Pressure Ulcer that deteriorated to larger in size this week and a Stage 3 Left Buttock Pressure Ulcer that improved this week. I am not sure why the orders were not in the computer for (R71's) Right Buttock and Left Buttock, but they should have been entered when I visited the patient (R71)." V4 Wound Physician stated the nurses would not know to change the dressing if the orders were not entered in the Electronic Medical Record (EMR).

On 8/24/22 at 10:15 AM V3 Licensed Practical Nurse (LPN) Wound Nurse stated (R71)'s skin care plan was not entered into care plan. V3 stated "this was my fault. I will get it entered today. (R71) has two separate pressure wounds, one is a Stage 2 on Right Buttock and the other is a Stage 3 on Sacrum. I am a clumsy at typing and sometimes have to put in orders two or three times. That is why there are three orders for the same day for (R71). (R71) has a Stage 2 on Right Buttock that progressed to a Stage 3 and then resolved. The Sacral wound remains. Each wound should have physician orders in place. If the order is not in the Electronic Medical Record (EMR), then that is my fault."

On 8/25/22 at 11:15 AM V3 Licensed Practical Nurse (LPN)/Wound Nurse stated (R71)'s Left Buttock Stage 3 pressure ulcer was not identified

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until 8/18/22. V3 stated "the staff have been interviewed and no one saw anything." V3 stated the staff were unaware of R71's Stage 3 pressure ulcer on Left Buttock. V3 stated R71's Stage 2 Sacral pressure ulcer worsened to a Stage 3 and then resolved when V4 Wound Physician assessed (R71) on 8/11/22. V3 stated a new Right Buttock Stage 2 pressure ulcer then developed and was assessed by V4 Wound Physician on 8/18/22.

3.) R72's undated Face Sheet documents an admission date of 7/14/22, a discharge date of 8/11/22 and medical diagnoses of Dementia without Behavioral Disturbance, Chronic Obstructive Pulmonary Disease (COPD), Iron Deficiency Anemia, Atrial Fibrillation, Combined Systolic and Diastolic Congestive Heart Failure and Spinal Stenosis.

R72's Pressure Ulcer Risk Assessment dated 7/14/22 documents R72 as at risk for developing pressure ulcers.

R72's Skin Only Evaluation dated 7/14/22 documents R72 admitted with a Stage 1 Coccyx pressure ulcer. This same evaluation does not document any further pressure ulcers.

R72's Electronic Medical Record does not document any further skin assessment of R72's Stage 1 Coccyx pressure ulcer.

R72's Minimum Data Set (MDS) dated 7/21/22 documents R72 as severely cognitively impaired and requires extensive assistance of two people for bed mobility and extensive assistance of one person for transfers, personal hygiene, dressing and toileting.

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S9999	Continued From page 15 R72's Nurse Progress Noted dated 7/22/22 at 11:01 AM documents "(R72) was seen by (V37) Nurse Practitioner today. Left Heel noted to be red purplish not open, (R72) verbalized it is painful. Skin prep cover with foam every day. Foam boot while on bed. (V3) Wound care nurse made aware." R72's Nurse Progress Note dated 7/22/22 at 1:09 PM documents "Left Lateral Heel center colored purplish blistery like (1.0 centimeters (cm) x 0.7 cm). Surrounding area 2.5 cm reddish. Wound care nurse notified." R72's Nurse Progress Note dated 8/1/22 at 10:22 AM documents "Noted a purplish discoloration on Right Heel while doing cares." R72's Nurse Progress Note dated 8/2/22 at 11:55 AM documents "(R72) has current skin issues. Skin Issue: Pressure Ulcer / Injury. Skin Issue Location: Left Lateral Heel Pressure Ulcer / Injury Stage: Stage II - Partial thickness skin loss. Length:1.0 centimeter (cm), Width 1.0 cm, Depth:0.1 cm Wound Bed: Epithelial. Wound Exudate: Serous. Peri Wound Condition: within normal limits (WNL). Dressing Saturation: Moderate (26-75%). No wound odor. No tunneling. No undermining. Tissue: Warm. Skin Issue: Pressure Ulcer / Injury. Skin Issue Location: Right Heel Pressure Ulcer / Injury Stage: Suspect Deep Tissue Injury (SDTI) - depth unknown. Length: 1.0-centimeter (cm) Width: 4 cm Depth: not measurable. Wound Bed: Epithelial. Wound Exudate: None. Peri Wound Condition: WNL. Dressing Saturation: None. No wound odor. No tunneling. No undermining. Tissue: Warm." R72's Pressure Ulcer Risk Assessment dated	S9999		

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S9999	Continued From page 16 8/1/22 documents R72 as being high risk for developing pressure ulcers. R72's care plan documents interventions were initiated for a Suspected Deep Tissue Injury (SDTI) of Right Heel and Stage 3 of Left Heel on 8/2/22. This same care plan does not document any interventions for R72's Stage 1 Coccyx pressure ulcer from admission. R72's Wound Evaluation and Management Summary dated 8/4/22 documents R72's initial visit of Right Heel SDTI and Left Heel Stage 3. R72's Wound Evaluation and Management Summary dated 8/11/22 document R72's Right Heel Suspected Deep Tissue Injury (SDTI) had no change. This same report documents R72's Left Heel Pressure Ulcer as a Stage 3. R72's Physician Order Sheet (POS) dated August 1-31, 2022, documents a physician order to cleanse Left Heel with wound cleanser, apply skin prep and foam daily beginning 7/23/22-8/2/22. This same POS documents a physician order to cleanse Left Heel Stage 2 Pressure Ulcer with wound cleanser, pat dry, apply Calcium Alginate to wound, then apply skin prep to peri wound, cover with foam daily from 8/2/22-8/4/22. This same POS documents a physician order to cleanse Left Heel Stage 2 Pressure Ulcer with wound cleanser, pat dry, apply Calcium Alginate to wound, then apply skin prep to peri wound, cover with foam twice per week from 8/4/22-8/8/22. This same POS documents a physician order to cleanse R72's Left Heel Stage 3 Pressure Ulcer with wound cleanser, pat dry, apply Calcium Alginate to wound then apply skin prep to peri wound, cover with foam twice per week and as needed beginning 8/8/22-8/11/22. This same POS documents a physician order to cleanse R72's Left Heel Stage 3 Pressure Ulcer	S9999		

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S9999	Continued From page 17 with wound cleanser, pat dry, apply antibiotic ointment to wound, apply Calcium Alginate to wound then apply skin prep to peri wound, cover with foam twice per week and as needed beginning 8/11/22-9/11/22. R72's Treatment Administration Record (TAR) dated August 1-31, 2022, documents R72's Left Heel Stage 2 Pressure Ulcer dressing change as not being completed on 8/4/22, 8/6/22, 8/7/22, 8/9/22, 8/10/22 and 8/11/22. This same TAR documents R72's Right Heel SDTI dressing was not completed on 8/2/22, 8/3/22, 8/4/22, 8/5/22, 8/7/22, 8/9/22, 8/10/22 and 8/11/22. On 8/24/22 at 3:45 PM V3 Licensed Practical Nurse (LPN) Wound Nurse stated anytime a nurse completes a dressing change for a Pressure Ulcer the treatment should be documented in the Treatment Administration Record (TAR). V3 stated "I do not know why the nurses did not sign out their treatments for (R72). They (staff) might have done the treatment and just forgot to sign them out. I really cannot say and have no documentation that proves those treatments for (R72)'s Left Heel Stage 3 Pressure Ulcer were completed." The facility policy titled 'Wound Treatment' dated 2/2022 documents the following: "Prepatory stage: Wash your hands thoroughly before beginning the procedure. Establish a clean field and place all items to be used during procedure on the clean field. Place disposable cloth or towel next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Apply exam gloves. Loosen tape and remove dressing. Remove gloves and discard into plastic bag, then wash your hands per facility protocol. Apply new disposable gloves and cleans	S9999		

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S9999	Continued From page 18 wound with wound cleanser as ordered by Physician, after that, remove gloves and discard into plastic bag, then wash your hands per facility protocol. Apply new disposable gloves and apply wound treatment." (A)	S9999		